Issue Brief

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KEY POINTS

- Reduces participating metropolitan statistical areas from 75 to 67; Cape Girardeau, Columbia, Kansas City and St. Louis MSAs remain in final rule.
- No repayment penalty for year one, stop-loss limit of 5 percent in year two, limit of 10 percent in year three and 20 percent in years four and five with similar parallel approaches used for stop-gains.
- Quality measure goals would be based on a composite quality score methodology.

CMS Announces Final Joint Replacement Payment Model; Effective Date Changed to April 1, 2016

The Centers for Medicare & Medicaid Services has issued a final rule calling for the creation and testing of a new payment model — the Comprehensive Care for Joint Replacement Model — under the authority of the Centers for Medicare & Medicaid Innovation Center. "CJR is to test whether bundled payments to acute care hospitals for lower-extremity joint replacement episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries."

The effective date is April 1, 2016, rather than the proposed date of Jan. 1, 2016. The first year will run from April 1 through Dec. 31, 2016. The program is to run for five years.

A copy of the 1,018-page rule is on the *Federal Register* website at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-29438.pdf. Publication is scheduled for Nov. 24.

COMMENT

As noted above, the effective date of the rule has been moved from Jan. 1 to April 1. The delay is good news for providers giving them more time to prepare and understand for potential payment issues.

This rule will mandate the participation of hospitals in multiple geographic areas that might not otherwise participate in the testing of bundled payments for episodes of care. CMS is modifying the number of metropolitan statistical areas that will involve hospital participation from 75 to 67.

The material is not only extensive it is highly complex. There are many facets in developing and implementing all sorts of payment and quality adjustments. One would think that paying for a 90-day bundled package against some target amount would be simple. This is not the case. The model is riddled with many adjustments to payment targets and quality that a simple concept has become quite complex and extremely complicated. This will add significantly to hospital understanding.

Overall, CMS claims it will save some $343 million during the five-year term of the experiment. This is up significantly from CMS' proposed model in which savings were estimated at $153 million more than the five years. CMS also says it does not expect any savings in year one, but will, in fact, incur additional costs of $11 million as hospitals will not be subject to any downside risk. The question, is this a cost cutting system or one intent on truly providing better outcomes? Perhaps, it is the former.

CMS says it "want(s) to gain experience with this model." Its one thing to gain experience, it's another to gain such at unwilling providers expense.

CMS says that "when hospitals have no repayment responsibility for excess episode

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spending above the target price, CMS bears full financial responsibility for Medicare actual episode payments for an episode that exceed the target price, and we believed our responsibility should have judicious limits." Hospitals are being mandated into the program. For CMS to assert that it needs judicious limits on its payments is simply wrong. Hospitals not mandated to participate have no caps. Why should those in the program incur such? This demonstrates further that this is a payment reduction model plan. Perhaps it needs to be made budget neutral with respect to total Medicare outlays akin to the concept in the hospital valued-based program.

The proposed rule lacked clear and concise summaries of the major actions being proposed. The final rule does contain many final action decision sections. The start of a final action section is obvious, but not always where it ends. There are many instances in which the end of the final decision section ends and flows right into the next section, or a final section flows into a final summary section. CMS should make these sections stand out more — either bolding or italicizing, for example.

This is a long and tedious rule to work through. The table of contents is nine pages in length. CMS has never opted to include page numbers for its table of contents.

SUMMARY OF THE MAJOR PROVISIONS

1. Model Overview: LEJR Episodes of Care

LEJR procedures are currently paid under the IPPS through one of two Medicare Severity-Diagnosis Related Groups: MS-DRG 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities) or MS-DRG 470 (Major joint replacement or reattachment of lower extremity without MCC).

With the CJR model, episodes will begin with admission to an acute care hospital for an LEJR procedure that is assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the IPPS and will end 90 days after the date of discharge from the acute care hospital. The episode will include the LEJR procedure, inpatient stay and all related care covered under Medicare Parts A and B within the 90 days after discharge.

2. Model Scope

CMS will require all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

3. Payment

CMS will test the CJR model for five performance years. The first performance year will begin April 1, 2016, and end Dec. 31, 2016. During these performance years, CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare Fee-For-Service payment systems. However, after the completion of a performance year, the Medicare claims payments for services furnished to the beneficiary during the episode, based on claims data, will be combined to calculate an actual episode payment. The actual episode payment is defined as the sum of related Medicare claims payments for items and services furnished to a beneficiary during a CJR episode.

The actual episode payment will then be reconciled against an established CJR target price that is stratified based on the beneficiary's fracture status, with consideration of additional payment adjustments based on quality performance, post-episode spending and policies to limit hospital financial responsibility. The amount of this calculation, if positive, will be paid to the participant hospital. This payment will be called a reconciliation payment. If negative, CMS

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will require repayment from the participant hospital. Medicare will require repayment of the difference between the actual episode payments and the CJR target price from a participant hospital if the CJR target price is exceeded, subject to stop-loss measures.

4. Quality Measures and Reporting Requirements

CMS is adopting two hospital-level quality of care measures for the CJR model. Those measures include a complications measure and a patient experience survey measure. CMS will use these measures to test the success of the model in achieving its goals under Section 1115A of the Act and to monitor for beneficiary safety. CMS intends to publicly report this information on the Hospital Compare website.

PROVISIONS OF THE FINAL RULE

The material that follows is based on rule's sequence and discussions of subject matter. Not all items are reflected.

A. Definition of the Episode Initiator and Selected Geographic Areas

Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid through the IPPS through MS-DRG 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital. The initiation of an episode is described in § 510.100.

The definition of hospital, for purposes of being included in the CRJ program, are only acute care hospitals paid under the IPPS. IPPS hospitals physically located in an area selected for participation in the CJR model will be based on the address associated with the CMS Certification Number, to participate in the model and bear the financial responsibility for LEJR episodes of care under the CJR model.

CMS will hold only the participant hospitals financially responsible for the episodes of care. As such, CJR participant hospitals may enter into relationships with other entities to manage the episode of care or distribute risk. All relationships established between participant hospitals and the organizations for purposes of the CJR model will only be those permitted under existing law and regulation, meaning that gainsharing agreements between hospitals and organizations that are neither providers nor suppliers is not permitted. The material on gainsharing arrangements is extensive (see pages 493-574 for specifics).

CMS is finalizing its proposal that hospitals selected for the model that are active Model 1 Bundled Payments for Care Improvement participant hospitals as of July 1, 2015, or episode initiators for LEJR episodes in the risk-bearing phase of Model 2 or 4 of BPCI as of Oct. 1, 2015, are excluded from participating in CJR during the time that their qualifying episodes are included in one of the BPCI models.

The definition of a "participant hospital" and "CJR-regional hospital" will be codified in § 510.2, exclusions to episodes being tested due to BPCI overlap will be codified in § 510.100(b).

CMS is removing eight MSAs as noted in the table below.

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MSAs That Were Previously Selected That Are No Longer Included in CJR		
CBSA_TITLE	Revised Exclusion Rule 2 Status	Revised Exclusion Rule 3 Status
Colorado Springs, CO	Fail	Pass
Evansville, IN-KY	Fail	Pass
Fort Collins, CO	Fail	Pass
Las Vegas-Henderson-Paradise, NV	Fail	Fail
Medford, OR	Fail	Pass
Richmond, VA	Fail	Pass
Rockford, IL	Fail	Pass
Virginia Beach-Norfolk-Newport News, VA-NC	Pass	Fail

MSAs Included in the CRJ Model	
MSA	MSA Name
10420	Akron, OH
10740	Albuquerque, NM
11700	Asheville, NC
12020	Athens-Clarke County, GA
12420	Austin-Round Rock, TX
13140	Beaumont-Port Arthur, TX
13900	Bismarck, ND
14500	Boulder, CO
15380	Buffalo-Cheektowaga-Niagara Falls, NY
16020	Cape Girardeau, MO-IL
16180	Carson City, NV
16740	Charlotte-Concord-Gastonia, NC-SC
17140	Cincinnati, OH-KY-IN
17860	Columbia, MO
18580	Corpus Christi, TX
19500	Decatur, IL
19740	Denver-Aurora-Lakewood, CO
20020	Dothan, AL
20500	Durham-Chapel Hill, NC
22420	Flint, MI
22500	Florence, SC
23540	Gainesville, FL
23580	Gainesville, GA
24780	Greenville, NC
25420	Harrisburg-Carlisle, PA
26300	Hot Springs, AR
26900	Indianapolis-Carmel-Anderson, IN
28140	Kansas City, MO-KS
28660	Killeen-Temple, TX
30700	Lincoln, NE
31080	Los Angeles-Long Beach-Anaheim, CA
31180	Lubbock, TX
31540	Madison, WI
32820	Memphis, TN-MS-AR
33100	Miami-Fort Lauderdale-West Palm Beach, FL

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MSAs Included in the CRJ Model	
MSA	MSA Name
33340	Milwaukee-Waukesha-West Allis, WI
33700	Modesto, CA
33740	Monroe, LA
33860	Montgomery, AL
34940	Naples-Immokalee-Marco Island, FL
34980	Nashville-Davidson--Murfreesboro--Franklin, TN
35300	New Haven-Milford, CT
35380	New Orleans-Metairie, LA
35620	New York-Newark-Jersey City, NY-NJ-PA
35980	Norwich-New London, CT
36260	Ogden-Clearfield, UT
36420	Oklahoma City, OK
36740	Orlando-Kissimmee-Sanford, FL
37860	Pensacola-Ferry Pass-Brent, FL
38300	Pittsburgh, PA
38940	Port St. Lucie, FL
38900	Portland-Vancouver-Hillsboro, OR-WA
39340	Provo-Orem, UT
39740	Reading, PA
40980	Saginaw, MI
41860	San Francisco-Oakland-Hayward, CA
42660	Seattle-Tacoma-Bellevue, WA
42680	Sebastian-Vero Beach, FL
43780	South Bend-Mishawaka, IN-MI
41180	St. Louis, MO-IL
44420	Staunton-Waynesboro, VA
45300	Tampa-St. Petersburg-Clearwater, FL
45780	Toledo, OH
45820	Topeka, KS
46220	Tuscaloosa, AL
46340	Tyler, TX
48620	Wichita, KS

B. Episode Definition for the CJR Model

An episode of care in the CJR model is triggered by an admission to an acute care hospital stay (hereinafter "the anchor hospitalization") paid under MS-DRG 469 or 470 under the IPPS during the model performance period.

Episodes of care have two significant dimensions - (1) a clinical dimension that describes what clinical conditions and associated services comprise the episode; and (2) a time dimension that describes the beginning, middle and end of an episode.

CMS is adding the following new definition for the CJR model: "Provider of outpatient therapy services" means a provider or supplier furnishing - (1) outpatient physical therapy services as defined in § 410.60 of this chapter, or (2) outpatient occupational therapy services as defined in § 410.59 of this chapter, or (3) outpatient speech-language pathology services as defined in § 410.62 of this chapter.

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CMS will remove the term "independent" preceding outpatient therapy services. All of the clinical conditions requiring an admission to an IPPS hospital that results in a discharge from MS-DRG 469 or 470 will be the following items and services paid under Medicare Part A or Part B, after any final exclusions are applied:

- Physicians' services
- Inpatient hospital services (including readmissions), with certain exceptions
- IPF services
- LTCH services
- IRF services
- SNF services
- HHA services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- DME
- Part B drugs
- Hospice

Medicare spending for related items and services will be included in the historical data used to set episode target prices, as well as in the calculation of actual episode spending that would be compared against the target price to assess the performance of participant hospitals. In contrast, Medicare spending for unrelated items and services (excluded from the episode definition) will not be included in the historical data used to set target prices or in the calculation of actual episode spending.

CMS will exclude inpatient hospital readmissions based on the list of excluded MS-DRGs and Part B services that report an excluded ICD-9-CM (or equivalent ICD-10-CM) diagnosis code as the principal diagnosis based on the list posted on CMS' website at http://innovation.cms.gov/initiatives/cjr/.

CMS will cancel episodes once they have begun but prior to their end if the beneficiary no longer meets the same inclusion criteria proposed for the beginning of the episode at any point during the episode.

The end of the episode of care is 90 days after discharge from the anchor hospitalization. CMS is revising the definition of episode of care to clarify that the day of discharge itself counts as the first day of the post-discharge period and adding the same clarification to § 510.210(a).

C. Methodology for Setting Episode Prices and Paying Model Participants Under the CJR Model

Hospitals will be eligible to receive reconciliation payments from Medicare based on their quality and actual episode spending performance under the CJR model in each of CJR performance years two through five.

All providers and suppliers caring for Medicare beneficiaries in CJR episodes will continue to bill and be paid as usual under the applicable Medicare payment system, and determination of any reconciliation payments or repayments to Medicare will be made retrospectively after the end of each performance year.

CMS will exclude special payment provisions from episode calculations. CMS will include IPPS capital payments in target price and actual episode expenditure calculations. CMS will use the CMS Price Standardization approach to remove the effect of any current and potential future special payment provisions. In performance year one, participant hospitals will not be required to pay Medicare back if episode actual spending is greater than its target price.

CMS is reducing the potential risk to participants in year two by lowering the stop-loss limit from 10 percent to

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5 percent (and from 20 percent to 10 percent in year three). It will be 20 percent in years four and five.

CMS will prorate payments for services that extend beyond the episode when calculating actual episode payments, setting episode target prices and calculating reconciliation and repayment amounts.

CMS will apply high episode payment ceilings when calculating actual episode payments, setting episode target prices, and calculating reconciliation and repayment amounts.

CMS will modify its proposed policy to risk stratify, or set different target prices, both for episodes anchored by MS-DRG 469 versus MS-DRG 470 and for episodes with hip fractures versus without hip fractures. CMS is instituting a sub regulatory process in order to allow for public comment and to finalize the ICD-9-CM and ICD-10-CM diagnosis codes to be used in identifying hip fracture cases in the CJR model, as of the public release of this final rule. This policy is codified at § 510.300(a).

CMS will use three years of historical expenditures, updated every other year, to set target prices. CMS is modifying its proposal to update historical episode payments so as to include in the definition of "CJR eligible hospitals" that are participants in BPCI Model 1 or in the risk bearing period of Models 2 or 4 for LEJR episodes, and rename "CJR eligible hospitals" to be "CJR regional hospitals."

CMS proposed to apply a 2 percent discount for performance years one through five when setting the target price. CMS is modifying its proposal by using a composite score methodology to link quality and payment in the CJR model.

CMS proposed three measures to determine hospital quality of care and to determine eligibility for a reconciliation payment under the CJR model. The final measures and weights in the composite quality score for the CJR model are displayed below.

Final Quality Measure Weights in Composite Quality Score

Quality Measure	Weight in Composite Quality Score
Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550)	50%
HCAHPS Survey (NQF #0166)	40%
THA/TKA voluntary PRO and limited risk variable data submission	10%

Hospitals that provide high-quality episode care will have the opportunity to receive quality incentive payments that will reduce the effective discount percentage as displayed in the tables below, based on their composite quality score that places each hospital into one of four quality categories, specifically "Below Acceptable," "Acceptable," "Good," and "Excellent." Three tables are required to display the effective discount percentages for each quality category due to the phase-in of hospital repayment responsibility from no responsibility in performance year one, to partial responsibility in performance years two and three, and finally full responsibility in performance years four and five.

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Performance Year 1: Relationship of Composite Quality Score to Reconciliation Payment Eligibility and the Effective Discount Percentage Experienced At Reconciliation					
Composite Quality Score	**Quality Category**	**Eligible for Reconciliation Payment**	**Eligible for Quality Incentive Payment**	**Effective Discount Percentage for Reconciliation Payment**	**Effective Discount Percentage for Repayment Amount**
<4.0	Below Acceptable	No	No	3.0%	Not applicable
≥4.0 and <6.0	Acceptable	Yes	No	3.0%	Not applicable
≥6.0 and ≤13.2	Good	Yes	Yes	2.0%	Not applicable
>13.2	Excellent	Yes	Yes	1.5%	Not applicable

Performance Years 2 and 3: Relationship of Composite Quality Score to Reconciliation Payment Eligibility and the Effective Discount Percentage Experienced at Reconciliation					
Composite Quality Score	**Quality Category**	**Eligible for Reconciliation Payment**	**Eligible for Quality Incentive Payment**	**Effective Discount Percentage for Reconciliation Payment**	**Effective Discount Percentage for Repayment Amount**
<4.0	Below Acceptable	No	No	3.0%	2.0%
≥4.0 and <6.0	Acceptable	Yes	No	3.0%	2.0%
≥6.0 and ≤13.2	Good	Yes	Yes	2.0%	1.0%
>13.2	Excellent	Yes	Yes	1.5%	0.5%

Performance Years 4 and 5: Relationship of Composite Quality Score to Reconciliation Payment Eligibility and the Effective Discount Percentage Experienced at Reconciliation					
Composite Quality Score	**Quality Category**	**Eligible for Reconciliation Payment**	**Eligible for Quality Incentive Payment**	**Effective Discount Percentage for Reconciliation Payment**	**Effective Discount Percentage for Repayment Amount**
<4.0	Below Acceptable	No	No	3.0%	3.0%
≥4.0 and <6.0	Acceptable	Yes	No	3.0%	3.0%
≥6.0 and ≤13.2	Good	Yes	Yes	2.0%	2.0%
>13.2	Excellent	Yes	Yes	1.5%	1.5%

When hospital repayment responsibility begins in the second performance year of CJR, hospitals would be required to repay Medicare for episode expenditures that are greater than the applicable target price. The following table illustrates CMS' final timeframe for reconciliation.

Model Performance Year	Model Performance Period	Reconciliation Claims Submitted By	Reconciliation Payment or Repayment	Second Calculation to Address Overlaps and Claims Run-out	Second Calculation Adjustment to Reconciliation Amount
Year 1*	Episodes ending June 30, 2016 to December 31, 2016	March 1, 2017	Q2 2017	March 1, 2018	Q2 2018
Year 2	Episodes ending January 1, 2017 through December 31, 2017	March 1, 2018	Q2 2018	March 1, 2019	Q2 2019
Year 3	Episodes ending January 1, 2018 through December 31, 2018	March 1, 2019	Q2 2019	March 2, 2020	Q2 2020

Model Performance Year	Model Performance Period	Reconciliation Claims Submitted By	Reconciliation Payment or Repayment	Second Calculation to Address Overlaps and Claims Run-out	Second Calculation Adjustment to Reconciliation Amount
Year 4	Episodes ending January 1, 2019 through December 31, 2019	March 2, 2020	Q2 2020	March 1, 2021	Q2 2021
Year 5	Episodes ending January 1, 2020 through December 31, 2020	March 1, 2021	Q2 2021	March 1, 2022	Q2 2022

CMS is finalizing a 5 percent stop-gain limit in performance years one and two, 10 percent stop-gain limit in performance year three, and a 20 percent stop-gain limit in performance years four and five.

The following hypothetical example from CMS' proposed rule illustrates the stop-loss percentage that would be applied in a given performance year for the episodes of a participant hospital.

In performance year three, a participant hospital had 10 episodes triggered by MS-DRG 469, with a target price for these episodes of $50,000. The hospital's episode actual spending for these 10 episodes was $650,000. The hospital's raw net payment reconciliation amount that would otherwise be $150,000 ((10 x $50,000) - $650,000) would be capped at the 20 percent stop-loss limit of $100,000 (0.2 X 10 x $50,000) so the hospital would owe CMS $100,000, rather than $150,000.

In performance year three, the same participant hospital also has 100 episodes triggered by MS-DRG 470, with a target price for these episodes of $25,000. The hospital's episode actual spending for these 100 episodes was $2.8 million. The hospital's raw NPRA would be $300,000 ((100 x $25,000) - $2,800,000), an amount that would be due to CMS in full as it would not be subject to the 20 percent stop-loss limit of $500,000 (0.2 x 100 x $25,000). **[Note, the example has not been updated to the final rule to recognize CMS' modification to the proposed 3rd year stop-loss amount of 10 percent rather than 20 percent. The 20 percent values would be accurate assuming a fourth or fifth year performance stop-loss calculation.]**

CMS proposed to identify rural hospitals, MDHs, SCHs and RRCs at the time of reconciliation using the Provider Specific File updated in December of the end of the performance year and information from the MACs, and those hospitals would be subject to the 3 percent stop-loss limit policy for that performance year two, and 5 percent stop-loss limit policy in performance years three through five.

CMS is finalizing the lower stop-gain limit for rural hospitals as noted above, but the stop-gain of 20 percent in performance years four and five will be for all hospitals in the model, including rural hospitals, SCHs, MDHs and RRCs.

FRAUD AND ABUSE WAIVERS

It appears CMS expects hospitals to enter into various gainsharing ventures with all other providers furnishing services to CRJ beneficiaries. On Nov. 16, 2015, the OIG and CMS jointly issued waivers for specified arrangements involving Comprehensive Care for Joint Replacement Model participants. This 11 page document is on CMS' website.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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