



Comprehensive Care for Joint Replacement Model Provider and Technical Fact Sheet

July 9, 2015

The Centers for Medicare & Medicaid Services (CMS) is proposing, through the notice and comment rulemaking process, a new model to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model, called the Comprehensive Care for Joint Replacement (CCJR) Model, would test bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. With publication of this proposed rule, CMS is seeking input and comments from the public, including beneficiaries, health care providers, and other stakeholders.

Model Design Features

Overall design

The proposed CCJR Model would hold participant hospitals financially accountable for the quality and cost of a CCJR episode of care and incentivize increased coordination of care among hospitals, physicians, and post-acute care providers. A LEJR episode would be 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 would continue for 90 days following discharge. Part A and Part B services related to the LEJR episode would be included in the episode. Every year during the five performance years of this demonstration, the model would set Medicare episode prices for each participant hospital that includes payment for all related services received by eligible Medicare fee-for-service beneficiaries who have LEJR procedures at that hospital. All providers and suppliers would 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) would be compared to the Medicare episode price for the responsible hospital. 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.

Participants

CMS has proposed to implement the proposed CCJR model in 75 geographic areas, defined by metropolitan statistical areas (MSAs). By definition, 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 must have had at least 400 eligible LEJR cases in between July 2013 and June 2014, of which no more than 50% occurred in a Maryland hospital or a hospital participating in the Bundled Payment for Care Improvement (BPCI) initiative for LEJR episodes. Among the eligible MSAs, the participant MSAs proposed in this rule were selected using a two-step stratified, randomization process. First, MSAs were placed into eight groups based on average wage-adjusted historic LEJR episode payment quartiles and the MSA population size divided at the median. Second, MSAs were randomly selected within each group using a selection percentage within each payment quartile (30% for lowest payment quartile to 45% for highest payment quartile). A list of the proposed MSAs can be found on our website. Participants in these selected geographic areas would be all acute care hospitals paid under the IPPS that are not currently participating in Model 1 or Phase II of Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes.

Episode definition

The model proposes that CCJR episodes begin with an admission discharged under MS-DRG 469 or 470 and end 90 days post-discharge in order to cover the complete period of recovery for beneficiaries. The episode would include 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 would be included in the CCJR episodes: physicians' services; inpatient hospital services (including 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; independent outpatient therapy services; clinical laboratory services; durable medical equipment (DME); Part B drugs; and hospice. Unrelated services would be excluded from the episode costs. Unrelated services are: 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 proposed exclusions can be found on our website.

Pricing and payment

The proposed CCJR Model is a retrospective bundled payment model. CMS intends to provide participant hospitals with Medicare episode prices, called the target prices, prior to the start of each performance year. The target price generally would include a 2% discount over expected episode spending and incorporate 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 episode care to beneficiaries throughout the year would be paid under existing Medicare payment systems. Following completion of a model performance year, participant hospitals that achieve LEJR actual episode spending below the target price and meet quality performance thresholds on three required quality measures would be eligible to earn a reconciliation payment from Medicare for the difference between the target price and actual episode spending, up to a specified cap. Hospitals with LEJR episode spending

that exceeds the target price would be financially responsible for the difference to Medicare up to a specified repayment limit. This repayment responsibility would be phased-in during performance year two of the model, and the repayment amount limit would increase in year three of the model.

Quality

The proposed CCJR model has the potential to improve quality in three ways. First, the model adopts a quality first principle where participant hospitals would be required to achieve quality performance requirements on three measures before they are eligible to receive reconciliation payments. These measures are:

- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550);
- Hospital-Level 30-day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551); and
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (NQF #0166) Survey.

Second, quality performance requirements for reconciliation payment eligibility would increase over the lifetime of the model in order to incentivize continuous improvement on these measures. CCJR Model participant hospitals would have an additional opportunity to have reconciliation payments adjusted annually if they successfully submit complete data on a patient-reported functional outcome measure, Hospital-Level Performance Measure(s) of Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty, beginning in performance year 1.

Third, in addition to quality performance requirements, the model would also incentivize hospitals to avoid expensive and harmful events, such as complications and readmissions, which increase episode spending and reduce the opportunity for reconciliation payments.

CMS would provide additional tools to improve the effectiveness of care coordination by participant hospitals in selected MSAs. Proposed 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.

Additional flexibilities for participant hospitals and collaborating providers and suppliers

The model proposes to waive certain existing payment system requirements to assist participant hospitals in caring for beneficiaries in the most cost-effective, convenient setting and to encourage timely, accessible care and facilitate improved communication and treatment adherence. These include: a proposed 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 a CCJR episode. Under these arrangements, a participant hospital might 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 proposed rule. Participant hospitals might also share financial accountability for increased episode spending with collaborating providers and suppliers.

Beneficiary benefits and protections

Beneficiaries would retain their freedom of choice to choose services and providers. Physicians and hospitals would be expected to continue to meet current standards required by the Medicare program. All existing safeguards to protect beneficiaries and patients would 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 by going to <http://www.qioprogram.org/contact-zones>. The proposed rule also describes additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services.

Joining the model

Except for those participating in Model 1 or Phase II of Models 2 or 4 of the BPCI initiative for LEJR episodes, hospitals paid under the IPPS and physically located in MSAs selected for participation would be required to participate in the proposed CCJR model. Hospitals outside these geographic areas would not be able to participate. There is no application process for this model.

Innovation Center

The proposed CCJR Model has been designed 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 CMS beneficiaries.

You can read the proposed rule in the Federal Register at <https://www.federalregister.gov/public-inspection> and can be viewed at <https://www.federalregister.gov> starting July 14, 2015.

We encourage all interested parties to submit comments electronically through the CMS e-Regulation website at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking> or on paper by following the instructions included in the proposed rule. Submissions must be received by September 8, 2015.

In addition, CMS will be holding a webinar to discuss the contents of this proposed rule.

For more information, visit: <http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-09.html>

Additional information can be found at: <http://innovation.cms.gov/initiatives/ccjr/>