Congressional Research Service
Informing the legislative debate since 1914

IN FOCUS

Updated March 31, 2016

The Comprehensive Care Joint Replacement Model

The Medicare program has been criticized for failing to include policies that financially incentivize health care providers to deliver efficient, high-quality health care. The Patient Protection and Affordable Care Act (P.L. 111-148) added Section 1115A to the Social Security Act (SSA), authorizing the creation of the Center for Medicare & Medicaid Innovation, the Innovation Center. The Innovation Center is an agency within the Centers for Medicare & Medicaid Services (CMS) that supports the development and testing of alternative payment and service delivery models to promote care coordination, quality, and efficiency of health care services.

Examples of alternative payment models under way at the Innovation Center include the Bundled Payment for Care Improvement (BPCI) initiative. The BPCI currently tests different retrospective or prospective episode-based payment initiatives to improve the efficiency of care delivery. For example, one such model allows hospitals and post-acute care providers that choose to participate to enter into gain-sharing agreements—agreements that retrospectively distribute a portion of reduced health care expenditures that fall below a target episode price among parties. However, after a preparation period (Phase I), under the risk-bearing phase (Phase II) participants must also repay a portion of health care expenditures that exceed a target episode price under risk-sharing agreements. Participants may choose the duration of the episode (30 days, 60 days, or 90 days) and the clinical episode that will trigger the bundled episode payment. As of October 13, 2015, roughly 298 acute-care hospitals were participating in the BPCI models that included lower-extremity joint replacement (LEJR) episodes.

Comprehensive Care Joint Replacement Model Participants

On November 24, 2015, CMS finalized in the *Federal Register* a new mandatory episode-based payment model for certain acute-care hospitals. Under CMS's SSA Section 1115A authority, beginning April 1, 2016, the Innovation Center will test a 90-day retrospective episode-based payment to certain acute-care hospitals for Medicare beneficiaries enrolled in Parts A and B who receive LEJR procedures. This model is being conducted to improve coordination and incentivize higher-value care across the different care settings for a common, high-expenditure medical procedure (i.e., LEJR) with substantial regional variation in care delivery and spending. The model is to include five performance years, beginning April 1, 2016, and ending after December 31, 2020. All providers continue to receive typical Medicare Part A and Part B reimbursements for care provided during the episode. However, under the model, each eligible hospital's Medicare episode spending will be reconciled against a hospital-specific target episode price following a performance year for hospitals in certain geographic areas. Under Section 1115A of the SSA, the Secretary may expand the duration, scope, and geographic areas included in the model if certain requirements are met.

CMS randomly selected metropolitan statistical areas (MSAs) to be included for participation in this Comprehensive Care Joint Replacement (CJR) model. An MSA is composed of a county or counties (or parishes and boroughs) and represents economically and socially integrated populations. Of the 384 total MSAs in the United States, 188 MSAs were ineligible to participate in the CJR model because too few LEJR episodes had been performed by acute-care hospitals within the MSAs over the past few years (not participating in the BPCI) or because more than 50% of LEJR episodes included acute-care hospitals, skilled nursing facilities, or home health agencies participating in the risk-bearing phase—where participants assume financial risk—of the BPCI model. The remaining 196 MSAs were stratified by population, LEJR procedure, and Medicare spending 90 days after discharge over the past three years. CMS randomly selected 67 MSAs using a methodology that proportionally underweighted more efficient MSAs and overweighted more expensive MSAs.

All acute-care hospitals located in the 67 MSAs will participate in the CJR model beginning April 1, 2016, unless otherwise excluded. Excluded hospitals include (1) hospitals not reimbursed under Medicare's inpatient prospective payment system and (2) hospitals participating in the BPCI models that include LEJR episodes. According to publically-available information on the Innovation Center website, 798 acute-care hospitals across the 67 MSAs will participate in the CJR model.

LEJR 90-Day Post-Discharge Episode

Under the CJR model, eligible acute-care hospitals located in one of the 67 MSAs will participate in the CJR model and be at financial risk of Medicare spending per beneficiary for LEJR episodes. The episode begins with a hospital inpatient admission for an LEJR procedure, most often a total hip or knee replacement procedure. The episode ends 90 days after the patient is discharged from the hospital following the LEJR procedure. Medicare episode spending will include physicians' services, inpatient hospital services and related hospital readmissions, post-acute care services (i.e., skilled nursing facility and home health services), hospital outpatient services, durable medical equipment, drugs reimbursed under Medicare Part B, and hospice services. The target episode price will be adjusted for LEJR episodes that begin with a hospital inpatient admission for hip fracture.

Two-thirds of the target episode price will initially be based on each hospital's average LEJR episode spending over the

past three years. The remaining one-third will be based on average LEJR episode spending over the past three years in all eligible CJR hospitals within the census region where the hospital is located. The share of regional episode spending within the target episode price will increase to two-thirds in performance year three and to 100% for performance years four and five. For low-volume hospitals (hospitals with fewer than 20 CJR episodes), target episode prices will be based on 100% of the regional episode spending from performance years one through five.

The target episode price will be reduced by a discount factor, which may be different for each CJR hospital depending upon the hospital's performance across quality measures and submission of certain patient-reported outcome data. The base discount factor is set at 3.0% and serves as Medicare's portion of reduced expenditures under the CJR model. The discount factor will be different in the first two performance years for repayment determinations and additional payment determinations. To be eligible for additional payments, referred to as *reconciliation payments*, CJR hospitals must meet a certain minimum quality threshold.

Quality Performance, Reconciliation Payments, and Repayments

The CJR model will adopt a composite quality score of three quality measures to assess quality of care of beneficiaries. The composite quality score will be used to determine if hospitals are eligible for reconciliation payments under the CJR model. The three measures are (1) a complications outcome measure following elective total hip or total knee replacement procedures; (2) a patient satisfaction survey measure conducted on a sample of hospital patients regarding their hospital stays; and (3) the successful submission of data on patient-reported outcomes related to total hip and total knee replacement procedures. The outcome and patient satisfaction measures are risk-adjusted to account for beneficiaries who may be more susceptible to complications.

Hospitals may be eligible for quality incentive payments by way of a reduced discount factor (of up to 1.5%) for meeting a high composite quality score threshold. Lower discount factors provide a relatively easier benchmark to receive reconciliation payments and avoid repayments.

Participating CJR hospitals that reduce LEJR episode spending for a given beneficiary below the discounted episode target price and meet minimum quality thresholds can receive a reconciliation payment in the amount of the full difference in episode spending. Hospitals may begin receiving reconciliation payments following performance year one. Hospitals will *not* be required to make repayments for any beneficiary's episode spending that exceeds the discounted episode target following performance year one. In performance year two, to mitigate the potential impact of repayments, the episode target price discount factor for determining repayments will be 2% but may be reduced based on the hospital's composite quality score. Beginning in performance year three, the discount factor for the episode target price for determining repayments will increase to 3% but may be reduced based on the hospital's composite quality score.

Both repayments and reconciliation payments will be capped. Repayments cannot exceed 5% of the target episode price in performance year two, referred to as the *stop-loss limit*. The stop-loss limit will increase to 10% in performance year three and to 20% in performance years four and five. To account for a potential lower risk tolerance of certain CJR hospitals, for hospitals that are (1) defined for Medicare reimbursement purposes as sole community hospitals, Medicare-dependent hospitals, or rural referral centers; (2) classified as located in a rural area; or (3) located in rural census tracts, the stop-loss limit will be 3% in performance year two and 5% in performance years three through five.

Reconciliation payments will also be subject to a limit, referred to as a *stop-gain limit*. Under the stop-gain limit, aggregate reconciliation payments cannot exceed 5% of the aggregate episode target prices in each of performance years one and two. The stop-gain limit will increase to 10% in performance year three and to 20% in performance years four and five.

Medicare Program Waivers Under the CJR Model

Under the CJR model, certain Medicare program requirements may be waived to provide added flexibility to hospitals and other participants. For example, the Medicare requirement of a prior three-day hospital inpatient stay for 100 days of post-discharge coverage in a skilled nursing facility is eligible for waiver under the model. Additionally, Medicare program requirements related to civil monetary penalties, the federal antikickback statute, and the physician self-referral prohibition are also waived under the CJR model.

Financial Arrangements

Hospitals may enter into financial arrangements with other providers and suppliers that provide care for beneficiaries during an LEJR episode (e.g., post-acute care providers) and choose to participate in the CJR model, referred to as *collaborators*. Such financial arrangements include gain-sharing agreements and repayment agreements. Financial agreements are required to be submitted to CMS and subject to certain specifications and restrictions. For instance, (1) hospitals must retain at least 50% of the repayment responsibility, (2) a collaborator cannot be responsible for more than 25% of the repayment responsibility, and (3) a participating physician or physician group practice cannot receive gain-sharing payments that exceed 50% of the Medicare reimbursement amount for the physician's or group practice's services during the LEJR episode. Although a hospital may enter into financial arrangements with providers that wish to participate in the CJR model, a hospital cannot require that a beneficiary receive services from a particular provider or interfere with the beneficiary's freedom of provider choice.

Marco A. Villagrana, Analyst in Health Care Financing

IF10310

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.