Frequently Asked Questions about Comprehensive Care for Joint Replacement

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1. What is CJR?

On November 24, 2015 CMS published a final rule changing the reimbursement for certain lower extremity joint replacement (LEJR) procedures.[1] While the proposed rule referred to "CCJR," for comprehensive care for joint replacement, CMS has elected to drop one "C," referring to the program as "CJR." Effective April 1, 2016, the rule changes the way almost all prospective payment hospitals in 67 metropolitan statistical areas are compensated for patients admitted with DRG 469 or 470.[2] Under the program, Medicare will establish a target price for an 'episode of care" that begins when the patient is admitted to the hospital and ends 90 days following the patient's discharge. The hospital will be responsible for managing costs to meet the target price. If the costs exceed the target, the hospital must repay Medicare. If the costs are lower than the target, the hospital receives a payment from Medicare. The calculation of payments to and from the hospital is complicated, and there are caps on both the amount that the hospital can receive and the amount it can be required to repay.

The "episode of care" covers a wide range of services that are provided by other Medicare providers and suppliers, including physicians, therapists, skilled nursing facilities (SNFs) and more. This means that the hospitals will be at financial risk for the services provided by these other organizations. (The rule refers to the other organizations as "collaborators.") Hospitals are permitted, but not required, to negotiate contracts with other care providers (collaborators) so they share in the payments to and/or from Medicare. Direct Medicare payments to all providers and suppliers other than hospitals will be unchanged. For example, physicians will continue to receive fee-for-service payment under the Medicare fee schedule.
A wide range of services are considered part of the episode. Specifically, the following types of services are included in the episode:

(1) Physicians' services
(2) Inpatient hospital services (including hospital readmissions)
(3) Inpatient psychiatric facility services
(4) Long-term care hospital services

1 You can find the full text of the regulations and the preamble (CMS Commentary) here: https://www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals
2 The 67 Metropolitan Statistical Areas can be found here: https://data.cms.gov/dataset/Comprehensive-Care-for-Joint-Replacement-Model-Met/qek8-9bd4

(5) Inpatient rehabilitation facility services
(6) SNF services
(7) Home health agency services
(8) Hospital outpatient services
(9) Outpatient therapy services
(10) Clinical laboratory services
(11) DME
(12) Part B drugs and biologicals
(13) Hospice services
(14) Per-beneficiary-per-month payments under models tested under section 1115A of the Act

Note that services in the list will be included in the episode even if they might seem unrelated to the joint replacement procedure. For example, mental health and chemical dependency services are included in the episode. When CMS calculates the target price they will be using historical data that includes the same bundle of services. However, it is still true that when determining whether a hospital meets the target price, it will examine the patient's costs for services listed above, even if such services would strike most people as entirely unrelated to joint replacement.

2. What services are excluded from the episode?
CMS may choose to exclude certain services it considers "unrelated" to the joint replacement. The final rule lists a number of services already determined to be excluded. These include inpatient admissions for oncology, trauma medical, certain surgical procedures like prostatectomy, and acute surgical procedures such as appendectomy. CMS may add services to the list over time.

3. Am I required to participate in CJR?
Only if you are a hospital in one of the 67 metropolitan statistical areas and you are not part of Model 1 of the Bundled Payment for Care Improvement (BPCI) or part of the risk-bearing period for Models 2 or 4. No one else is required to be part of CJR.

4. Can the hospital require patients to go to certain physicians, therapists or other entities?
No. CMS has made it quite clear that patients remain free to choose the supplier or provider. In fact, the hospital is generally not permitted to offer an incentive to patients to choose particular providers or suppliers. The hospital is free to recommend patients choose particular physicians and facilities, but the patient is free to choose.

5. Can a hospital require physicians to share in the gain or risk?

No. There is no legal mechanism under which the hospital can compel such sharing. The hospital may request it, but it is not allowed to punish professionals or organizations who refuse.

6. Are there limits on the gain that can be shared?
Yes. While the hospital and physician (or other participant) can determine many of the terms of the gainsharing arrangement, the regulations place many restrictions on the relationship. First, any gainsharing must be done pursuant to a written collaborator agreement. While there are many restrictions and requirements contained in the regulations, among the more important are:

- The sharing agreement must be reached before care is furnished to any patients.

- The collaborator and hospital must agree upon quality criteria that the collaborator must satisfy in order to receive the payment.

- The total distribution payments paid to a physician practice in a year may not exceed 50% of the total Medicare physician fee schedule payments for services to CJR beneficiaries. In other words, the gainsharing for the CJR payments may not be more than half of what the physician was paid by Medicare for caring for the patients.

- Only physicians who actually perform services to CJR beneficiaries during at least one episode of care may receive any portion of the gainsharing payment.

7. Can a hospital require physicians to share the risk?
No. A hospital cannot require anyone to share the downside risk. However, a hospital is free to limit gainsharing payments to physicians who have agreed to accept downside risk, if the hospital so chooses. Physicians (and other collaborators) are free to reject the offer.

8. Can you enter a gainsharing agreement without also sharing downside risk?
Yes.

9. Are there any limits on risk sharing?
Yes. First, unless the hospital owes a repayment to Medicare, the hospital may not collect any money from the collaborators. The hospital may not collect more than 50% of the amount it must repay Medicare from its collaborators. Finally, the hospital may not collect more than 25% of its repayment amount from any single collaborator.

10. How can hospitals and physicians reduce costs?
The regulations permit great latitude for hospitals and physicians. Any strategy that lowers the charges Medicare receives can lower the Medicare payments and trigger payment to the hospital following the reconciliation process. In addition,

the hospital can also attempt to lower costs by reducing its internal expenses. While internal hospital cost reductions will not have an immediate effect on the CJR reconciliation process, they will have an immediate impact on the hospital's economic performance.

11. Must gainsharing payments be limited to the amount that the hospital receives from Medicare after the reconciliation?
No! The gainsharing payment may be based on the amount the hospital is paid *or* on internal hospital savings, or a combination of the two. If the hospital relies on assistance from physicians to lower its internal costs, the hospital may share the savings with the physicians as long as the payments are consistent with Stark, the Medicare antikickback statute, and other laws.

12. Can a medical clinic divide any gainsharing payment evenly among its physicians?
It depends. Only physicians who provide care to patients during CJR episodes are eligible to receive any payment. If the physician is eligible to receive a payment, an even split of the money is permitted, but not required.

13. Must the medical clinic divide the gainsharing payment evenly?
No. The clinic can use a variety of methods to distribute the money, as long as every physician who is receiving payment performed services to CJR patients. The fact that the regulations limit payment to physicians who actually performed services to CJR patients strongly suggests that it is permissible to pay a higher share of the gainsharing to physicians who are more involved in CJR care.