Late yesterday, the Centers for Medicare & Medicaid Services finalized a new payment model that bundles payment to acute care hospitals for hip and knee replacement surgery – the Comprehensive Care for Joint Replacement (CJR) model. Under this model, the hospital in which the joint replacement takes place will be held financially accountable for quality and costs for the entire episode of care, from the date of admission through 90 days post-discharge. The model will be implemented in 67 geographic areas across the country and mandatory for most hospitals in those areas (see “Participation in the CJR Model” below).

The AHA is pleased that this final rule makes several critical improvements to the CJR model, which will help provide the support hospitals need to be successful under the program and better serve patients.

Details of the final rule follow.

**Participation in the CJR Model:** CMS finalized its proposal that the participating hospital will be the episode initiator and bear financial risk. Specifically, the agency will require inpatient prospective payment system (PPS) hospitals in 67 metropolitan statistical areas (MSAs) to participate in the model (see Appendix A for a listing of the 67 MSAs). Certain hospitals participating in the Bundled Payments for Care Improvement (BCPI) program will be excluded. We estimate that about 800 inpatient PPS hospitals will be required to participate in the CJR model.

**Episode of Care:** CMS delayed its proposed start date for the CJR model – it will begin on April 1, 2016 instead of Jan. 1, 2016. However, the program will still end Dec. 31, 2020, as proposed. An episode will begin with a beneficiary’s admission to an inpatient PPS hospital for a procedure (either elective or non-elective) assigned to either
Medicare-severity diagnosis-related group (MS-DRG) 469 or 470. The episode will end 90 days after the date of discharge from the hospital. It will include the surgical procedure and inpatient stay, as well as all related care covered under Medicare Parts A and B within 90 days of discharge. Unrelated services will be excluded from the episode.

**Payment Methodology:** CMS will use a retrospective payment methodology with one-sided risk in the first year of the program (meaning, no hospital would be penalized in year 1), and two-sided risk in subsequent years. Under the rule, all providers will continue to receive payment under fee-for-service (FFS) Medicare in the same manner as would otherwise be made. After the completion of a performance year, services furnished to beneficiaries in that year’s episodes will be grouped into episodes and aggregated. CMS will compare a participating hospital’s total episode payments to its “target price.” If total episode payments are below the target price, Medicare will pay the hospital the difference in the form of a “reconciliation payment,” subject to quality performance requirements. If spending is in excess of the target price, the hospital will pay Medicare the difference.

CMS finalized its proposal to set separate target prices for MS-DRGs 469 and 470. Although the agency did not incorporate a comprehensive risk-adjustment methodology into the program, as urged by the AHA, we are pleased that it did finalize a policy to set separate target prices for patients with and without hip fractures.

In order to determine reconciliation payments, CMS will set a target price equal to a hospital’s hospital-specific and regional blended historical payments minus a percent discount that will vary depending on its quality score (see Table 1 as well as “Linking Performance to Quality” below for more information). Hospitals will keep any savings they achieve in excess of this percent discount, again subject to quality performance. In order to determine repayments to Medicare, CMS also will set a target price equal to a hospital’s hospital-specific and regional blended historical payments minus a percent discount that will vary depending on the hospital’s quality score. Hospitals will not be subject to repayments in year 1 of the program but, in years 2 through 5, they will bear risk for spending above this percent discount.

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1 MS-DRG 469 is Major Joint Replacement or Reattachment of Lower Extremity with Major Complications or Comorbidities (MCC) and MS-DRG 470 is Major Joint Replacement or Reattachment of Lower Extremity without MCC.
Table 1: Discount Factor by Performance Year

<table>
<thead>
<tr>
<th>Quality Score</th>
<th>Reconciliation Discount</th>
<th>Year 1</th>
<th>Years 2 &amp; 3</th>
<th>Years 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below acceptable</td>
<td>N/a</td>
<td>N/a</td>
<td>2.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Acceptable</td>
<td>3.0%</td>
<td>N/a</td>
<td>2.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Good</td>
<td>2.0%</td>
<td>N/a</td>
<td>1.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Excellent</td>
<td>1.5%</td>
<td>N/a</td>
<td>0.5%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Stop-loss and Stop-gain Policies: We are pleased that, as urged by the AHA, CMS reduced the limits it sets on hospitals' repayment responsibility to Medicare. Specifically, in year 2 of the program, the agency will set a stop-loss limit equal to 5 percent (instead of 10 percent, as proposed) of a hospital's target price multiplied by its number of episodes. For example, if a hospital's target price is $50,000 and it had 20 episodes, its repayment risk to Medicare would be capped at 5 percent of $50,000 x 20, or $50,000. The agency will increase this stop-loss limit to 10 percent (instead of 20 percent as proposed) in year 3 and 20 percent in years 4 and 5 of the program.

CMS makes additional protections to limit repayment responsibility for sole-community hospitals, Medicare-dependent hospitals and rural referral centers. Specifically, it finalized its proposals to use reduced stop-loss limits of 3 percent in year 2, and 5 percent in years 3 through 5. Under the example above with a target price of $50,000 and 20 episodes, these hospitals' repayment risk will be limited to $30,000 (3 percent) in year 2 and $50,000 (5 percent) in years 3 through 5.

The agency also modified its proposed stop-gain policy that limits hospitals' reconciliation payments. Specifically, instead of a limit equal to 20 percent in all years of the program, CMS finalized reduced limits of 5 percent of a hospital's target price multiplied by its number of episodes in years 1 and 2; 10 percent in year 3; and 20 percent in years 4 and 5. For example, if a hospital's target price is $50,000 and it had 20 episodes, its reconciliation payments from Medicare in year 1 would be capped at 5 percent of $50,000 x 20, or $50,000.

Linking Performance to Quality: As urged by the AHA, CMS chose not to finalize its proposal to require hospitals to achieve the 30th or 40th percentile of performance on specific quality measures to be eligible for reconciliation payments. Instead, CMS will tie each hospital's level of reconciliation payment or repayment responsibility to a composite quality score. The score will be based on three measures:

- Complications (such as infections or blood clots in the lungs) within 90 days of hospitalization for elective total hip and total knee replacements;
• The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; and
• A voluntarily-submitted patient reported outcome (PRO) measure.

Hospitals will receive points on the complications and HCAHPS measures based on their percentile of performance compared to all other hospitals nationally. Hospitals will not be scored on their level of performance on the voluntary PRO measure; rather, they will receive points for successfully submitting measure data. Based on the composite quality score, CMS will place hospitals into four quality categories – “below acceptable,” “acceptable,” “good” and “excellent.” Hospitals in the “below acceptable” category will not be eligible for reconciliation payments and will bear the highest repayment risk. By contrast, hospitals in the “excellent” category will receive the highest reconciliation payments and will have the lowest repayment risk. See “Payment Methodology” above for more information.

Gainsharing: Participating hospitals may share hospital internal cost savings and payments received from Medicare as a result of reduced episode spending with collaborating providers and suppliers. Participants also may share financial accountability for increased episode spending with collaborating providers and suppliers.

Waivers: Although the final rule does not include any waivers to the fraud and abuse laws, CMS and the Department of Health and Human Services Office of Inspector General issued a joint statement that waives the federal Anti-kickback statute and the physician self-referral law with respect to certain financial arrangements. Specifically, the waivers protect payments made under gainsharing and shared risk agreements that comply with CJR program requirements. The joint statement also waives the federal Anti-kickback statute and civil monetary penalty law with respect to certain incentives that participating hospitals may offer Medicare beneficiaries during an episode to promote beneficiaries’ engagement in managing their care.

CMS also waives several Medicare regulations. Specifically, although it does not waive the home health (HH) “homebound” requirement, it does waive the “incident to” rule. This will allow a beneficiary who does not qualify for HH services to receive post-discharge visits in his or her home any time during the episode. The agency also waives the geographic site requirements that limit telehealth payment to services furnished within specific types of geographic areas or in an entity participating in a federal telemedicine demonstration project approved as of Dec. 31, 2000. In addition, CMS waives, in performance years 2 through 5, the skilled-nursing facility (SNF) three-day rule, but only if the SNF is rated an overall of three stars or better in the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website for at least seven of the 12 preceding months.
We are disappointed that CMS did not make additional waivers, such as to the inpatient rehabilitation facility “60% Rule” or discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services. Instead, the agency stated it would consider the comments it received during the public comment period along with its early model implementation experience and may make additional waiver proposals in the future.

**Beneficiary Choice and Incentives:** Beneficiaries will not be able to opt-out of the CJR model. The rule notes that hospitals may identify and recommend "preferred providers," as long as such recommendations do not result in violations of current laws or regulations. However, participant hospitals may not restrict beneficiaries to any such list of preferred or recommended providers and must clearly advise beneficiaries that their choices are not constrained.

In addition, CMS will allow certain in-kind patient engagement incentives under the CJR model, subject to certain conditions. For example, there must be a reasonable connection between the item or services and the beneficiary’s medical care, and it must be a preventive care item or advance a clinical goal for the beneficiary.

**Next Steps**

The rule will be published in the Nov. 24 Federal Register. AHA staff continues to review and analyze this final rule – watch for an in-depth AHA Regulatory Advisory, as well as data on how this rule affects your facility, in the coming weeks.

If you have further questions, contact Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.
Appendix A: MSAs included in the CJR Model

Akron, OH  
Albuquerque, NM  
Asheville, NC  
Athens-Clarke County, GA  
Austin-Round Rock, TX  
Beaumont-Port Arthur, TX  
Bismarck, ND  
Boulder, CO  
Buffalo-Cheektowaga-Niagara Falls, NY  
Cape Girardeau, MO-IL  
Carson City, NV  
Charlotte-Concord-Gastonia, NC-SC  
Cincinnati, OH-KY-IN  
Columbia, MO  
Corpus Christi, TX  
Decatur, IL  
Denver-Aurora-Lakewood, CO  
Dothan, AL  
Durham-Chapel Hill, NC  
Flint, MI  
Florence, SC  
Gainesville, FL  
Gainesville, GA  
Greenville, NC  
Harrisburg-Carlisle, PA  
Hot Springs, AR  
Indianapolis-Carmel-Anderson, IN  
Kansas City, MO-KS  
Killeen-Temple, TX  
Lincoln, NE  
Los Angeles-Long Beach-Anaheim, CA  
Lubbock, TX  
Madison, WI  
Memphis, TN-MS-AR  
Miami-Fort Lauderdale-West Palm Beach, FL  
Milwaukee-Waukesha-West Allis, WI  
Modesto, CA  
Monroe, LA  
Montgomery, AL  
Naples-Immokalee-Marco Island, FL  
Nashville-Davidson-Murfreesboro-Franklin, TN  
New Haven-Milford, CT  
New Orleans-Metairie, LA  
New York-Newark-Jersey City, NY-NJ-PA  
Norwich-New London, CT  
Ogden-Clearfield, UT  
Oklahoma City, OK  
Orlando-Kissimmee-Sanford, FL  
Pensacola-Ferry Pass-Brent, FL  
Pittsburgh, PA  
Port St. Lucie, FL  
Portland-Vancouver-Hillsboro, OR-WA  
Provo-Orem, UT  
Reading, PA  
Saginaw, MI  
San Francisco-Oakland-Hayward, CA  
Seattle-Tacoma-Bellevue, WA  
Sebastian-Vero Beach, FL  
South Bend-Mishawaka, IN-MI  
St. Louis, MO-IL  
Staunton-Waynesboro, VA  
Tampa-St. Petersburg-Clearwater, FL  
Toledo, OH  
Topeka, KS  
Tuscaloosa, AL  
Tyler, TX  
Wichita, KS

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2 CMS did not finalize participation for the following MSAs: Colorado Springs, CO; Evansville, IN-KY; Fort Collins, CO; Las Vegas-Henderson-Paradise, NV; Medford, OR; Richmond, VA; Rockford, IL; and Virginia Beach-Norfolk-Newport News, VA-NC.