Comprehensive Care Joint Replacement (CJR) Model Frequently Asked Questions (FAQs)

What is the Comprehensive Care for Joint Replacement (CJR) Model?

The Comprehensive Care Joint Replacement Model (CJR) is a Medicare alternative payment model focused on elective hip and knee joint replacement patients. The model began April 1, 2016, and will run for 5 years. CJR was the first mandatory alternative payment model under Medicare—it required all acute care hospitals in the designated metropolitan areas to participate. In August 2017, CMS proposed major changes to the model that would continue the CJR mandated model for 34 of the original 67 mandated regions, allowing voluntary continued participation for the remaining 33 regions beginning in 2018. Additionally, CMS proposed to implement exceptions from mandatory participation for low-volume and rural hospitals in the 33 mandatory areas.

Where are the designated metropolitan areas?

There were 67 selected metropolitan areas across the United States. Tose highlighted in the list below are proposed to continue as mandatory participants:

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

What if my region is not included in the CJR model?

If your region is not among those designated, then you are not included in the model at this time. However, it still may be a good idea to keep track of CJR and other alternative payment models, as they may become applicable to your area and/or practice in the coming years. The US Department of Health and Human Services (HHS) has established milestones in its efforts to create payment systems based on outcomes rather than services provided. Its goal is to tie 50% of payment to models such as CJR by the end of 2018, and we anticipate continued growth of alternative payment models.

What is an alternative payment model?

An alternative payment model uses a payment structure that is not based on "fee for service" and generally ties payment to quality measurement and improved outcomes of care. Examples include accountable care organizations, the bundled payment care improvement (BPCI) initiative, and CJR.

What is included in CJR?

A CJR episode is triggered by an anchor hospitalization in which MS DRG (medical severity diagnostic related group) 469 or 470 is billed—major joint replacement (or reattachment) of the lower extremity with or without major complication or comorbidity. The episode includes the hospitalization and 90 days of care postdischarge (the date of discharge counts as the first day in the 90-day period). The episode includes all related postacute and outpatient care, and includes readmissions if related.

Does CJR include Medicare Advantage plans?

No. CJR is for Medicare fee-for-service patients. Medicare Advantage plans and private payers are not included in this initiative, but they may adopt models like CJR in the future.

How do providers get paid under CJR?

Providers will continue to be paid under their respective payment systems during the course of the CJR episode. For example, physical therapists (PTs) in private practice will continue to bill Medicare directly for their services and receive payment. CMS will establish target prices for each participant hospital annually. Cases will be reconciled at the end of the performance year to determine if they have met the target price. If aggregate target prices are greater than actual episode spending, hospitals may receive a reconciliation payment; however, if aggregate target prices are less than actual episode spending, hospitals will be responsible for making a payment to Medicare. (In 2016 only, the repayment requirement is waived.)

If PTs have entered into agreements to share in reconciliation payments with the hospital, those funds will be paid to the physical therapist provider directly from the hospital.

Is there a specific dollar amount allotted to physical therapy services in CJR?

No, hospitals are given a target price to include all services provided in the CJR episode. Hospitals may work with their collaborators to break down the target price further, but this would depend on each hospital's approach.

Can I share in the CJR savings?

Yes, participant hospitals may have financial relationships with collaborators allowing them to share risk and savings in the episode to support their efforts to improve quality and reduce costs. All collaborators are required to engage with the hospital in its care redesign strategies and to furnish services during a CJR episode in order to be eligible for such payments. Collaborators may include: skilled nursing facilities, home health agencies, long-term care hospitals, inpatient rehabilitation facilities, physician

group practices, physicians, nonphysician practitioners, and providers and suppliers of outpatient therapy (such as physical therapists in private practice and rehabilitation agencies).

Does APTA have recommendations for collaborators?

APTA has created a variety of resources to assist providers in planning for CJR, including a contracting checklist and toolkit that can be found on our CJR website: www.apta.org/cjr.

Has CMS set up clinical pathways for CJR?

CMS does not have specific clinical pathways for the CJR model. Clinical pathways or protocols may be used to standardize care and to control costs and outcomes in models such as CJR. APTA has a variety of clinical resources for this patient population on our website: www.apta.org/cjr.

How do I code patients in CJR; are there specific ICD-10 codes I need to use?

There are no specific billing codes for the CJR model. Aftercare visit codes (Z codes) cover situations in which the initial treatment of a disease has been performed, or the injury or disease has been removed, and the patient requires continued care during the healing or recovery phase or for the long-term consequences of the disease.

Example:

Patient is seen by the PT after a total knee replacement to remove osteoarthritis in the right knee. Codes include:

- Z47.1 Aftercare following joint replacement surgery
- Z96.651 Presence of right artificial knee joint

Please see our ICD-10 resources for additional coding questions: www.apta.org/ICD10.

Does CJR require hospitals to collect and report on specific quality measures?

Yes, during year 1, hospitals will be required to collect 2 quality measures:

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

Additionally, hospitals may voluntarily collect patient-reported outcome measures to earn additional points toward their annual quality score. These include:

- PROMIS Global ***or*** VR (Veterans RAND) 12, ***and 1 of the following:***
- HOOS Jr
- HOOS Pain Subscale ***and*** HOOS Function, Daily Living Subscale
- KOOS Jr
- KOOS Stiffness Subscale, KOOS Pain Subscale, ***and*** KOOS Function, Daily Living Subscale

If hospitals collect the patient-reported outcome measures, they also will be required to collect risk-variable data.

Do physical therapists need to collect specific quality measures if they participate in CJR?

No. However, APTA encourages PTs to use the HOOS or the KOOS for patients included in this model, as well as the PROMIS or Veterans RAND instrument to align with hospital data collection efforts.

How does quality measures performance affect hospital payment in CJR?

Hospitals will be placed in 1 of 4 quality categories for each performance year, based on their quality composite score: Below Acceptable, Acceptable, Good, and Excellent. The category will determine the hospital's eligibility for reconciliation and incentive payments.

Quality Category	Eligible for Reconciliation Payment	Eligible for Quality Incentive Payment
Below Acceptable	No	No
Acceptable	Yes	No
Good	Yes	Yes
Excellent	Yes	Yes

Is there a savings and risk structure for CJR?

Yes, CMS has established a savings and risk structure with increasing risk and incentives over the 5-year model period.

CJR Year	Dates	Stop-loss* limit of target price	Hospital (minimum)	CJR Collaborator (maximum)
1	4/1-12/31/2016	0%	0%	0%
2	1/1-12/31/2017	5%	2.5%	1.25%
3	1/1- 12/31/2018	10%	5%	2.5%
4	1/1- 12/31/2019	20%	10%	5%
5	1/1- 12/31/2020	20%	10%	5%
*Stop-loss = Stop-gain; except year 1, when stop-gain=5%				

Are there any program waivers for CJR?

Yes, there are 3 waivers in the CJR model:

- The SNF 3-day acute care stay rule can be waived if the patient is being transferred to a SNF that is rated 3 stars or higher on Nursing Home Compare.
- The "incident to" rule for physician services can be waived to allow clinical staff of a physician to furnish home visits ***This is only for non-HHA-covered patients and does not include physical therapy services***.
- The telehealth originating site requirements can be waived to allow services to be originated in patient's home. ***At this time, the telehealth waiver does not apply to physical therapy, as PTs are not yet recognized as telehealth providers under Medicare.***

Are there any fraud-and-abuse waivers for CJR?

Yes, portions of the Stark laws and anti-kickback legislation and regulations are waived to allow distribution of incentive payments between hospitals and CJR collaborators. Providers must be in good standing with Medicare and have a written agreement be in place to share payments. Providers must meet all CJR program requirements, including quality of care, to qualify for the fraud-and-abuse waivers. Hospitals cannot impose any additional restrictions on sharing of incentive payments outside of the CJR regulations.

What are the beneficiaries' rights? Do they still have freedom of choice?

As with other alternative payment models, beneficiaries retain freedom of choice to select any provider, whether or not the provider is participating in the CJR bundle. Cost-sharing responsibilities, such as

copays and coinsurance, for the beneficiary remain the same, and beneficiaries continue to be entitled to care for all Medicare-covered services.

Does the therapy cap apply to therapy services billed under CJR?

Yes, the therapy services billed under CJR count toward the therapy cap.

Can hospitals provide free services to patients under CJR?

Hospitals may offer beneficiaries certain items and services free or at a discount during the CJR episode; however, these may not be inducements for referrals, and they must be closely tied to the patient's participation in CJR. CMS allows for "in-kind patient engagement incentives" to CJR beneficiaries which:

- May be offered for free or below market value
- Can be provided only during the CJR episode
- Must be reasonably connected to medical care
- Must be preventive or tied to specific health goals
- Must not be tied to care from a specific provider
- Must be provided directly from the hospital or approved agent
- Cannot have the cost shifted to another federal health care program

How will CMS monitor cherry picking and patient steering?

CMS is looking for provider feedback regarding unintended consequences of CJR so that the appropriate measures can be taken. PTs are encouraged to report issues to APTA at our advocacy email: avocacy@apta.org. We will use this information in our communications with HHS to address unfair practices by hospitals and other CJR participants.

What is the appeals process if there is a question about CJR payment?

The participating hospital may initiate an appeal if it believes there is an error in payment. The first step is to review the reconciliation report, followed by the submission of a written notice to CMS with a calculation error form. Submission deadline is 45 days; after that, the hospital loses its appeal rights.

Can CJR overlap with other existing alternative payment models? If so, how does this impact payment?

Yes, CJR can overlap with other existing alternative payment models. The impact varies depending on which models overlap.

- Hospitals participating in BPCI in the applicable metropolitan areas are not required to participate in CJR.
- Hospitals participating in the Medicare Shared Savings Program can also participate in CJR.
- CJR reconciliation payments and repayments attributed to a specific episode may not be counted toward determining the cost of care in other models.
- If the beneficiary is assigned to CJR and the Medicare Shared Saving Program, savings paid back under the Shared Savings Program may not be counted toward the CJR episode savings.

Are there specific record retention requirements under CJR?

Yes, participating hospitals and CJR collaborators must maintain books and records for a 10-year period, which begins on the last day of participation in CJR. Record retention is extended an additional 6 years in the case of a dispute or allegation of fraud.