Adapt.

Understanding the Comprehensive Care for Joint Replacement (CJR) Model from CMS

KEY POINTS:

- Mandatory retrospective bundled payment model for lower extremity joint replacement (LEJR)*
- The CJR episode of care includes all Medicare Part A and B services for LEJR procedures during the "anchor" inpatient admission, a 3-day pre-admission payment window, and extends to 90-days post-discharge for MS-DRGs 469 and 470
- Fee-for-service usual payments for all parties, then retrospective reconciliation to episode target price
- Hospitals in 67 metropolitan statistical areas (MSAs) are included. Visit https://innovation.cms.gov/initiatives/cjr for the list
- Hospital participants are responsible for the bundle and financial risks; however, gain-sharing is permitted
- Begins April 1, 2016 and concludes December 31, 2020
- Positive financial reconciliation is dependent on meeting quality measurements such as complication rate, readmissions and patient satisfaction
- Facilities participating in BPCI model 1 or Phase II of models 2 or 4 for LEJR episodes are exempt

The final rule on the Comprehensive Care for Joint Replacement model was released by the Centers for Medicare and Medicaid Services (CMS) on November 12, 2015. Its overarching goal is to promote better quality and financial accountability for episodes of care surrounding a LEJR. These procedures were selected specifically because they represent high-expenditure, high utilization procedures commonly furnished to Medicare beneficiaries, and because there is a large disparity in expenditures among providers of these procedures across US Census Divisions. Beginning in specified geographies, the model will test whether bundled payments to acute care hospitals for CJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

Similar to Medicare's voluntary Bundled Payments for Care Improvement (BPCI) initiative that was instituted in 2013, the goal of the CJR model is to provide a financial incentive to hospitals that proactively work with physicians, home health agencies, skilled nursing facilities and other healthcare providers to ensure beneficiaries receive optimal coordinated care throughout a CJR episode of care. This episode is inclusive of all related items and services paid currently under Medicare Part A and B, with some exclusions defined. This alternative payment model will contribute to goals set forth by the administration of having 30% of all Medicare fee-for-service payments made through alternative payment models by 2016 and 50% by 2018.

The first performance period of the CJR model begins on April 1, 2016. Approximately 800 hospitals are required to participate in the model in 67 identified MSAs, each with a core urban area population of at least 50,000. The list can be accessed here: https://innovation.cms.gov/initiatives/cjr.

The first performance year ends December 31, 2016, while the remaining performance years are a full 12 months. Under the CJR model hospitals are considered participants and are directly regulated by the CMS. As such, each hospital participant is entirely responsible for ensuring its compliance, and the compliance of its collaborators, with CJR rules and regulations.

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* Note that while the CJR initiative is often described as a hip/knee replacement model, these MS-DRGs also include total ankle replacement, partial hip replacement and hip resurfacing, and certain reattachment cases that may involve different resources than total hip and total knee replacement alone.

According to the model, a hospital must always retain a minimum of 50% of the total financial risk, and collaborators can account for no more than 25% of the repayment amount.

The CJR model represents a full financial risk bundled-payment approach for participants. Under the model, hospitals can achieve financial gain when they provide quality, patient-centered care at a lower cost than the adjusted episode target price. Hospitals are held liable for repayment of cost overruns to CMS if they surpass the adjusted episode target price. Episode target price is determined by a two to one "blend" in years one and two of an individual hospital's and its region's specific three year historical episode expenditures for the included MS-DRGs by years four and five. It will be exclusively the regions' historical expenditures. These will be updated at least twice per year and are further modified for patients with hip fractures.

To help mitigate losses, CMS has implemented a stop-loss limit. CMS has also implemented an associated stop-gain limit. Stop-gain limits will be implemented beginning in year one, and stop-loss limits will be implemented beginning in year two so participating hospitals will have no downside risk in 2016. These limits are to be set at 5% of the target price in performance years one and two, 10% of the target price in performance year three, and 20% in performance years four and five. Repayment responsibility is expected to be phased, with a reduced discount percentage for repayment responsibility in years two and three.

Reconciliation under the CJR model will be retrospective, and CMS will conduct annual reconciliation after the end of a performance year. Reconciliation payments are made to participating hospitals if savings are achieved. Repayment of over spending will be due to CMS if overall costs surpass the expected costs, based on the performance period target pricing.

> *"By focusing on episodes of care, rather than a piecemeal system, we provide hospitals and physicians an incentive to work together to deliver the best care possible to patients."*
>
> ***Sylvia Burwell***
> *HHS Secretary*

The information presented here represents an overview of some of the goals, objectives and details as they relate to the CJR.

For more information, and to access the final rules associated with this alternative payment model, please visit: innovation.cms.gov/initiatives/cjr

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Source: Federal Register, Vol. 80, No. 226, Tuesday, November 24, 2015, Rules and Regulations.

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