American Physical Therapy Association

1111 North Fairfax St. Alexandria, VA 22314
800/999-2782
www.apta.org

HIGHLIGHTS OF THE FINAL COMPREHENSIVE CARE FOR JOINT REPLACEMENT PAYMENT MODEL RULE

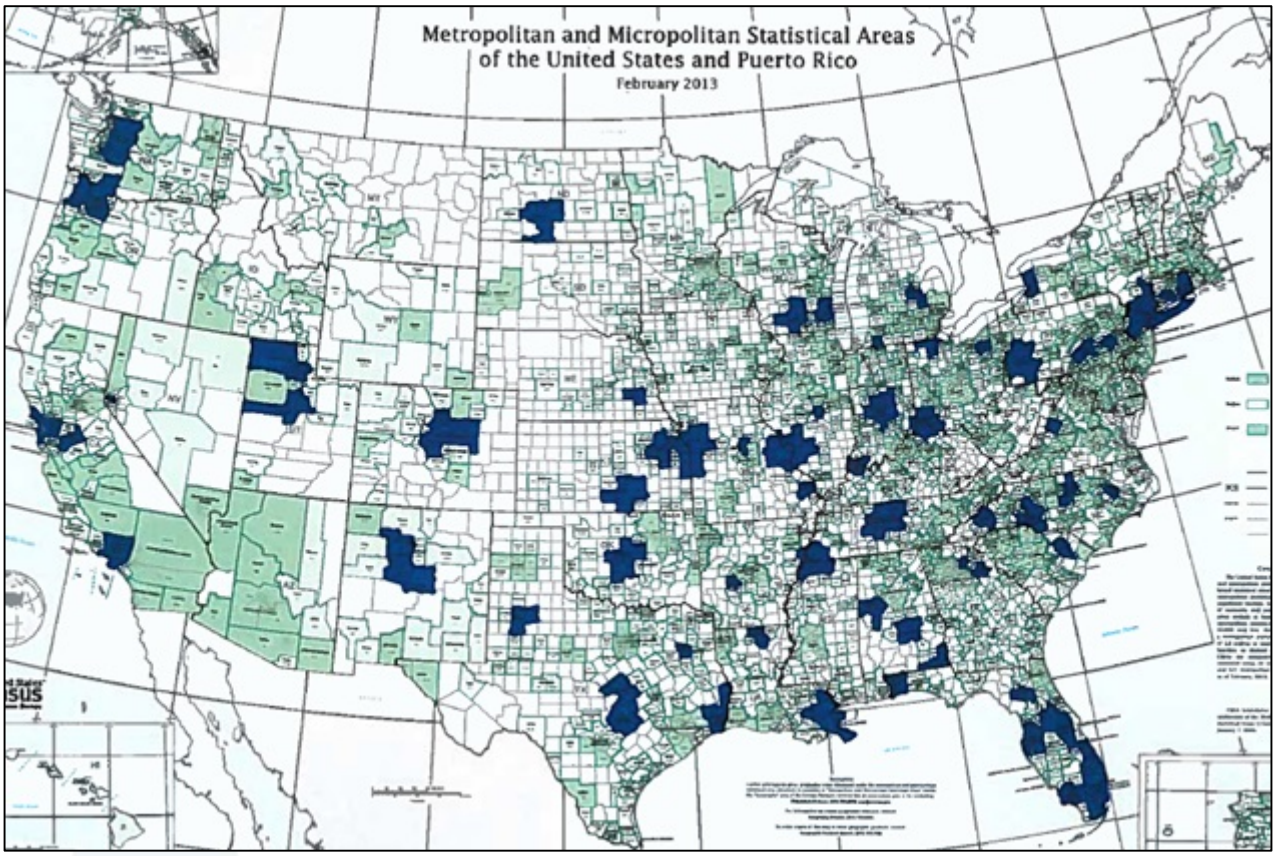
December 14, 2015

INTRODUCTION

On November 16, 2015, the Centers for Medicare and Medicaid Services (CMS) released the final rule on the Comprehensive Care for Joint Replacement (CJR) Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services for fiscal year 2016. The CJR model is focused on elective primary hip and knee replacement patients and covers all of the joint replacement procedures, including the inpatient stay and all related care within 90 days of hospital discharge. The CJR model holds participant hospitals financially accountable for the quality and cost of an episode of care, and it incentivizes increased coordination of care among hospitals, physicians, and postacute care providers. The CJR model begin April 1, 2016, and continues for 5 years. The rule requires all inpatient prospective payment hospitals in the 67 selected metropolitan areas to participate in this model.

METROPOLITAN STATISTICAL AREAS

The final rule outlines the method CMS used to select the 67 metropolitan statistical areas (MSAs) for the model. Below are a map and a list showing the selected MSAs.


Metropolitan and Micropolitan Statistical Areas
of the United States and Puerto Rico
February 2013

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

EPISODE OF CARE AND SERVICES

Because an episode of care for knee and hip replacement always begins with an acute-care hospital stay, hospitals will be financially responsible for the episode of care. An episode begins with the admission for an anchor hospitalization and ends 90 days postdischarge from the anchor hospitalization. The episode is triggered by hospitalizations of Medicare fee for service (FFS) beneficiaries discharged with the following diagnoses:

- MS-DRG 469: Major joint replacement or reattachment of lower extremity with major complications or comorbidities
- MS-DRG 470: Major joint replacement or reattachment of lower extremity without major complications or comorbidities

Following are services included and excluded from the episode:

Included Services	**Excluded Services**
Physicians' services	Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the LEJR surgery
Inpatient hospitalization (including readmissions)	Chronic conditions that are generally not affected by the LEJR procedure or postsurgical care
Inpatient psychiatric facility Long-term care hospital (LTCH) Inpatient rehabilitation facility (IRF) Skilled nursing facility (SNF) Home health agency (HHA) Hospital outpatient services Outpatient therapy services Clinical laboratory Durable medical equipment Part B drugs Hospice	

PAYMENT AND PRICING: RISK STRUCTURE

The model calls for a retrospective 2-sided risk. This means:

For each year of the model program, CMS will establish target prices for each participant hospital.

Providers and suppliers will continue to be paid via the Medicare fee schedule for services as usual.

After a performance year, CMS will compare actual episode spending with the target. If actual spending is less than the aggregate target prices, the hospital may receive reconciliation payment, as long as it has met quality performance thresholds. If actual spending is more than the aggregate target prices, the hospital will be responsible for making a payment back to Medicare. However, the responsibility for repaying Medicare begins in year 2; it is waived for the first year.

PAYMENT AND PRICING: LINK TO CJR QUALITY MEASURES

In the first year of the CJR model, CMS will include 2 quality measures that hospitals must meet to be eligible for a reconciliation payment:

- Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550), an administrative claims-based measure
- HCAHPS Survey measure

Additionally, CSM will reward hospitals that voluntarily submit data for the following patient-reported outcome measures:

- PROMIS Global *or* VR (Veterans RAND) 12
- Condition specific measures:
  - HOOS Jr *or* HOOS Pain AND Function, Daily Living Subscales
  - KOOS Jr *or* Stiffness, Pain AND Function, Daily Living Subscales

FINANCIAL ARRANGEMENTS: GAIN SHARING

Participant hospitals may have certain financial relationships with collaborators to support their efforts to improve quality and reduce costs. These collaborators can share in the reconciliation payments and internal cost savings realized through care redesign activities. To be eligible for the reconciliation payments, these collaborators must engage with the hospital in its care redesign strategies and furnish services during a CJR episode. Collaborators may include the following provider and supplier types, which include physical therapists in the various settings in which they practice:

- Physicians and nonphysician practitioners
- Home health agencies
- Skilled nursing facilities
- Long term care hospitals
- Physician group practices
- Inpatient rehabilitation facilities
- Providers or suppliers of therapy services

Participant hospitals will be required to retain 50% of the downside risk and cannot share more than 25% of its repayment responsibility with any 1 provider or supplier.

WAIVERS OF MEDICARE PROGRAM RULES

CMS will waive certain rules in order to test the CJR model, specifically:

- Beginning in performance year 2 (not applicable for year 1), CMS will waive the 3-day inpatient hospital stay requirement for eligibility for a covered SNF stay—known as the SNF 3-day rule—if the SNF is rated 3 stars or higher on Nursing Home Compare.
- CMS will waive the "incident to" rule for physician services to allow a physician's clinical staff to furnish home visits (only for non-HHA-covered patients). CMS will limit the number of home visits to 9 during the episode of care.
- CMS will waive current limitations on payment for telehealth services that relate to the geographic area in which telehealth originating sites may be located. CMS also will allow telehealth services to be furnished in the beneficiary's home or other place of residence. These waivers apply only to telehealth services that already are covered and paid for

under section 1834(m) of the Social Security Act; physical therapist services currently are not covered.

BENEFICIARY PROTECTIONS: ACCESS TO CARE

Beneficiaries included in the CJR model:

- May still select any provider of choice with no restrictions
- May still receive any Medicare-covered service with no restrictions
- Will not have any changes to copayments

Hospitals may offer certain items and services to beneficiaries during an episode of service, as long as they are not inducements.

CMS will monitor for potential risks, such as:

- Attempts to increase profit by delaying care
- Attempts to decrease costs by avoiding medically indicated care
- Attempts to avoid high-cost beneficiaries
- Evidence of compromised quality or outcomes

APPEALS PROCEDURES FOR RECONCILIATION

CMS has set up an appeals process for the CJR model that participant hospitals can use to dispute a calculation or to otherwise ask CMS to reconsider a review it has conducted.

Key points about the process:

- Resolution dispute is afforded only to the participant hospital.
- Hospital repayment is determined under a CJR reconciliation report for each given performance year.
- The hospital must provide written notice of the error in dispute to CMS within 45 days of the reconciliation report being issued.
- CMS is mandated to take reasonable efforts to make a decision on the appeal within 15 days of receipt of the review request and issue a written determination within 30 days.

- For requests not related to payment matters, the hospital must submit a request for reconsideration within 10 days of receipt of the notice of the initial determination.

NOTICE OF WAIVERS OF CERTAIN FRAUD AND ABUSE LAWS IN CONNECTION WITH THE CJR MODEL

In conjunction with the CJR final rule, OIG released a notice that explains the conditions under which certain fraud and abuse laws such as gainsharing, physician self-referral, and anti-kickback will be waived to ensure providers can comply with CJR lawfully.

CJR Model Waiver Conditions

- Physician-self referral and certain portions of the federal anti-kickback statue are waived for distribution of gainsharing payments and alignment payments under a sharing agreement between a participant hospital and CJR collaborator.
- To qualify for waivers, the parties must meet all of the requirements as laid out in the CJR final rule.
- All parties must also have active Medicare billing privileges.
- The parties must ensure they are not prohibiting beneficiary choice, and they must notify the beneficiary of the arrangement.
- The participant hospital cannot add any outside restrictions regarding the sharing agreement other than those allowed in the CJR final rule.
- CJR collaborating providers must be chosen based on their ability to provide quality care and must agree to CJR quality criteria.
- Gainsharing payments must be based on quality of care provided to the beneficiary during the episode of care.
- Distribution payments must be made based on a written agreement.

The waiver starts on the date of the OIG notice (November 16, 2015) and ends when any of the following occur: (1) the sharing agreement is terminated, (2) 24 months after the final performance year, (3) the date on which a participant hospital is terminated from the CJR agreement, or (4) the date that the collaborator agreement is terminated by the participant hospital.

Explanation of Waiver Requirements

Arrangements must fit squarely into one of the waivers, meet all of the conditions, and meet previously delineated safe harbors and exceptions. OIG will assess arrangements that do not meet these stipulations on a case-by-case basis. The waivers are intended to mitigate fraud and

abuse and should be consistent with measures to improve quality, coordinate care, and reduce costs.

All arrangements must continue to comply with Internal Revenue Service laws and regulations regarding tax-exempt status for hospitals. OIG, in collaboration with CMS and the Center for Medicare and Medicaid Innovation (CMMI), reserves the right to modify, suspend, or terminate these waivers with proper notice to stakeholders. This may be done through the rulemaking process or subregulatory correspondence.

These waivers are exclusive to the CJR program and do not extend to other arrangements made by the participant hospital or collaborators. Payments or distributions covered by the waivers must be made by electronic transfer.