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Medicare Releases Comprehensive Care for Joint Replacement Model

In November of 2015, the *Centers for Medicare & Medicaid Services* (CMS) published a final rule detailing the *Comprehensive Care for Joint Replacement* (CJR) program.[1] In brief, CJR is a bundled payment model that holds hospitals accountable for all of the care associated with hip and knee replacement surgeries, as opposed to only holding hospitals responsible for the cost and quality of the inpatient stay associated with these surgeries.[2] In enacting this program, which is slated to begin on April 1, 2016, CMS is continuing its drive towards value-based care, by offering incentives for providers to reduce spending, and improve the quality and coordination of care for many Medicare beneficiaries.[3] This *Health Capital Topics* article will detail the methodology behind the CJR model as well as explore how the CJR program may impact participating providers.

The CJR program seeks to bundle payments made to providers for major joint replacement services into a single payment. Under the CJR program, CMS will modify the payments made to any hospitals that meet three conditions: (1) hospitals that are reimbursed under the *Inpatient Prospective Payment System* (IPPS); (2) hospitals that discharge Medicare beneficiaries in one of the two *Medical Severity Diagnosis Related Groups* (MS-DRGs) related to major joint replacement or reattachment of a lower extremity (i.e., MS-DRGs 469 and 470); and, (3) hospitals that are located in one of 67 *metropolitan statistical areas* (MSAs) selected by CMS for inclusion in the CJR model.[4] The only hospitals that meet all three of these conditions that are not required to participate in the CJR model are hospitals that are already participating in models 1, 2, or 4 of the *Bundled Payments for Care Improvement* (BCPI) Initiative, a separate CMS bundled payment program.[5] As of November 12, 2015, approximately 800 hospitals across the United States meet all three of these conditions (and are not already participating in the BCPI), and therefore will be included in the CJR model.[6]

The CJR will go into effect on April 1, 2016, and will continue through five *performance years* (PYs), concluding on December 31, 2020 (PY1 is only nine months long, concluding on December 31, 2016).[7] During each of the five PYs, Medicare will pay all relevant providers according to their normal *fee-for-service* (FFS) payment schedules.[8] However, CMS will track all payments on related Medicare claims for items or services rendered during a *CJR episode*, which begins at the admission of Medicare beneficiary in one of the relevant MS-DRGs, and ends 90 days after the discharge of said Medicare beneficiary.[9] At the end of each of the PYs, CMS will compare the actual payments made during CJR episodes to a *target payment*. The target payments are based on a blend of the following: (1) three years of historical data on expenditures for CJR episodes in a specific hospital; and, (2) three years of historical data on expenditures for CJR episodes in other hospitals in the specific hospital's region.[10] Further, the target payments incorporate a 3% discount, which serves as Medicare's savings under the CJR model.[11] If a hospital's actual payments are lower than CMS's target payment for that hospital, then CMS will pay the hospital a *reconciliation payment* equal to the difference.[12] Conversely, if the hospital's actual payments are higher than CMS's target payment for that hospital, then the hospital must repay the difference to CMS.[13] However, for PY1, CMS will not require hospitals to make payments to the Medicare program if actual expenditures exceed target expenditures.[14]

Notably, the payments between hospitals and the Medicare program are subject to a cap. In PYs 1 and 2, payments between hospitals and the Medicare program (whether in the form of reconciliation payments to hospitals from CMS, or payments to the Medicare program from hospitals) are capped at 5% of the target payment.[15] However, in PY1, this cap operates purely as a stop-gain mechanism for hospitals, as hospitals have no downside risk in PY1 of the CJR model.[16] In PY3, this cap on payments between hospitals and the Medicare program rises to 10% of the target payment, and in PYs 4 and 5, the cap rises to 20% of the target payment.[17]

Although hospitals are the primary target of reforms in the CJR program, the bundled payment model is designed to improve care coordination with other, non-hospital providers.[18] Under the CJR program, participant hospitals may contract to share risks and rewards with certain other types of providers, which include, but are not limited to: (1) *skilled nursing facilities* (SNFs); (2) physician and non-physician practitioners; and, (3) long-term care hospitals.[19] In addition to potentially reaping the financial rewards associated with sharing in reconciliation payments or any inherent cost reductions, these associated providers may also be incentivized to collaborate with hospitals

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due to the presence of various waivers of current Medicare program policies for providers who are participating in the CJR.[20] For example, for those providers participating in the CJR, beginning in PY2, CMS will waive the requirement that Medicare beneficiaries must receive at least three consecutive days of inpatient hospital care in order for that beneficiary's subsequent stay in an eligible SNF to be covered under Medicare.[21] Similarly, for post-discharge visits to a CJR beneficiary's home, CMS will waive the *direct* supervision rule for physician services, instead allowing the clinical staff of a physician or a non-physician practitioner to furnish services in a beneficiary's home under a physician's *general* supervision.[22] These waivers of Medicare payment policies may allow providers that are collaborating with CJR participating hospitals to provide services to more beneficiaries, simultaneously improving the beneficiary's access to care and the collaborating provider's revenue. However, in order to ensure that quality of care is maintained, these Medicare program waivers are subject to certain restraints. For example, in order to be eligible for waiver of the SNF three-day rule, beneficiaries must be discharged to an SNF with a rating of at least three stars on the CMS *Nursing Home Compare* website.[23]

Participating hospitals should note that the hospital, not the collaborating provider, is ultimately responsible for expenditures in CJR episodes of care as well as for the regulatory compliance of other providers with which the participant hospitals collaborate.[24] Further, under the CJR model, participant hospitals must retain at least 50% of the downside risk of repayments to the Medicare program (resulting from actual expenditures in excess of target expenditures), and participant hospitals may not assign more than 25% of their repayment responsibility to any one provider or supplier.[25]

In addition to reducing costs, the CJR model also includes provider incentives that seek to improve the quality of care for Medicare beneficiaries undergoing hip or knee replacement surgery. In order to receive *reconciliation payments* for reducing actual expenditures below target expenditures, participant hospitals must earn sufficiently high composite quality scores.[26] These composite quality scores are calculated using quality metrics related to both patient satisfaction and complications in hip and knee replacement surgeries.[27] Hospitals may also voluntarily submit data pertaining to patient-reported outcomes of total hip and knee replacement surgeries, the *submission* of which will improve a hospital's composite quality score (i.e., this provision incentivizes hospitals for reporting, not for performance).[28] In addition to *reconciliation payments*, participant hospitals with high composite quality scores may be eligible for a quality incentive payment, which takes the form of a reduced discount related to the calculation of the participant hospital's target payments (typically at 3%).[29] Based on their composite quality scores, participant hospitals may be rated as *below acceptable*, *acceptable*, *good*, or *excellent*.[30] After rating the participant hospitals based on their composite quality scores, CMS will: (1) make *reconciliation payments* to those participant hospitals with a quality rating of as at least *acceptable*; (2) reduce the discounts for hospitals with a quality rating of *good* by 1% (for an effective discount of 2%); and, (3) reduce the discounts for hospitals with a quality rating of *excellent* by 1.5% (for an effective discount of 1.5%).[31]

The CJR model serves as yet another step in CMS's continued efforts to improve the value of the healthcare services provided to Medicare beneficiaries. The CJR model's bundled payment methodology, which incorporates both regional trends and inherent discounts on historical expenditures, encourages providers to control costs.[32] Further, the use of quality metrics, both as a source of inherent bonus payments and as a determining factor in eligibility for *reconciliation payments*, encourages providers to furnish high quality care.[33] In addition, under the CJR model, CMS will offer providers valuable tools to improve the coordination of care, including spending and utilization data, Medicare policy waivers, and programs to disseminate best practices among providers.[34] If the CJR payment model is able to effectively control costs and improve the quality of care, it may serve as a foundation for other, perhaps broader, bundled payment programs, thus continuing the trend towards paying for value instead of volume in healthcare.

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1 "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" Federal Register Vol. 80, No. 226 (November 24, 2015), p. 73274.

2 "CMS Finalizes Bundled Payment Initiative for Hip and Knee Replacements" U.S. Department of Health and Human Services, November 16, 2015, http://www.hhs.gov/about/news/2015/11/16/cms-finalizes-bundled-payment-initiative-hip-and-knee-replacements.html (Accessed 12/1/2015).

3 *Ibid*.

4 "Comprehensive Care for Joint Replacement (CJR) Model: Provider and Technical Fact Sheet" Centers for Medicare & Medicaid Services, https://innovation.cms.gov/Files/fact-sheet/cjr-providerfs-finalrule.pdf (Accessed 12/1/2015), p. 1-2.

5 *Ibid*, p. 3.

6 "Comprehensive Care for Joint Replacement (CJR) Model: Frequently Asked Questions" Centers for Medicare & Medicaid Services, https://innovation.cms.gov/Files/x/cjr-faq.pdf (Accessed 12/1/2015), p. 3.

7 "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" Federal Register, November 24, 2015, p. 73276, 73280.

8 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services, https://innovation.cms.gov/Files/slides/cjr-finalruleintro-slides.pdf (Accessed 12/1/2015), p. 15.

9 "Comprehensive Care for Joint Replacement Model" Centers for Medicare & Medicaid Services, https://innovation.cms.gov/initiatives/cjr (Accessed 12/1/2015).

10 "Comprehensive Care for Joint Replacement (CJR) Model: Provider and Technical Fact Sheet" Centers for Medicare & Medicaid Services, p. 4.

11 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services, p. 16.

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13 *Ibid*.
14 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services, p. 15.
15 "Comprehensive Care for Joint Replacement (CJR) Model: Provider and Technical Fact Sheet" Centers for Medicare & Medicaid Services, p. 4-5.
16 *Ibid*.
17 *Ibid*.
18 "CMS Finalizes Bundled Payment Initiative for Hip and Knee Replacements" U.S. Department of Health and Human Services, November 16, 2015, http://www.hhs.gov/about/news/2015/11/16/cms-finalizes-bundled-payment-initiative-hip-and-knee-replacements.html (Accessed 12/1/2015).
19 "Comprehensive Care for Joint Replacement (CJR) Model: Frequently Asked Questions" p. 6.
20 "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" Federal Register, November 24, 2015, p. 73437-39.
21 *Ibid*, p. 73455, 73460.
22 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services, p. 28.
23 *Ibid*.
24 "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" Federal Register, November 24, 2015, p. 73281-73282.
25 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services, p. 25.
26 "Comprehensive Care for Joint Replacement (CJR) Model: Frequently Asked Questions" Centers for Medicare & Medicaid Services, p. 5.
27 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services, p. 8; "Comprehensive Care for Joint Replacement (CJR) Model: Frequently Asked Questions" Centers for Medicare & Medicaid Services, p. 1.
28 "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" Federal Register, November 24, 2015, p. 73376.
29 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services, p. 16-18.
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31 "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" Federal Register, November 24, 2015, p. 73377-73378.
32 "Comprehensive Care for Joint Replacement (CJR) Model: Frequently Asked Questions" Centers for Medicare & Medicaid Services, p. 2, 5.
33 *Ibid*.
34 "Comprehensive Care for Joint Replacement (CJR) Model: Provider and Technical Fact Sheet" Centers for Medicare & Medicaid Services, p. 5-6.

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