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**Comprehensive Care for Joint Replacement (CJR): Understanding the CMS Mandatory TJR Bundling
Webinar**

December 8, 2015

Director: Craig Robert Mahoney, MD

Faculty: Alexandra Page, MD and Brian McCardel, MD

Webinar times: 8:15 to 9:45 pm ET; 7:15 to 8:45 pm CT; 6:15 to 7:45 pm MT; 5:15 to 6:45 pm PT

Times Listed Below in Central Time

7:15 pm **Introductions**

Craig Robert Mahoney, MD

7:18 pm **Key Points in the Final Rule**

Brian McCardel, MD

7:48 pm **Wins and Losses: AAOS Advocacy Plan**

Alexandra Page, MD

8:28 pm **Discussions / Questions & Answers**

Craig Robert Mahoney, MD

8:45 pm **Webinar adjourns**

Brief Description:

The Comprehensive Care for Joint Replacement Model (CJR) has been finalized by the Centers for Medicare & Medicaid Services (CMS) and is set to begin on April 1, 2016 in 67 randomly selected Metropolitan Statistical Areas (MSAs).

Learn what this payment model entails and how it requires mandatory retrospective bundled payments associated with primary total hip and knee arthroplasty (THA, TKA) procedures performed in hospital inpatient settings. The model will hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for all DRG 469 & 470 episodes (THA, TKA, Hip Fractures treated with hemi-arthroplasty or THA, & Total Ankle Arthroplasty) from surgery through recovery.

Your faculty discusses the impact this payment model will have on you and your practice, and covers the Academy's advocacy efforts to continue to define this payment model.

At the conclusion of this webinar, learners should be able to:

- Understand the latest government activities regarding alternative payment models.
- Recognize the impact of health care reform changes on your practice.

Disclosures

Craig Robert Mahoney, MD Submitted on: 10/01/2015

AAOS: Board or committee member

Liventa Biosciences: Research support

Mercy Medical Center - Des Moines, Iowa: Board or committee member

Mid America Orthopaedic Association: Board or committee member

Polk County Medical Society: Board or committee member

Smith & Nephew: Paid consultant; Research support

Trak Surgical, Inc.: Board or committee member

Alexandra Elizabeth Page, MD Submitted on: 10/01/2015

AAOS: Board or committee member

American Medical Association: Board or committee member

California Medical Association: Board or committee member

California Orthopaedic Association: Board or committee member

Intersocietal Accreditation Commission - MRI: Board or committee member

Ruth Jackson Orthopaedic Society: Board or committee member

San Diego Country Medical Society: Board or committee member

Brian R McCardel, MD (Lansing, MI) Submitted on: 12/08/2015

AAOS: Board or committee member

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Comprehensive Care for Joint Replacement (CJR): Understanding the CMS Mandatory TJR Bundling Webinar

December 8, 2015



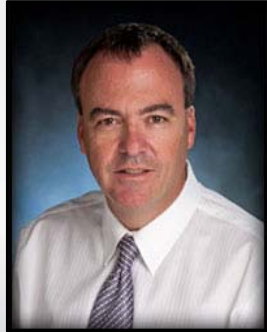
Webinar Director

Craig R. Mahoney, MD

- Physician Dyad Leader for Orthopaedics at Mercy Hospital in Des Moines
- Executive Committee for Orthopaedics and Spine, Catholic Health Initiatives
- AAOS - Health Care Systems Committee
- AAOS – Board of Councilors



Webinar Faculty



Brian McCardel, MD



Alexandra Page, MD



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Overview

- Proposed rule for CJR published July 9, 2015
- Comment period ended September 8, 2015
 - Approximately 400 comments from the public were reviewed
 - Several major changes were made from the proposed rule
- The final rule displayed on November 16, 2015

<https://innovation.cms.gov/initiatives/cjr>



Previous Webinar

- Status of bundled care
- CJR, MACRA (Medicare Access and CHIP Reauthorization Act), Alternative Payments Models (APMs) and the potential impact on orthopaedic surgeons
- Potential Pitfalls of CCJR and AAOS's response to CMS



- **Agenda**

- **Key Points in the Final Rule**

Brian McCardel, MD

- **Wins and Losses: AAOS Advocacy Plan**

Alexandra Page, MD

- **Discussions / Questions & Answers**

Mahoney, McCardel, Page

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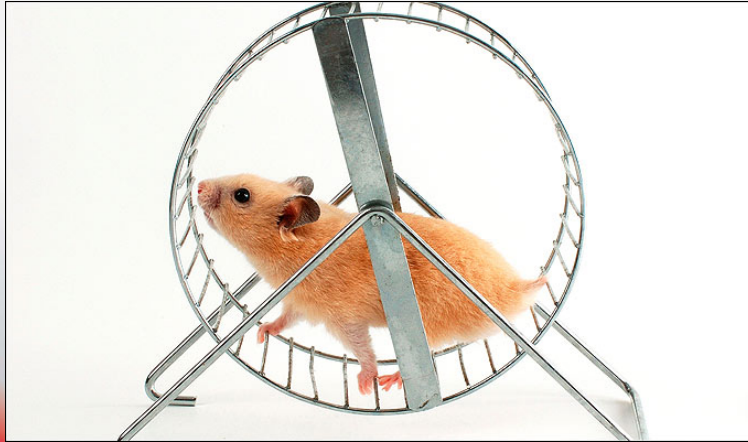


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December 8, 2015



No matter how fast I talk.....



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Very Brief Background

- So what is a “Final Rule”?
- Value: Quality/Cost
- Bundling: Single price for defined event, with “Quality Measures” backstop
- CMS ACE 2009: Cardiac and TJR
- BPCI: Final wave this year
- CMS Pronouncements on VBP 1/2015

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Other shoe dropped 7/9/2015: CJR

- 800 Hospitals in 67 MSA's for 5 years
- All LEJR's, including for hip fractures
- 1.5-3% (+/-) Discount applied to bundle
- Retrospective "Reconciliation"
- Roughly 1/3 of TJR's in US
- Excludes BPCI hospitals
- Includes "Collaborator" Gain-sharing

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Changes in Final Rule

- Starts 4/1/16 and drops 8 MSA's
- Quality factor based on point system
- Discount rate and "reconciliation payments" based on Quality measures
- Risk stratification for hip fractures
- Stop gain = Stop loss
- Slowed the rate of "regionalization"
- Decreased downside risk years 2 & 3

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Stop-loss = Stop-gain 2-sided and Optional

Target Price % Repayment	Year 1	Year 2	Year 3	Year 4	Year 5
Stop-loss limit of target price	0%	5%	10%	20%	20%
Hospital (minimum)	0%	2.50%	5%	10%	10%
CJR collaborator (maximum)	0%	1.25%	2.50%	5%	5%

- Hospitals are the focus
- Surgeons/others: Collaborators
- Gain-share only to “service providers”
- Physicians/groups limited to 50% FFS upside

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Quality Measures Scoring

Mandatory (50%/40%)

- Risk-Standardized Complication Rate
- HCAHPS (all comers, not just TJR's)

“Optional” (10%): Think exam “extra credit”

- Patient Reported Outcomes Measures
- General Well-being and Joint-Specific

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Some Flexibility

- Up to 9 post-discharge home visits without being “home-bound”
- 3-night stay waived after year 1
- Slight delay in implementation
- Payments for telehealth

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New Twists

- Progressively “regional”
- Lack of risk-factor inclusion
- Mandatory “2-sided” program

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Overall Impressions-Personal

- Many issues remain
- Timeline is daunting
- Most sites likely underprepared, somewhat by self-selection
- More rounds seem likely
- It ain't over 'til it's over

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CJR Wins and Losses: AAOS Advocacy Plan

Understanding the next steps for
Bundled Payments,
Medicare and Beyond

Alexandra (Alexe) Page, M.D.
Chair, AAOS Health Care Systems
Committee

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CJR: Is Bundled Payment the future of Orthopaedic Reimbursement?



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CJR: Is Bundled Payment the future of Orthopaedic Reimbursement?



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CJR: Is Bundled Payment the future of Orthopaedic Reimbursement?



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CJR: AAOS Perspective

“AAOS supports efforts by CMS to make appropriately structured alternative payment models available to physicians and other providers, BUT

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CJR: AAOS Perspective

... payments that reward higher quality care must be based on appropriately *risk-adjusted, patient-centric*, transparent measures that *empower physicians and surgeons* to deliver the *best value for the patients* they serve.”

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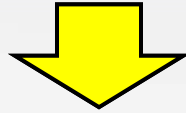
First, the good news

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CJR “Wins”

Quality Measures for Hospital:
Use of *composite* quality score methodology,
(change from *threshold* in Proposed Rule)



Stronger incentives for hospitals to improve
quality

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CJR “Wins”

Recognized higher
spending with hip fx.

Specific pricing
methodology to be
developed for hip
fracture patients



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CJR Wins:

Patient Reported Outcomes

Remains voluntary (modest financial incentive)

VR-12 **-or-** PROMIS Global

TKA: KOOS Jr. (Only) **-or-** KOOS Stiffness
Subscale *and* KOOS Pain Subscale *and* KOOS
Function, Daily Living Subscale

THA: HOOS Jr. (Only) **-or-** HOOS Pain Subscale
and HOOS Function, Daily Living Subscale

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CJR Wins:

Patient Reported Outcomes

Responded to stakeholder (Ortho Surgeon) input

Selection of agreed-upon metrics

Consider this a paradigm for future collaborative
efforts, CMS & Commercial?

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Next, where the challenges remain. . .

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Ongoing CJR Concerns: Mandatory Nature

Final Rule

- Decrease from 75 to 67 Metropolitan Statistical Areas (MSA)

For the
Hospital

- All Inpatient Prospective Payment System (IPPS) hospitals in selected MSA *not* participating in BPCI Model 1 or Phase II of Models 2 or 4 for LEJR episodes to be included in CJR model.

Next step for
Surgeon

- Are you in an impacted MSA? Is your hospital exempt (BPCI)?
- Be proactive in connecting with hospital administrators

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Ongoing CJR Concerns: Rapidity of Implementation

Final Rule

- Full implementation delayed by only three months, set to begin April 1, 2016.

For the Hospital

- Baseline data available upon request prior to the April 1st start date
- Allows assessment for necessary practice changes prior to the CJR start date.

Next step for Surgeon

- Take a DEEP breath . . . and contact your legislator.

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Ongoing CJR Concerns: Lack of Physician Leadership

Final Rule

- Acute care hospital will initiate (own) the bundle

Physician Leaders

- Lack of leadership can limit physician ability to impact quality and cost

Next step for Surgeon

- Consider Physician – Hospital Alignment strategies
- What aspects of the bundle do you control?

Next step for Surgeon

- Consider this as prep for future bundle ownership

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Ongoing CJR Concerns: Gainsharing as Collaborator

Final Rule


- No fraud and abuse waivers in final rule.

For the Hospital

- CMS and OIG will jointly issue waivers as needed to test the model

Next step for Surgeon

- Position yourself for **CJR Collaborator contracts**
- Recognize the down and up sides to gainsharing

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Ongoing CJR Concerns: Lack of Infrastructure Support

Final Rule

- Full-scale implementation and other requirements finalized as in proposed rule.

EHR


- CMS claims most hospitals have infrastructure in place related to interoperable health information technology (HIT) and qualified electronic health records (EHRs).

Mandates

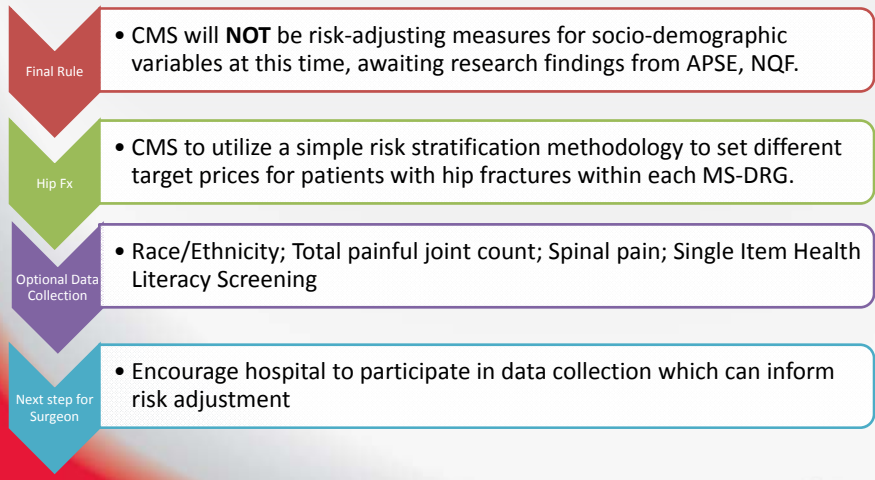
- Timeline ignores multiple competing mandates (ICD-10-CM implementation, EHR Meaningful Use, other quality-related programs), current state of (non!) interoperable infrastructure.

Next step for Surgeon

- Work toward aligning office, post-acute, and in-patient interoperability

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Ongoing CJR Concerns: Lack of Risk Adjustment



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Ongoing CJR Concerns: Inclusion of Inappropriate Conditions



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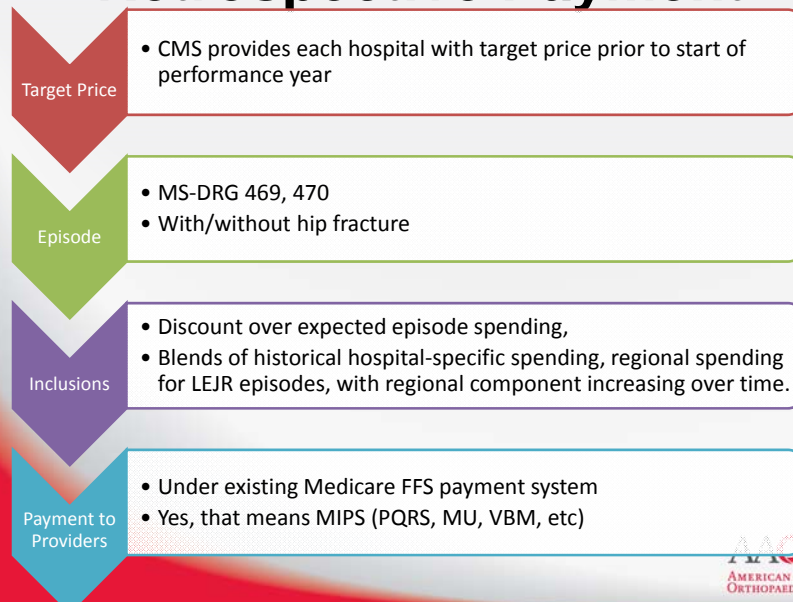
Ongoing CJR Concerns: Inclusion of Inappropriate Conditions



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Ongoing CJR Concerns: Retrospective Payment



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Bundled Payments – Beyond CJR

From the HHS Press Release:

*“The CJR model incorporates successful design elements from other initiatives. This model also **reflects best practices from the private sector**, where major employers and leading providers and care systems are moving towards bundled payments for orthopedic services.”*

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CJR: Is Bundled Payment the future of Orthopaedic Reimbursement?



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Bundled Payments – Beyond CJR

- AAOS development of orthopaedic bundles which reflect input of Orthopaedic Surgeon stakeholders
- Offer paradigm for private and government payers.
- Physicians as bundle initiators

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Advocacy – TKA/THA Beyond CJR

Increasingly stringent Utilization Review

- Cigna - National
- Blue Shield of California
- Your market?

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AAOS Advocacy Beyond CJR

Meaningful Use

- Delay implementation of Stage 2 and Stage 3

Congress of the United States
Washington, DC 20515

November 20, 2015

The Honorable Paul Ryan
Speaker of the House
H-232 Capitol
Washington, DC 20515

Dear Mr. Speaker:

As medical providers and elected representatives, we, the members of the GOP Doctors Caucus, urge you to work with us to prevent the harmful effects of two policies proposed by the Centers for Medicare and Medicaid Services (CMS): Modified Stage 2/Stage 3 of the Meaningful Use (MU) program and the Comprehensive Care for Joint Replacement (CJR) payment model. We believe both Stage 3 of the MU program and CJR should be delayed. We also encourage a blanket hardship waiver exception for Stage 2 of the MU program.

Finally,
the take home message


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Hospital own the bundle, but
surgeons understand the value
for the patient

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“CJR collaborator”

- Providers who furnish direct care to CJR beneficiaries
- Share in reconciliation payments or repayments
- Requires written **“Participation Agreement”** with the hospital.
- Must be outlined in a “CJR Sharing Arrangement”
- Gainsharing predicated on volume/value of case referral not allowed

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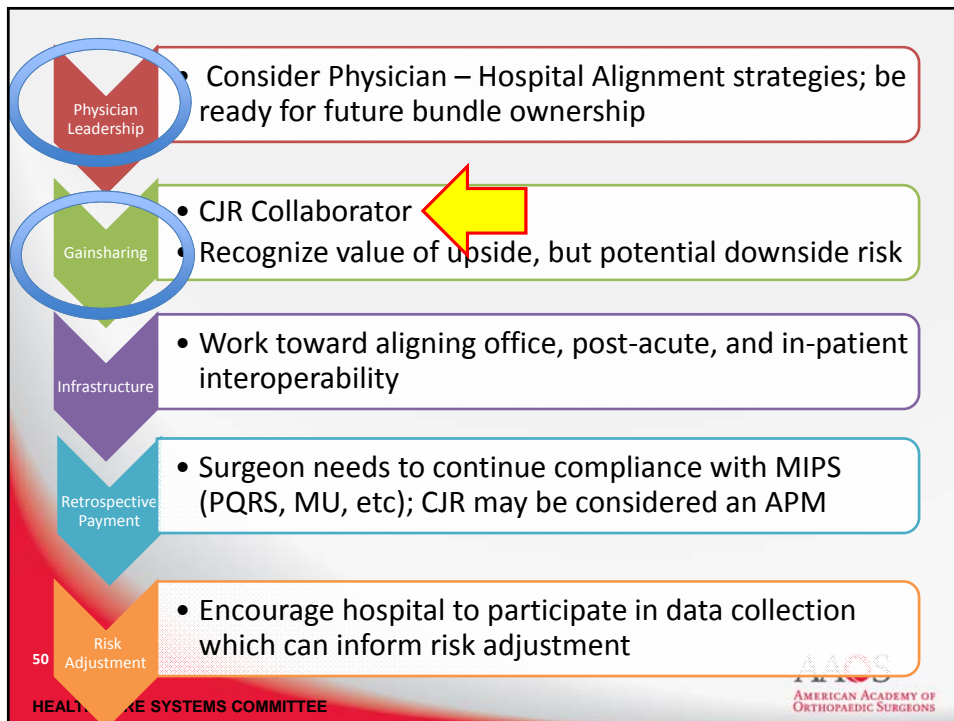
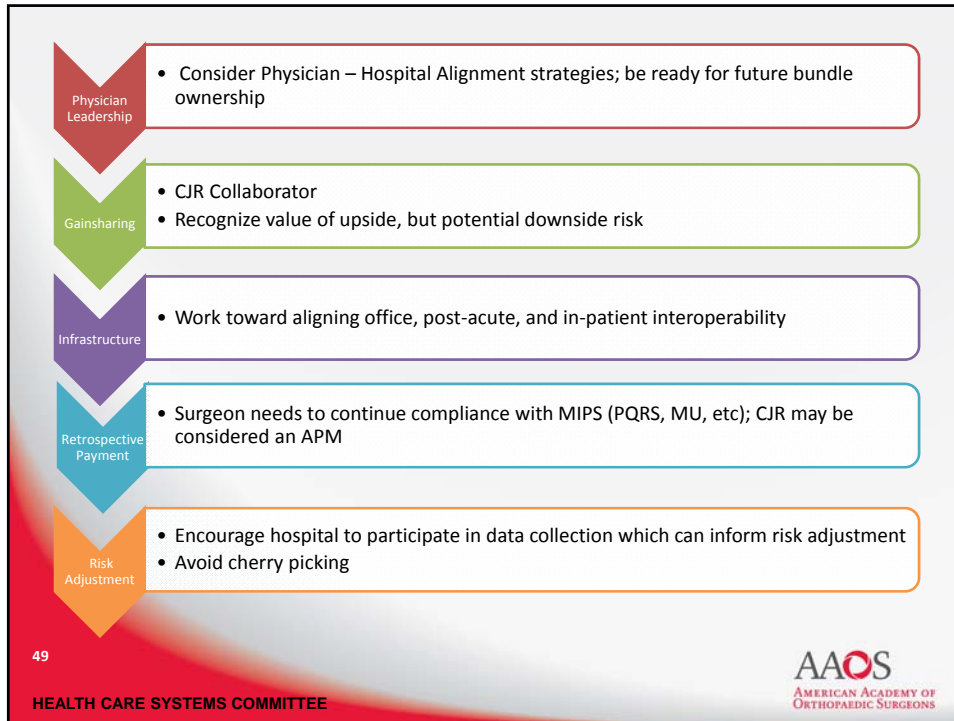
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“CJR collaborator”

**Know which costs *you*
control**
**Negotiate the value of those
savings**

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Physician Leadership

- Consider Physician – Hospital Alignment strategies; be ready for future bundle ownership

Care Coordination

- Establish care coordination office, post-acute, and in-

Retrospective Payment

- Share savings with MIPS (PQRS, HEDIS, etc.)

Risk Adjustment

- Encourage hospital to participate in risk adjustment collection which can inform risk

**Know which costs you control
Negotiate the value of those savings**

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Thank you

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Comprehensive Care for Joint Replacement (CJR) Model Major Provision Final Rule Summary

On November 16, 2015, the Centers for Medicare and Medicaid Services (CMS) issued the [final rule](#) for the Comprehensive Care for Joint Replacement (CJR) payment model, which creates a mandatory lower extremity joint replacement (LEJR) program for 791 hospitals in 67 Metropolitan Statistical Areas (MSAs). Beginning April 1, 2016, these hospitals will be held accountable for the quality and total cost of care provided to Medicare fee-for-service beneficiaries for LEJR procedures and recovery, reflecting CMS' intent to test and evaluate the impact of bundled payments for LEJRs through CY 2020. A high-level summary of the major provisions of the CJR final rule is provided below beginning with an overview of the model and its scope followed by more a more in-depth discussion of specific requirements.

CJR Model Overview/Scope: Executive Summary

- The start date for the CJR model is April 1, 2016, pushed back from the proposed start date of January 1, 2016 and slated to last five program years, with the first program year being a nine-month period from April 1 through December 31, 2016;
- CMS proposed to test the model in 75 MSAs, but eight were eliminated in the final rule based on additional information regarding BPCI participation, leaving 67 MSAs mandated to participate in the program;
- Hospitals in the 67 MSAs cannot opt out of the program; the only excluded hospitals are CAHs and hospitals already at risk for LEJR episodes under the BPCI program. Small and/or rural hospitals are not excluded;
- Medicare beneficiaries cannot opt out of the program unless they choose to have their procedure performed in a facility not located within a mandatory MSA;
- CJR episodes include the initial inpatient stay and all Medicare Parts A and B services for 90 days post-discharge, with limited exclusions;
- Episodes are triggered by an admission to the acute care setting that is discharged under Medicare Severity Diagnosis Related Group (MS-DRG) 469 or 470;
- Hospitals will be responsible for episodes of care; physicians, post-acute care providers, and conveners cannot be episode initiators under the program. Thus, hospitals are the only episode initiators and awardees under CJR;
- Providers will be paid according to current Medicare Fee-for-Service (FFS) rules, with retrospective reconciliation to the episode target prices on an annual basis;
- Target prices for the two LEJR DRGs will be stratified to reflect the difference between elective procedures and those involving more complex hip fractures, a change from the proposed rule;
- Payments for all services provided will be compared to the target amounts – CMS will recover payment amounts that exceed the target or render reconciliation payments for amounts falling under the target price;

- Target prices will be set based on a phased-in blend of regional and hospital-specific base year data. The baseline time period will be updated every two years while performance period targets will be updated twice per year;
- The maximum discount factor – originally proposed at 2% – that will be taken off the top of the target price will be 3%;
- The episode discount factor and eligibility for reconciliation payments will be linked to quality performance, to be determined using a composite quality score methodology;
- Stop-loss and stop-gain limits will be gradually phased-in, a change from the proposed rule which did not include a gradual phase-in of these limits;
- Providers who furnish direct care to CJR beneficiaries and intend to share in reconciliation payments or repayments are referred to as “CJR collaborators” and agreements must stipulate that gainsharing will not be allowed in the event of any integrity issues on the part of the collaborator;
- CMS will provide certain policy waivers only for those beneficiaries part of a CJR episode of care who meet certain conditions under CJR;
- Participating hospitals will be provided both aggregated and claims-level Medicare data on their target price calculation and regular updates on performance. While aggregated data will be provided automatically, hospitals must request claim-level data;
- Data on target prices will be provided prior to the start of the program on April 1st;
- Two quality measures and the voluntary reporting of Patient Reported Outcome (PRO) data were adopted in the Final Rule and will be used in a composite quality score methodology to link the quality of total hip arthroplasty/total knee arthroplasty (THA/TKA) procedures to payment; and
- While beneficiaries have the right to choose a provider, they cannot opt out of the program unless they choose to have the procedure performed in an alternative facility not located in one of the mandatory MSAs.

Mandatory MSAs (*FR 73288 – 73299*)

CMS selected MSAs with low BPCI saturation and high LEJR volumes. The selected MSAs were then weighted based on population size and efficiency with higher weight given to more expensive MSAs. The final 67 MSAs represent a random, stratified sample and any hospital geographically located in an MSA will be paid under CJR program rules.

CMS had proposed 75 MSAs, but deleted 8 after updating the list of BPCI participants to include the October 2015 additions and Model 2 BPCI physician episode initiators. The remaining 67 MSAs may be viewed [here](#).

Concurrent Models (*FR 73387 – 73398*)

BPCI awardees located in one of the 67 selected MSAs and currently at-risk for LEJR episodes are excluded from CJR for as long as they continue to participate in the program for LEJR. BPCI awardees in the selected MSAs *not* at-risk for LEJR episodes will be subject to CJR. The BPCI demonstration is a 3-year program; BPCI participants in the 67 MSAs that had been at-risk for LEJR episodes will automatically convert to the CJR model at the end of the demonstration. Converts will be subject to the CJR program year rules; they will not begin with program year 1 rules.

Episode Parameters (FR 73282 – 73358 and 73299 – 73318)

Under the CJR model, episodes begin with admission to an acute care hospital for an LEJR procedure assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the hospital inpatient prospective payment system (IPPS) and will end 90 days following the date of discharge from the acute care hospital. The episode will include the LEJR procedure and related hospital costs, the inpatient stay, and all related care under Medicare Parts A and B within 90 days post-discharge including hospital care, post-acute care – including a skilled nursing facility (SNF) stay – and outpatient care including physical and occupational therapy billed under Part B during a nursing center stay, related readmissions, and physician services.

Thus, while hospitals will establish desired parameters for post-discharge Medicare costs, CMS will only set episode target prices for the 2 included MS-DRGs inclusive of all hospital costs as well as Medicare costs 90 days post-discharge. CMS does not define parameters for Medicare costs for a portion of the total episode price.

CMS does identify a number of [excluded services](#) that, if delivered to a CJR patient during the 90-day window following hospital discharge, will *not* be incorporated into the episode target price or be counted toward episode spending.

Payment (FR 73324 – 73358 and 73381 – 73387)

Target Prices

CMS will set target prices for each LEJR DRG (469 and 470). Target prices will be stratified to reflect the differences in spending between elective LEJR procedures and those involving hip fractures for the 90-day episodes initiated by each MS-DRG. Targets for the first 2 program years will reflect a 3-year baseline period of CY 2012 – CY 2014. The baseline period will be updated biannually: CYs 2014 – 2016 for program years 3 and 4 and CYs 2016 – 2018 for program year 5. Each hospital will receive its own set of target prices for each program year that will reflect a phased-in blend of hospital specific and regional data to calculate the historical benchmark against which actual spending will be compared. The regional component of the blend will increase over time until hospital-specific data is phased-out as follows:

- Program years 1 and 2: 1/3 regional and 2/3 hospital specific;
- Program year 3: 2/3 regional and 1/3 hospital specific; and
- **Program years 4 and 5: 100% regional.**

Hospitals with fewer than 20 eligible episodes during any baseline period will receive 100% regional targets for the applicable years.

Baseline amounts will be trended forward to the performance year using published, payment system-specific update factors weighted by the proportion of spending in each payment system and adjusting for changes in the hospital's wage index. Targets will be adjusted to account for the impact of low volumes in DRG 469.

Discount Rate

Each hospital's target price will be discounted by 3%. This discount will be reduced (range of 1.5 and 3%) for hospitals that achieve good or excellent performance based on the composite quality measure score. With the composite score methodology, each hospital will receive a discount factor of 3%, though the discount factor would be 2% for purposes of calculating repayments to Medicare in performance years 2 and 3, reflecting the proposed discount factor reduction by 1 percentage point and the extension to performance year 3 of this reduction, to phase in downside risk.

Provider Payments

All providers – including SNFs – and suppliers will continue to be paid under the customary Medicare fee-for-service payment system rates, rules, and procedures for episode services throughout the year. However, after completion of a performance year, the Medicare claims payments for services furnished to the beneficiary during the episode, based on claims data, will be combined to calculate the actual episode payment to the provider.

Reconciliation and Repayment

The actual episode payment is defined as the sum of related Medicare claims payments for items and services furnished to a beneficiary during a CJR episode. The actual payment for CJR episodes will be reconciled retrospectively, following the end of each program/calendar year, against an established CJR target price that is stratified based on the beneficiary's fracture status, with consideration of additional payment adjustments based on quality performance, post-episode spending, and policies to limit hospital financial responsibility.

Hospitals that produce Medicare program savings below the discounted target price will be eligible to receive reconciliation payments *if they also achieve at least an "Acceptable" performance rating on the composite quality measure*. Hospitals with higher quality rankings – "Good" or "Excellent" – will be rewarded with a reduced target discount for calculating reconciliation payments – 2% for "Good" and 1.5% for "Excellent." Hospitals deemed "Below Acceptable" on the composite quality measure *will not be eligible* to receive reconciliation payments, *regardless of the amount of savings they generate*.

Hospitals producing financial results exceeding the target will be responsible for repaying overages to Medicare. However, CMS will not attempt to recover overpayments in year one, *and therefore there is no downside risk in year 1*. In the second and subsequent program years, hospitals exceeding their target will be required to pay back any excess to CMS. For years 2 and 3 of the program, the target discount will be reduced to between 0.5% and 2%, depending on quality performance. The discount will range from 1.5% to 3% in years 4 and 5.

Loss/Gain Limitations

CJR participants will be protected from the impact of individual episodes with extremely high costs – which would otherwise result in repayments to Medicare – by a high cost threshold (stop-loss limits).

Any episode payments in excess of the two standard deviations from the mean – which would otherwise result in reconciliation payments from Medicare – will not count toward either target or performance period calculations (stop-gain limits). Both stop-loss and stop-gain limits gradually increase over the course of the CJR program as shown below:

Year	Stop-Gain Limit	Stop-Loss Limit
PY1 (Apr-Dec 2016)	5%	N/A
PY2 (CY 2017)	5%	5%
PY3 (CY 2018)	10%	10%
PY4 (CY 2019)	20%	20%
PY5 (CY 2020)	20%	20%

Financial Arrangements and Waivers (FR 73412 – 73465)

Financial Arrangements

Providers who furnish direct care to CJR beneficiaries and intend to share in reconciliation payments or repayments are referred to as “CJR collaborators” and must do so under a written “Participation Agreement” with the hospital. Collaborator arrangements must be outlined for CMS in a “CJR Sharing Arrangement” and must stipulate that gainsharing will not be allowed in the event of any integrity issues on the part of the collaborator. Participating hospitals and their CJR collaborators must agree to the terms of their agreement(s) prior to providing any care under that agreement. CJR collaborators may be any of the following:

- Physicians or non-physician practitioners;
- Physician group practices;
- Inpatient rehabilitation facilities;
- Long-term care facilities;
- Skilled nursing facilities (SNFs);
- Home health agencies; and
- Providers/suppliers of outpatient therapy services.

CMS explicitly does not permit a CJR hospital to partner with a non-provider or third-party entity – such as a care management organization – where the financial relationship between the hospital and the entity is dependent on financial performance within the CJR program. Hospitals *may* continue to partner with these entities so long as the financial arrangement is not directly tied to performance under CJR.

Gainsharing payments fall into 2 categories under the CJR model: reconciliation payments and internal cost savings (ICS). Gainsharing is voluntary for the hospital, but if agreed to, the hospital must provide these payments annually; gainsharing cannot be predicated on the volume or value of referrals. Gainsharing payments made to physicians or physician group practices are capped at 50% of the total Medicare amount approved under the Physician Fee Schedule (PFS) for services furnished by the physician to any CJR beneficiaries during the calendar year.

CJR collaborators can also share in “downside” risk. Payments to hospitals under such an arrangement would be designated as “alignment payments” and are *not* permitted if the hospital is *not* in a repayment situation. Alignment payments from an individual collaborator cannot exceed 25% of the amount owed to CMS. The total amount of alignment payments a hospital receives from all collaborators cannot exceed 50% of the amount owed to CMS and may be collected at any time.

Waivers

CMS will provide certain policy waivers only for those beneficiaries part of a CJR episode of care as follows:

- **Home-Health Homebound Requirement:** CMS will waive the “incident to” direct physician supervision rule to allow a beneficiary who received care under CJR that does not satisfy requirements for home health services to receive up to 9 post-discharge home visits during an episode;
- **Telehealth:** CMS will waive the geographic site requirement for telehealth services as well as the eligible types when the otherwise eligible individual is receiving telehealth services in his or her home; and
- **SNF 3-Day Stay:** Beginning in Year 2, CMS will waive the 3-day hospital stay required for SNF payment. Using this waiver is contingent upon the SNF having an overall quality rating of 3 stars or better on the Nursing Home Compare website.

Data Sharing (*FR 73507 – 73516*)

CMS will provide baseline claims data for episodes attributed to the hospital prior to the start of Year 1 (April 1, 2016). CMS will provide performance period data on a regular basis (no less frequently than quarterly, monthly if practical). Participants must request claims data, available in 2 formats: 1) summary claims data; and 2) beneficiary-level raw claims data. CMS will automatically provide aggregated data on average episode spending by DRG for each participant hospital and its region.

Quality Measures and Reporting (*FR 73358 -73381 and 73465 – 73507*)

CMS rejected its original proposal to require at least 30th percentile performance on 3 separate quality standards – THA/TKA complications, HCAHPS, and THA/TKA readmissions – to qualify for reconciliation payments. Alternatively, CMS will adopt a composite quality measure to determine eligibility for reconciliation payments and to reward participating hospitals for quality performance, thereby linking quality and payment.

CMS will assign each CJR acute care hospital a quality composite score based on the following quality measures and how the hospital ranks on the program’s quality measures relative to other hospitals in the program. The CJR program quality measures are defined as follows:

- **THA/TKA Complication Measure:** Hospital level risk-standardized complication rate (RSCR) following elective primary THA and/or TKA;
- **HCAHPS Survey:** Hospital Consumer Assessment of Healthcare Provider and Systems Survey; and
- **THA/TKA Patient-Reported Outcomes (PRO):** With a focus on pain management and limited set of information about the patient termed “Risk Variable Data,” submitting the PRO and list of pre- and post-operative data elements for 50% or 50 total eligible patients will be used to develop PRO measures.

The new composite quality measure will combine scores on the THA/TKA complications measure (50%, maximum score of 10), the HCAHPS patient experience survey measure (40%, maximum score of 8), and recognition for collecting and reporting the new THA/TKA outcomes measure (10%, maximum score of 2). The quality composite score will be noted on a scale from 0-20, with each measure contributing a different weight and corresponding numerical score to the overall score as previously noted. Quality performance in the bottom 30% as compared to other CJR hospitals for a particular measure will receive no points.

Hospitals will be deemed the following based on their composite score: 1) “Below Acceptable”; 2) “Acceptable”; 3) “Good”; or 4) “Excellent.” Hospitals deemed “Below Acceptable” will be ineligible to receive reconciliation payments and will be subject to the largest discount – 3% – off the target price. Hospitals designated as “Good” or “Excellent” will receive smaller discounts to their target price – what CMS is calling a Quality Incentive Payment. Hospitals that do not meet the minimum volume threshold for a particular measure will be placed in the 50th percentile for scoring purposes.

Beneficiary Protections (*FR 73516 – 73528*)

The final rule states beneficiaries presenting to a hospital in any of the 67 MSAs must be notified they are part of the CJR program and are unable to opt out of inclusion in the model; however, the beneficiary’s freedom to choose a provider must be maintained. In other words, the beneficiary is permitted to change providers as they retain the right to obtain health services from any individual or organization qualified to participate in the Medicare program. CMS requires CJR hospitals to supply beneficiaries with written information regarding the design and implications of the model as well as their right to use their provider of choice.

CMS will monitor claims for issues, such as changes in case mix between the baseline and performance period to identify potential cherry-picking and will publish its findings. CMS will also audit participant hospitals’ and collaborators’ claims to ensure access to care