Comprehensive Care for Joint Replacement (CJR) Model
Provider and Technical Fact Sheet for Performance Years 6-8

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 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 3 through 5.

On May 3, 2021, CMS published a final rule in the Federal Register (https://www.federalregister.gov/public-inspection/current) to extend and make various changes to the CJR model. This final rule revises certain aspects of the model, including the episode of care definition, the target price calculation, the reconciliation process, the beneficiary notice requirements, gainsharing caps, the appeals process, and which hospitals are required to participate in the model. This final rule extends the CJR model for an additional 3 Performance Years until December 31, 2024.

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 Hip and Knee Joint Replacement or Reattachment of Lower Extremity with Major Complications or Comorbidities (MCC), 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC), 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC), or 522 (Hip Replacement with Principal Diagnosis of Hip Fracture without MCC). Beginning in Performance Year 6, Total Knee Arthroplasty (CPT 27447) or Total Hip Arthroplasty (CPT 27130) procedures performed in the Hospital Outpatient Department (HOPD) setting and paid under the Outpatient Prospective Payment System (OPPS) also initiate a CJR episode. The

episode of care continues for 90 days following discharge from the inpatient hospitalization or the date of the outpatient procedure.

Part A and Part B services related to the CJR episode are included in the episode. For each performance year of the model, CMS sets Medicare episode prices for participant hospitals 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 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 was originally implemented in 67 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. 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 remained mandatory participation areas and all hospitals, except low volume or rural hospitals, in those areas were 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 Performance Years 3 through 5.

Beginning October 1, 2021, hospitals that are located in one of the 34 MSAs and not designated as low volume or rural will be required to participate in the CJR model 3-year extension. There will be approximately 330 participant hospitals participating in the CJR model for Performance Years 6 through 8. The list of CJR participant hospitals is available on the CJR webpage: https://innovation.cms.gov/initiatives/cjr.

Episode definition

During Performance Years 1 through 5, the CJR model 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, except for 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.

The May 2021 final rule addressing Performance Years 6 through 8 changes the definition of a CJR 'episode' to address the removal of the Total Knee Arthroplasty (TKA) and Total Hip Arthroplasty (THA) from the inpatient-only (IPO) list in calendar year 2018 and calendar year 2020 respectively. The IPO List is published annually in the Outpatient Prospective Payment System (OPPS) rule and contains a list of procedures for which Medicare will only pay when performed in the hospital inpatient setting. In response to these coverage changes regarding site of service, the final rule proposes to change the definition of an 'episode of care' for Performance Years 6 through 8 to include outpatient (OP) procedures for TKAs (OP TKAs) and THAs (OP THAs), in addition to inpatient procedures.

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. During PYs 1-5, target prices for episodes anchored by MS-DRG 469 vs. MS-DRG 470 and for episodes with hip fractures vs. without hip fractures were provided to participant hospitals each year. The target price generally included a discount over expected episode spending and incorporated a blend of historical hospital-specific spending and regional spending for LEJR episodes, with the regional component of the blend increasing over time and eventually being 100 percent regional for Performance Years 4 and 5. All providers and suppliers furnishing LEJR episodes of care to beneficiaries throughout the year were 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 receive an additional payment from Medicare or be required to repay Medicare.

All hospital participants that achieve LEJR actual spending below the target price and achieve a minimum composite quality score were 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 were 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 had stop-loss limits of 3 percent in Performance Year 2 and 5 percent in Performance Years 3 through 5). For Performance Years 6 through 8, stop-loss and stop-gain limits of 20 percent will continue to apply.

We implemented a parallel approach for the stop-loss and 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.

In the May 2021 final rule, CMS finalized several changes to the target price calculation for Performance Years 6 through 8. Specifically, the rule changed the basis for the target price from 3 years of claims data to the most recent one year of claims data and made other adjustments to improve the accuracy of the target price.

Additionally, several changes were made to the reconciliation process for Performance Years 6 through 8. Specifically, the rule reduced the number of reconciliation periods from two reconciliation periods (conducted 2 and 14 months after the close of each performance year) to one reconciliation period that would be conducted 6 months after the close of each performance year and several additional changes to meant to improve the accuracy of the reconciliation process.

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.

In conjunction with the change to include specific outpatient procedures in the CJR episode definition during PYs 6 through 8, the May 2021 final rule also extended the waiver of the Skilled Nursing Facility (SNF) 3-day rule and the waiver of direct supervision requirements for certain post-discharge home visits to hospitals furnishing services to CJR beneficiaries in the outpatient setting.

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 considers 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.

CMS also finalized the use of the Complications and HCAHPS measures performance periods for Performance Years 6 through 8 in alignment with the performance periods used for Performance Years 1 through 5. For patient reported outcome measures, we also finalized their use for Performance Years 6 through 8 in alignment with previous performance periods, as well as changes to the thresholds for successful submission. We finalized these changes to the thresholds for successful submission as participant hospitals gain experience with patient reported outcome data and to continue the trend of increased thresholds set by the earlier performance years of the model.

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 December 2017 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 meeting 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.

Since we changed the definition of an 'episode of care' to include outpatient procedures, for which the beneficiary would not be admitted to the participant hospital, we have changed the beneficiary notification requirements (which are currently tied to admission). CJR participant hospitals must notify the beneficiary of his or her inclusion in the CJR model as soon as the anchor procedure or anchor hospitalization is scheduled if the procedure takes place in an outpatient setting. In circumstances where, due to the patient's condition, it is not feasible to provide notification at such times, the notification must be provided to the beneficiary or his or her representative as soon as is reasonably practicable but no later than discharge from the CJR participant hospital accountable for the CJR episode.

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 or the ENHANCED track.

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. Advanced APMs are APMs that meet these 3 criteria:

- Requires participants to use certified EHR technology;
- Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
- Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a significant financial risk.

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

CMS 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. 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.

COVID- 19 Policy

We understand the impact COVID-19 had and continues to have on participant hospitals. Therefore, we established a policy to remove downside risk for episodes that contain a COVID-19 diagnosis code. Specifically, actual episode payments are capped at the target price determined for that episode for episodes that contain a COVID-19 Diagnosis Code.

COVID-19 Diagnosis Code means any of the following ICD-10-CM diagnoses codes B97.29; U07.1; or any other ICD-10-CM diagnosis code that is recommended by the Centers for Disease Control and Prevention for the coding of a confirmed case of COVID-19.

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 is available here: https://www.federalregister.gov/documents/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals

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.

The full text of the May 2021 CJR final rule is available here: https://www.federalregister.gov/documents/2021/05/03/2021-09097/medicare-program-comprehensive-care-for-joint-replacement-model-three-year-extension-and-changes-to#h-34

For more information about the CJR Model, go to: https://innovation.cms.gov/initiatives/CJR

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