MODEL OVERVIEW

The Comprehensive Care for Joint Replacement (CJR) model is a five year model that launched on April 1, 2016 and tests whether a mandatory episode based payment approach for lower extremity joint replacement (LEJR) can lower payments while maintaining or improving quality. CJR participant hospitals are financially accountable for the cost and quality of health care services for an LEJR episode of care, which begins with the hospitalization for the surgery and extends for 90 days after the hospital stay. Actual episode payments are compared to the hospital’s quality-adjusted target price. Hospitals can earn money if episode payments are below their target price and, starting in 2017, hospitals with episode payments above their target price repay Medicare. Beginning in year 3, hospitals in 34 selected geographic areas with the highest historical spending were required to continue in the model. This report focuses on model performance across three years in these “always mandatory” areas.

PARTICIPANTS

Medicare began covering total knee replacements performed in the hospital outpatient department in 2018, the third year of the CJR model.

Mandatory CJR hospitals shifted a lower proportion of knee replacement surgeries to the outpatient department than control group hospitals (19% vs 29%).

HOSPITAL STRATEGIES

Interviewees from CJR hospitals indicated they engaged interdisciplinary teams to coordinate care for LEJR patients.

Financial arrangements between hospitals and surgeons and the availability of surgeons in the market influenced hospitals’ ability to control care redesign.

Some non-CJR hospitals received information about the CJR model, as well as strategies and best practices in care redesign, from their health system, which included CJR participant hospitals.

“CJR has taken us from working in silos…to looking at the bigger picture of pre-op and post-discharge.”
- Hospital Interviewee

“Surgeons at this hospital are employed by the hospital, but are also owners so they do have incentives to make sure that they lower their cost.”
- Hospital Interviewee

“Even though we’re not [in CJR], we kind of act like we are. That way, if and when we [join CJR], it would be an easy transition because we’re already doing it.”
- Interviewee from non-CJR hospital

This document summarizes the evaluation report prepared by an independent contractor. For more information about this model and to download the 3rd annual evaluation report, visit https://innovation.cms.gov/initiatives/cjr.
KEY TAKEAWAYS

During the first three years of the model, mandatory CJR hospitals achieved a statistically significant decrease in average payments for all LEJRs (inpatient and outpatient) relative to the control group. After accounting for net reconciliation payments, estimated net savings for these LEJRs was $61.6 million (a savings of 2% of the baseline). The gross reduction in payments was due to decreases in institutional post-acute care use. Measures of quality of care improved or were maintained under the CJR model. Hospital interviewees reported strategies to coordinate care throughout the episode, however the amount of control hospitals had over care redesign was influenced by hospital resources and market conditions.