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CJR Proposed Rule Executive Summary
February 21, 2020

CMS released on Feb. 20 a rule proposing changes to the Comprehensive Care for Joint Replacement program. If finalized, the rule would extend participation for mandatory hospitals to an additional three years. Additionally, the rule makes significant changes to the program's target price calculation, reconciliation process and gainsharing provisions, among other changes, which are discussed below.

Adding Outpatient Episodes of Care: Beginning in performance year (PY 6) —CMS is proposing to change the definition of an *episode of care* to include outpatient (OP) procedures for Total Knee Arthroplasty (OP-TKA) and Total Hip Arthroplasty (OP-THA).

CMS is proposing to group the OP-TKA and OP-THA procedures together with the MS-DRG 470 without hip fracture historical episodes in order to calculate a single, site-neutral target price for this category of episodes, given that spending on OP-TKA episodes most closely resembles spending on MS-DRG 470 without hip fracture episodes. Prices for the other three categories (MS-DRG 469 with hip fracture, MS-DRG 469 without hip fracture and MS-DRG 470 with hip fracture) would continue to be calculated based on historical inpatient episodes only.

Target Price Calculation: The proposed rule makes multiple changes, as detailed below, to the target price calculation.

Uses One Year of Data: CMS proposes to change the basis for the target price from three years of claims data to the most recent one year of claims data for proposed PY 6 through PY 8 (2021 – 2023). CMS is proposing to use one year's worth of data because CMS's initial concern of insufficient episode volume stemmed from the fact that CMS incorporated hospital-specific pricing for the first three years of the CJR model. Making this change will also allow it to capture pricing data related to OP-TKA and OP-THA episodes.

Removes and Replaces National Trend Factor: Using one year of data rather than three removes the need for the national trend update factor that CMS previously used to trend forward the older two years of historical data to the most recent of the three years of data being used to set target prices. Therefore, CMS also proposes to remove the national trend update factor. Instead, CMS proposes using a market trend factor that would be the regional/MS-DRG/fracture mean cost for episodes occurring during the performance year divided by the regional/MS-DRG/fracture mean cost for episodes occurring during the target price base year.

For example, at the first reconciliation for PY 6 (calendar year 2021), which, as proposed, will occur in June of 2022, CMS would compute the regional/MS-DRG/fracture mean cost for episodes occurring during 2021 and would divide that by the regional/MS-DRG/fracture mean cost for episodes that occurred during calendar 2019 as the target prices for PY 6 will be set using 2019 data.

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Risk Cap: CMS proposes to change its method of deriving the high episode spending cap amount applied to initial target prices by setting the high episode spending cap at the 99th percentile of historical costs. The current method caps costs at two standard deviations.

Like the current methodology, the high episode spending cap calculation would utilize the national summary of episode data to calculate the 99th percentile of each MS-DRG and hip fracture combination for each region. Total episode costs above the 99th percentile would be capped at the 99th percentile amount prior to calculating target prices for each MS-DRG and hip fracture combination for each region.

Reconciliation Process Changes*:* Beginning in PY 6, which includes all CJR episodes ending on or after Jan. 1, 2021, and on or before Dec., 31, 2021, CMS proposes to move from two reconciliation periods, conducted 2 and 14 months after the close of each performance year, to one reconciliation period that would be conducted six months after the close of each performance year.

For instance, for PY 6 (which includes all CJR episodes ending on or after Jan. 1, 2021, and on or before Dec. 31, 2021), CMS proposes to reconcile a participant hospital's CJR actual episode payments against the applicable target prices one time only, based on claims data available on July 1, 2022. Despite this change, the current CJR post episode spending policy still applies.

Risk Adjustment: For PY 6 through PY 8, the proposed rule would adjust the target price at reconciliation using two patient-level risk factors, the CMS-HCC condition count risk adjustment factor and the age-bracket risk adjustment factor.

CMS proposes to use five CMS-HCC condition count variables, representing beneficiaries with zero, one, two, three or four or more CMS-HCC conditions. CMS will estimate a coefficient from the subgroup of beneficiaries in the sample with the specific count of conditions for each count variable.

For example, all beneficiaries with two CMS-HCC conditions would receive a coefficient that is estimated independently of the coefficient for beneficiaries with zero, one, three or four conditions. The coefficient for the "two CMS-HCC condition count" variable would represent the expected marginal cost of having any two CMS-HCC conditions, as compared to having zero CMS-HCC conditions.

Like the strategy for incorporating the CMS-HCC condition count, CMS would create binary, yes/no variables for beneficiaries that fall into certain age ranges. The rule proposes four age variables for the risk adjustment methodology to represent beneficiaries aged less than 65 years, 65 to 74 years, 75 years to 84 years, and 85 years or more, based on the patient's age at the time the HCC files were created.

The proposed risk adjustment method for CJR would also be prospective in that it would use the most recently available data to predict the average expected adjustment in target price relative to the two risk adjustment variables for future performance years.

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Quality Adjusted Discount Factor: For PY 6 through PY 8, CMS proposes to continue to use 3 percentage points as the discount factor applied during calculation of regional target prices. However, CMS is proposing to increase an individual participant hospital's potential quality incentive payment; that is, CMS is proposing a larger reduction in the discount factor based on the composite quality score.

The rule proposes a 1.5 percentage point reduction to the applicable discount factor for participant hospitals with "good" quality performance and a 3-percentage point reduction to the applicable discount factor for participant hospitals with "excellent" quality performance.

The change is proposed in recognition that the changes to the target price calculation (discussed above) which is intended to increase the accuracy of target prices, may also narrow the potential for participant hospitals to earn reconciliation payments.

CMS will continue in years six through eight using the same set of quality measures — THA/TKA Complications Rate (NQF #1550) and HCAHPS. Additionally, participating hospitals may continue submitting the patient reported outcomes measure.

Beneficiary Notification Requirements: CJR participant hospitals are also required to notify the beneficiary of his or her inclusion in the CJR model if the procedure takes place in an outpatient setting. Further, the rule proposes that a participant hospital must provide the beneficiary with a written notice of any potential financial liability associated with non-covered services recommended or presented as an option as part of discharge planning(as part of outpatient joint replacement procedures), no later than the time that the beneficiary discusses a particular post-acute care option or at the time the beneficiary is discharged from an anchor procedure or anchor hospitalization, whichever occurs earlier.

Gainsharing Cap: For the three additional performance years, CMS is proposing to eliminate the cap (equal to 50% of the total Medicare approved amounts under the Physician Fee Schedule for items and services that are furnished to beneficiaries by that individual or entity during the performance year) on gainsharing payments, distribution payments and downstream distribution payments when the recipient of these payments is a physician, non-physician practitioner, physician group practice (PGP) or non-physician practitioner group practice (NPPGP).

Three-Day Waiver*:* The rule proposes to extend the waiver of the Skilled Nursing Facility (SNF) three-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 as well.

CJR Extended: The rule proposes to extend the CJR model for an additional three years, PY 6 through PY 8, for participant hospitals located in the 34 mandatory metropolitan statistical areas (MSAs), except for rural hospitals and low-volume hospitals. If finalized, the model would now end on Dec. 31, 2023 for mandatory hospitals.

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The changes and extension will apply only to those participant hospitals with a CMS Certification Number (CCN) primary address in the 34 *mandatory* MSAs, excluding participant hospitals in those mandatory MSAs that are "low-volume hospitals" or that have received a notification from CMS dated prior to Oct. 4, 2020, that they have been designated as "rural hospitals" and that voluntarily elected to participate in the CJR model for PY 3 through PY 5.

CMS does not propose to provide any additional opt-in period for these hospitals (low-volume hospitals and rural hospitals with a CCN primary address in a mandatory MSA) or for any hospitals with a CCN primary address located in the 33 *voluntary* MSAs and therefore, participation of these hospitals in the model will end at the end of PY 5.

CMS will use the notification date of the rural reclassification approval letter as the determining factor of participation in the CJR model for PY 6 through PY 8, since it is an objective factor for determining participation based on rural reclassification. Thus, for PY 6 through PY 8, hospitals that applied for rural reclassification and have been notified by CMS *before* Oct. 4, 2020, that their application for rural status has been approved and will no longer be participating in the model beginning PY 6 (which includes all CJR episodes ending *on* or *after* Jan. 1, 2021, and *on* or *before* Dec., 31, 2021). Participant hospitals reclassified as rural that are notified that their application for rural status has been approved *on* or *after* Oct. 4, 2020 (even if the effective date of the rural reclassification is retroactively effective to *before* Oct. 4, 2020), will continue to participate in the CJR model for PY 6 through PY 8 and will remain the financially accountable entities for PY 6 through PY 8.

Impact Estimate: CMS estimates that the CJR model changes proposed will save the Medicare program approximately $269 million over the additional three model years.