

## **Comprehensive Care for Joint Replacement (CJR) Model Provider and Technical Fact Sheet**

On November 16, 2015, the Centers for Medicare & Medicaid Services (CMS) finalized regulations implementing the Comprehensive Care for Joint Replacement (CJR) Model to further our goals of improving the efficiency and quality of care for Medicare beneficiaries and to encourage hospitals, physicians, and post-acute care providers to work together to improve the coordination of care from the initial hospitalization through recovery.

The CJR model is a Medicare Part A and B payment model implemented under section 1115A of the Social Security Act, in which acute care hospitals in certain selected geographic areas receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity (collectively referred to as LEJR). All related care within 90 days of hospital discharge from the LEJR procedure is included in the episode of care. The first performance period began on April 1, 2016.

On December 1, 2017, CMS finalized a final rule and interim final rule with comment period in the Federal Register (<https://www.federalregister.gov/public-inspection/current>), which implemented several changes to the CJR model for performance years three through five.

### **Overall Model Design**

The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers. A CJR episode is defined by the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the Inpatient Prospective Payment System (IPPS) that eventually results in a discharge paid under MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities).

The episode of care continues for 90 days following discharge. Part A and Part B services related to the CJR episode are included in the episode. For each performance year of this model, CMS sets Medicare episode prices for each participant hospital that include payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who have LEJR procedures at that hospital. All providers and suppliers continue to be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year. Following the end of a model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) is compared to the Medicare episode price for the participant hospital where the beneficiary had the initial LEJR surgery. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.

## General Model Overview

### Participants

The CJR model has been implemented in 67 geographic areas, defined by MSAs. MSAs are counties associated with a core urban area that has a population of at least 50,000. Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection. Eligible MSAs had to have at least 400 eligible (not included in the BPCI initiative) cases between July 2013 and June 2014, and they could not have more than 50 percent of otherwise qualifying LEJR procedures occurring in a Maryland hospital, hospital participating in BPCI, or receiving post-acute care services at a skilled nursing facility (SNF) or home health agency (HHA) participating in BPCI. Hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) and located in the 67 selected MSAs, with few exceptions, were required to participate in the model for the first 2 performance years. As of February 1, 2018, 34 of the 67 areas remain mandatory participation areas and all hospitals, except low volume or rural hospitals, in those areas are required to participate. CJR participant hospitals in the 33 voluntary areas, along with those hospitals in all 67 areas identified as low-volume or rural, were given a one-time opportunity during January of 2018 to voluntarily opt-in to the CJR model for the remainder of the model. The list of CJR participant hospitals is available on the CJR webpage: <https://innovation.cms.gov/initiatives/cjr>.

### **PARTICIPATION REQUIREMENTS FOR HOSPITALS IN THE CJR MODEL**

	<b>REQUIRED TO PARTICIPATE AS OF FEBRUARY 1, 2018</b>	<b>MAY ELECT VOLUNTARY PARTICIPATION</b>	<b>PARTICIPATION ELECTION PERIOD</b>	<b>ELECTION EFFECTIVE DATE</b>
<b>Mandatory Participation MSAs</b>				
All IPPS participant hospitals, except rural and low-volume*	Yes	No	N/A	N/A
Rural hospitals *	No	Yes	1/1/2018-1/31/2018	2/1/2018
Low-volume hospitals	No	Yes	1/1/2018-1/31/2018	2/1/2018
<b>Voluntary Participation MSAs</b>				
All IPPS participant hospitals	No	Yes	1/1/2018-1/31/2018	2/1/2018

\*Note: Participation requirements are based on the CCN status of the hospital as of January 31, 2018. A change in rural status after the voluntary election period does not affect the participation requirements.

#### Participation Election Timing

Hospitals located in a voluntary MSA, or those identified as low-volume or rural, were able to voluntarily elect continued participation in the model by submitting an opt-in letter during the one-time participation election period from January 1, 2018 to January 31, 2018. The opt-in letter acts as a participation agreement for the model and the requirements for opting into the CJR model are codified at 42 CFR 510.115.

#### Episode definition

The episode of care begins with an admission to a participant hospital of a beneficiary who is ultimately discharged under MS-DRG 469 or 470 and ends 90 days post-discharge in order to cover the complete period of recovery for beneficiaries. The episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with the exception of certain exclusions. The following categories of items and services are included in the episodes: physicians' services; inpatient hospital services (including hospital readmissions); inpatient psychiatric facility (IPF) services; long-term care hospital (LTCH) services; inpatient rehabilitation facility (IRF) services; skilled nursing facility (SNF) services; home health agency (HHA) services; hospital outpatient services; outpatient therapy services; clinical laboratory services; durable medical equipment (DME); Part B drugs; hospice; and some per beneficiary per month (PBPM) care management payments under models tested under section 1115A of the Social Security Act. Unrelated services are excluded from the episode. Unrelated services are for acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of LEJR surgery; and chronic conditions that are generally not affected by the LEJR procedure or post-surgical care. The complete list of exclusions can be found on our website at <https://innovation.cms.gov/initiatives/cjr>, accompanied by the list of excluded MS-DRGs and ICD-10-CM diagnosis codes.

#### Pricing and payment

The CJR model is a retrospective bundled payment model. CMS provides participant hospitals with Medicare episode prices, called the target prices, prior to the start of each performance year. Target prices for episodes anchored by MS-DRG 469 vs. MS-DRG 470 and for episodes with hip fractures vs. without hip fractures are provided to participant hospitals each year. The target price generally includes a discount over expected episode spending and incorporates a blend of historical hospital-specific spending and regional spending for LEJR episodes, with the regional component of the blend increasing over time. All providers and suppliers furnishing LEJR episodes of care to beneficiaries throughout the year are paid under existing Medicare payment systems.

Following completion of a CJR model performance year, participant hospitals that achieve LEJR actual episode spending below the target price and achieve a minimum composite quality score

are eligible to earn a reconciliation payment from Medicare for the difference between the target price and actual episode spending, up to a specified cap.

All hospital participants that achieve LEJR actual spending below the target price and achieve a minimum composite quality score are eligible to earn up to 5 percent of their target price in performance years 1 and 2, 10 percent in performance year 3, and 20 percent in performance years 4 and 5. Hospitals with LEJR episode spending that exceeds the target price are financially responsible for the difference to Medicare up to a specified repayment limit. The stop-loss limits are 5 percent in performance year 2, 10 percent in performance year 3, and 20 percent in performance years 4 and 5 for participant hospitals other than rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals. (These providers have stop-loss limits of 3 percent in performance year 2 and 5 percent in performance years 3 through 5.) We have implemented a parallel approach for the stop-gain limits to provide proportionately similar protections to CMS and hospital participants, as well as to protect the health of beneficiaries. We believe it is appropriate that as participant hospitals increase their financial responsibility, they can similarly increase their opportunity for additional payments under this model. We also believe that these changes facilitate participants' ability to be successful under this model and allow for a more gradual transition to financial responsibility under the model.

*Additional flexibilities for participant hospitals and collaborating providers and suppliers*

The model waives certain existing payment system requirements to assist participant hospitals in caring for beneficiaries in the most efficient, convenient setting, to encourage timely, accessible care, and to facilitate improved communication and treatment adherence. These include: a waiver of the requirement for a three-day inpatient hospital stay prior to admission for a covered SNF stay under certain conditions; allowing payment for certain physician visits to a beneficiary in his or her home via telehealth; and allowing payment for certain types of physician-directed home visits for non-homebound beneficiaries. In addition, a participant hospital may wish to enter into certain financial arrangements with collaborating providers and suppliers who are engaged in care redesign with the hospital and who furnish services to the beneficiary during an episode. Under these arrangements, a participant hospital may share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating providers and suppliers, subject to parameters outlined in the rule. Participant hospitals may also share financial accountability for increased episode spending with collaborating providers and suppliers. Finally, participant hospitals may provide beneficiaries with certain incentives to advance the clinical goals of their care, under certain conditions.

No waivers of any fraud and abuse authorities were issued in the CJR final rules. However, CMS and HHS Office of the Inspector General (OIG) have jointly issued waivers of certain fraud and abuse laws for purposes of testing this model. The fraud and abuse waiver notice is published on the CMS and OIG websites and can be accessed via this link:

<https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html>.

### *Quality and the Pay-for-Performance Methodology*

The CJR model has the potential to improve quality in four ways. First, the model adopts a quality first principle where hospitals must achieve a minimum level of episode quality before receiving reconciliation payments when episode spending is below the target price. Second, higher episode quality, considering both performance and improvement, may lead a hospital to receive a higher reconciliation payment or have less repayment responsibility at reconciliation based on the hospital's composite quality score, a summary score reflecting hospital performance and improvement on the following two measures:

- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF#1550); and
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF#0166).

The composite quality score also takes into consideration a hospital's submission of THA/TKA patient-reported outcomes and limited risk variable voluntary data.

Third, in addition to quality performance requirements, the model incentivizes hospitals to avoid expensive and harmful events, which increase episode spending and reduce the opportunity for reconciliation payments.

Fourth, CMS provides additional tools to improve the effectiveness of care coordination by participant hospitals in selected MSAs. These tools include: 1) providing hospitals with relevant spending and utilization data; 2) waiving certain Medicare requirements to encourage flexibility in the delivery of care; and 3) facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.

More information on quality in the pay-for-performance methodology can be found on our website at <https://innovation.cms.gov/initiatives/cjr>.

### Beneficiary benefits and protections

Medicare beneficiaries retain their freedom to choose their providers and services, and providers may continue to provide any medically necessary covered services. As stated in the CJR final rule, each participant hospital must provide written notice to any Medicare beneficiary that meets the criteria in § 510.205 of his or her inclusion in the CJR model. The participant hospital and any CJR collaborator must provide the CJR beneficiary with notification. Physicians and hospitals are expected to continue to meet current standards required by the Medicare program. All existing safeguards to protect beneficiaries and patients remain in place. If a beneficiary believes that his or her care is adversely affected, he or she should call 1-800-MEDICARE or contact their state's Quality Improvement Organization. CMS will also conduct additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services.

### Interaction with other models and programs

Hospitals participating in other CMS models or programs such as the Shared Savings Program and other ACO initiatives are included in the CJR model if they are located in a selected MSA. Beneficiaries included in an LEJR episode under the CJR model may also be assigned or aligned to an ACO. We note that for episodes beginning on or after July 1, 2017, CJR episodes are not initiated for beneficiaries who are prospectively aligned with 1) a Next Generation ACO, 2) an ESRD Seamless Care Organization (ESCO), or 3) a Medicare Shared Savings Program ACO participating in Track 3.

### CJR Participant Hospital CEHRT Track

Track 1 of the CJR model is an Advanced APM and the participation of eligible clinicians in track 1 will be considered in the determination of eligibility for an APM incentive payment. Track 2 of this model is an APM, but does not meet the Advanced APM criteria in the Quality Payment Program. To be an Advanced APM, an APM must meet the following three criteria:

- Require participants to use certified electronic health record technology (CEHRT);
- Provide payment for covered professional services based on quality measures comparable to those used in the Merit-based Incentive Payment System (MIPS) quality performance category; and
- Require participating APM Entities to bear a more than nominal amount of financial risk.

### Interim Final Rule Regarding Significant Hardship due to Extreme and Uncontrollable Circumstances in the CJR Model

We issued an interim final rule with comment period in conjunction with the December 2017 final rule in order to address the need for a policy to provide some flexibility in the determination of episode costs for CJR hospitals located in areas impacted by extreme and uncontrollable circumstances. Specifically, this policy is designed to apply to CJR hospitals

located in areas for which a waiver under section 1135 of the Social Security Act has been invoked by the Secretary of Health and Human Services (the Secretary) if those CJR hospitals are also located in a county, parish, U.S. territory, or tribal government designated as a major disaster area under the Stafford Act. For performance years 2 through 5, for participant hospitals that are located in an emergency area during an emergency period (as those terms are defined in section 1135(g) of the Social Security Act), for which the Secretary has issued a waiver under section 1135, and are located in a county, parish, U.S. territory or tribal government designated as major disaster areas under the Stafford Act, the following policies apply for all CJR Model episodes. For non-fracture episodes with a date of admission to the anchor hospitalization on or within 30 days before the date that the emergency period (as defined in section 1135(g)) begins, actual episode payments are capped at the target price determined for those episodes under §510.300. For fracture episodes with a date of admission to the anchor hospitalization on or within 30 days before or after the date that the emergency period (as defined in section 1135(g)) begins, actual episode payments are capped at the target price determined under §510.300. Comment on this policy was sought through January 31, 2018.

#### *Innovation Center*

The CJR model was designed and is being managed by the Center for Medicare and Medicaid Innovation (Innovation Center), which was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center to test innovative payment and service delivery models to reduce CMS program expenditures and improve quality for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries.

The original CJR model final rule can be viewed at <https://www.federalregister.gov>.

The full text of the December 2017 CJR final rule and interim final rule with comment is available here: <https://www.federalregister.gov/documents/2017/12/01/2017-25979/medicare-program-cancellation-of-advancing-care-coordination-through-episode-payment-and-cardiac>. This rule contains updated CJR model parameters as well as increased flexibility in determination of episode costs for participant hospitals located in areas impacted by extreme and uncontrollable circumstances.

For more information about the CJR Model, go to:

<https://innovation.cms.gov/initiatives/CJR>.

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