

April 30, 2021

## CMS Finalizes Changes to Hip and Knee Bundled Payment Program

The Centers for Medicare & Medicaid Services (CMS) April 29 issued a [rule](#) finalizing changes to the Comprehensive Care for Joint Replacement (CJR) model, which bundles payment to acute care hospitals for hip and knee replacement surgery. Under this model, hospitals in which a joint replacement has taken place are held financially accountable for episode quality and costs.

Among other policies, CMS will extend the CJR model for an additional three years, through Dec. 31, 2024, beyond its current timeline. However, this extension will apply only to hospitals in the 34 metropolitan statistical areas (MSAs) in which participation was mandatory. Hospitals participating in the “voluntary” MSAs, as well as all low-volume and rural hospitals that have elected to participate, will continue to see the model end on Sept. 31, 2021.

**AHA Take: The AHA has long been supportive of voluntary participation in alternative payment models as a pathway to potentially improve care coordination and efficiency. As such, we are disappointed that CMS is not extending voluntary participation options in the CJR model, as we had advocated.**

A summary with highlights of the final rule follows.

### Key Takeaways

- CMS will extend the CJR model for an additional three years, through Dec. 31, 2024.
- This extension will apply only to hospitals participating on a mandatory basis.
- CMS will add outpatient procedures to the CJR model, and, as a result, add additional risk adjustment as well.
- The agency will provide more favorable shared savings thresholds for hospitals with higher quality scores.
- CMS will use one year of data to set hospital pricing targets as compared to the current three years of data.
- CMS will retain the same quality measures for the extension of the model.

## HIGHLIGHTS OF THE FINAL RULE

**Extension of Model.** The CJR model had originally been scheduled to end after five years, on Dec. 31, 2020. Due to the COVID-19 public health emergency, CMS extended the last year of the model (performance year (PY) 5) through Sept. 31, 2021. It is now extending the model again, through Dec. 31, 2024. However, this extension will apply only to hospitals in the 34 metropolitan statistical areas (MSAs) in which participation was mandatory. Hospitals participating in the “voluntary” MSAs, as well as all low-volume and rural hospitals that have elected to participate, will continue to see the model end on Sept. 31, 2021. The additional PYs will be:

- PY 6: Oct. 1, 2021 through Dec. 31, 2022;
- PY 7: Jan. 1, 2023 through Dec. 31, 2023; and
- PY 8: Jan. 1, 2024 through Dec. 31, 2024.

**Episode of Care.** Currently, a CJR episode begins with a beneficiary’s admission to an inpatient prospective payment system hospital for a procedure assigned to either Medicare-severity diagnosis-related group (MS-DRG) 469 or 470.<sup>1</sup> However, CMS finalized its proposal to change this definition to address the fact that total knee arthroplasty (TKA) and total hip arthroplasty (THA) procedures have been removed from the inpatient-only list and are now being performed in both outpatient and inpatient settings. Specifically, CMS will include outpatient TKAs and THAs as episode “triggers” for CJR.

**Payment Methodology.** CMS currently uses three years of historical data to calculate hospital target prices. It set this policy because it was concerned that using less data would not generate stable target prices. However, as of PY 4 of the program, target prices are based entirely on historical data across an entire region, rather than across individual hospitals, which has mitigated CMS’ concerns about low volume. Thus, it will use one year of data to set target prices. Due to the COVID-19 public health emergency, CMS will *not* use fiscal year (FY) 2020 data to set target prices. It will use FY 2019 data to set target prices for PY 6, FY 2021 data to set target prices for PY 7, and FY 2022 data to set target prices for PY 8.

In addition, as a means of risk adjustment for the model, CMS currently sets four separate target prices for each hospital: for MS-DRGs 469 and 470, for patients with and without hip fractures. However, the agency states that given its inclusion of outpatient THA and TKA procedures in the model, it believes additional risk adjustment is warranted. Thus, it finalized its proposal to also incorporate data on CMS hierarchical condition category (HCC) condition count and beneficiary age into the target price calculation. In addition, it also will incorporate dual-eligibility status into the target price calculation. CMS will use five CMS-HCC condition count variables to account for the expected marginal cost of treating beneficiaries with zero, one, two, three or four or

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<sup>1</sup> 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.

more CMS-HCCs. It will use four age categories: less than 65, 65 to 74, 75 to 84 and 85 or more.

In order to determine any shared savings, CMS currently compares a hospital's actual spending to its target price minus a percent discount that varies depending on its quality score. Hospitals keep any savings they achieve in excess of this percent discount, again subject to quality performance. For the extension of the model (PYs 6 through 8), CMS finalized as proposed its changes to the discount amounts, which would provide more favorable factors for higher quality scores (see Table 1 below).

**Table 1: Discount Factor by Performance Year**

Quality Score	Year 5	Years 6-8
Below acceptable	N/A	N/A
Acceptable	3.0%	3.0%
Good	2.0%	1.5%
Excellent	1.5%	0.0%

**Reconciliation.** CMS finalized its proposed change to the high-episode spending cap used at reconciliation. Specifically, the agency implemented a high-episode spending cap policy to prevent hospitals from being held responsible for catastrophic episode spending that they could not have reasonably been expected to prevent. Under this policy, CMS caps the spending amount of episodes at two standard deviations above the mean. However, CMS is changing the methodology to cap episode spending at the 99<sup>th</sup> percentile. The agency believes this will more accurately represent the cost of infrequent and potentially non-preventable complications.

CMS also finalized its proposal to move from two reconciliation periods (conducted two and 14 months after the close of each performance year) to one reconciliation period conducted six months after the close of each performance year. The agency has determined that the full 14 months is not necessarily required to sufficiently capture claims run out and overlap with other models. Rather, CMS believes that six months is adequate for capturing episode costs, and that one less reconciliation will reduce administrative burden for the agency and hospitals alike.

**Quality Measurement.** CMS retains the same quality measures for the extension of the model. The two mandatory quality measures are the hip/knee complications and Hospital Consumer Assessment of Providers and Systems measures that hospitals already report for the inpatient quality reporting program. In addition, CMS retains an optional patient-reported outcome (PRO) measure that enables hospitals to increase their composite quality score. However, CMS finalizes three modifications to its proposed PRO measure policies. First, it will adopt less aggressive increases to the data completeness thresholds. Instead of requiring that hospitals report on 100% of eligible cases by the final year of the extension, hospitals would now be required to report on 90% of cases. Second, CMS will extend the post-operative data collection

window to 14 months to allow hospitals more time to collect data. Lastly, as a result of the extension of PY 5 of the model, CMS will shift the PY 6 pre-operative PRO data collection window by one year, to April 1, 2021 through June 30, 2022. The other performance periods and reporting deadlines will remain roughly consistent with prior years.

## **NEXT STEPS**

The final rule will be published in the May 3 *Federal Register*. AHA staff will continue to review and analyze it.

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