

Comprehensive Care for Joint Replacement (CJR) Model Three-Year Extension and Changes to Episode Definition and Pricing Final Rule

On April 29, 2021 the Centers for Medicare and Medicaid Services (CMS) released the much-anticipated Comprehensive Care for Joint Replacement (CJR) Model Three-Year Extension and Changes to Episode Definition and Pricing Final Rule (CMS-5529-F). The Final Rule extends the model an additional three performance years through December 31, 2024. The final rule also addresses changes to the episode definition, target price calculation, the elimination of the gainsharing cap, the reconciliation process, and risk adjustment methodologies. The AAOS expressed its concerns and suggestions on the proposed rule in a [comment letter](#) submitted in June 2020.

Below is a summary of key finalized proposals:

Extension of Model Performance Years

Due to the impact of the COVID-19 public health emergency, CMS previously extended Performance Year 5 (PY5) of the CJR model to September 30, 2021 in the Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Interim Final Rule with Comment (IFC) (referred to as the “November 2020 IFC” throughout the remainder of this summary). This rule makes the PY5 extension final.

The final rule extends the length of the CJR model by three additional performance years through December 31, 2024; however, the extension only applies to participant hospitals located in the 34 mandatory metropolitan statistical areas (MSAs). ***AAOS strongly urged CMS to revise the mandatory nature of the proposal and are disappointed to learn voluntary participants are being excluded from the extension.***

Performance year time frames for the three-year extension are as follows:

- PY 6 will begin on October 1, 2021 and end on December 31, 2022;
- PY 7 will begin on January 1, 2023 and end on December 31, 2023; and
- PY 8 will begin on January 1, 2024 and end on December 31, 2024.

Episode Definition to Include Outpatient Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)

Beginning with PY6, permitted outpatient TKA/THA procedures will be included in the revised the definition of an episode of care in the CJR model. Due to the extension of PY5, the revised definition now applies to episodes initiated by an anchor procedure furnished on or after July 4, 2021, because the 90-day episode would end on or after October 1, 2021.

The November 2020 IFC effectuated the incorporation of MS-DRG 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC) and MS-DRG 522 (Hip Replacement with Principal Diagnosis of Hip Fracture without MCC) into the CJR episode definition, which were introduced after the CJR proposed rule was published. This update is effective for service dates on or after October 1, 2020.

Target Price Calculation

Per the revised episode definition, this rule finalizes that target prices will be calculated for each of these four CJR episode categories:

MS-DRG 469	Major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)	
MS-DRG 470	Major joint replacement or reattachment of lower extremity without MCC	Permitted OP THAs without hip fracture and permitted OP TKAs without fracture
MS-DRG 521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC	
MS-DRG 522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC	Permitted OP THAs with hip fracture*

*Please note, CMS stands by its assumption will be NO OP TKA w/ hip fracture episodes.

In our comments on the proposed rule, AAOS urged CMS to reconsider making multiple changes to the target price calculation concurrently over concerns for creating unpredictability and unstable target prices. Despite these concerns from AAOS and other stakeholders, CMS decided to move forward with finalizing the majority of its proposed changes to the target price calculation, citing the interdependent nature of the changes.

- CMS finalized the proposals to no longer use the national anchor factor calculation and the subsequent regional & hospital weighting steps from the original CJR model target price calculation methodology beginning with PY6.
 - Only regional episode spending data will be used to calculate target prices for PY6-PY8.
- The Agency also finalized its proposal to no longer do annual updates to target price to account for changes in the Medicare Prospective Payment Systems and Fee Schedule rates.
- CMS is finalizing its proposal to use only 1 year of data to calculate target prices for PY6 – PY8.
 - To mitigate the effects of the COVID-19 pandemic on 2020 claims data, PY6 target prices will be based upon CY 2019 data. CY 2020 will be skipped completely and PY7 target prices will be based on 2021 calendar year data.
 - *AAOS urged CMS to not implement this policy due to concerns over 2019 claims data not adequately reflecting the true cost of outpatient TKA/THA, thus skewing the target price benchmarks.*
- For initial target price calculation, CMS will change the high episode spending cap from 2 standard deviations from the regional mean to the 99th percentile of national, historical costs.
 - *AAOS asked CMS to reconsider setting the cap at such a high level without precedent in our proposed rule comment letter. Alternatively, we suggested CMS take a more conservative approach and set the high episode spending cap at a lower percentile.*

In response to stakeholder feedback, CMS withdrew a proposal which would have adjusted for shared savings payments when a CJR participant hospital is also a participant or provider/supplier in certain Accountable Care Organization (ACO) models or programs to which a CJR beneficiary is aligned.

Official target prices for PY6 will be posted on the CMS website in June 2021.

Reconciliation Process and Methodology

CMS is finalizing its proposal to reduce the number of reconciliations to once per year for PY 6 – 8. Reconciliation will happen 6 months following the end of the PY (e.g. PY 6 reconciliation will happen based on claims data available on July 1, 2023). The post episode spending calculation will take place at the single reconciliation for PYs 6 through 8.

In alignment with the initial target price high episode spending cap, CMS finalized changing the high episode spending cap amount applied at reconciliation to the 99th percentile of performance year regional spending.

The Agency is also finalizing the proposed policy to include a retrospective market trend factor that will be the regional/MS-DRG mean cost for episodes occurring during the performance year divided by the regional/MS-DRG mean cost for episodes occurring during the target price base year. The purpose of the market trend factor is to account for ongoing, national spending trends un-related to the CJR model and it will be applied during reconciliation calculations.

Additional Risk Adjustment Factors

When revising its risk adjustment regression analysis with 2019 claims data, CMS discovered an error in the original programming regarding the definition of a dual-eligible beneficiary that inadvertently included beneficiaries enrolled in Medicare Part A and/or Part B and receiving full or partial Medicaid benefits. The original intent was to include only those beneficiaries with full Medicaid benefits. In its revised analysis, results showed a statistically significant impact of dual-eligibility status on episode cost.

In addition to dual-eligibility status as a risk adjustment factor (defined as beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits on the first day of the CJR model episode), CMS also finalized its previous proposal to include beneficiary age and CMS-Hierarchical Condition Category (CMS-HCC) count as risk adjustment factors. Per CMS, “the risk adjustment factors could have the effect of increasing target prices up to 250 percent for a beneficiary that is dual-eligible, 85 years or older, and with four or more HCC conditions.”¹

We appreciate CMS reevaluating its analysis of dual-eligibility status as a risk adjustment factor and the decision to include it in the final rule. In our formal comments, AAOS highlighted a recent study that found in the CJR model, hospitals with a high percentage of Medicare-Medicaid dual-eligible patients must reduce spending at a higher rate than

¹ Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Medicare and Medicaid Programs; Policies and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 86 Fed. Reg. 23496-23576 (May 3, 2021) (to be codified at 45 CFR pt. 510) <https://www.federalregister.gov/d/2021-09097>

others to obtain a positive bonus despite their high share of patients with complex social and clinical needs.² AAOS also asked CMS to consider other potential risk adjustment factors, including functional status, disability status and socioeconomic status; however, CMS chose not to include any additional risk factors at this time citing the need to maintain simplicity in the CJR program.

To mitigate the impact of the COVID-19 pandemic, risk adjustment variables will be calculated from Medicare claims data dated January 1, 2019 to December 31, 2019 for PY6 and PY7, and from January 1, 2021 to December 31, 2021 for PY8.

Changes to Composite Quality Score (CQS) Adjustment

The discount factor will remain unchanged at 3%; however, due to changes to the target price calculation in PY 6- 8, CMS is also changing the reduction to the discount factor for good quality performance to 1.5% and to 3% for participants with excellent quality scores.

Reduction to 3% Discount Factor			
	Composite Quality Score	(PY 1- 5)	(PY 6-8)
Good	6.9 – 15.0	1.0%	1.5%
Excellent	>= 15.0	1.5%	3.0%

In this way, “Excellent” quality scores will essentially cancel out the discount factor.

AAOS expressed appreciation for greater recognition and rewards for “Good” and “Excellent” quality scores in the proposed rule and are happy to see that policy finalized. We also provided several recommendations for how CMS may make the CQS measures more clinically relevant to orthopaedic surgeons and reflective of the patient perspective; however, CMS chose to not act upon those suggestions in the final rule.

Beneficiary Notification

In response to concerned stakeholders, CMS modified its proposal on beneficiary notification timing requirements. Participant hospitals must now provide notification to the CJR beneficiary prior to discharge from the anchor hospitalization, or prior to discharge from the anchor procedure, as applicable.

² Kim, H., Meath, T. H., Dobbertin, K., Quiñones, A. R., Ibrahim, S. A., & McConnell, K. J. (2019). Association of the Mandatory Medicare Bundled Payment With Joint Replacement Outcomes in Hospitals With Disadvantaged Patients. *JAMA network open*, 2(11), e1914696-e1914696.



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Elimination of 50 Percent Cap on Gainsharing Payments, Distribution Payments, and Downstream Distribution Payments

CMS finalized the proposal to eliminate the 50 percent cap on gainsharing payments, distribution payments, and downstream distribution payments when the recipient of these payments is a physician, non-physician practitioner, physician group practice, or non-physician practitioner group practice for episodes that end on or after October 1, 2021.

Though CMS did not address AAOS's recommendation to revise the CJR model to give operating surgeons and physician groups the ability to be in charge of the bundle, we are encouraged by the elimination of the gainsharing cap.

Overall CMS estimates the changes adopted in this final rule will “result in net Medicare program savings of approximately \$217 million over the 3 performance years (2021 through 2024).”³

CMS's factsheet on the CJR Extension Final Rule can be found here:

<https://innovation.cms.gov/media/document/cjr-fs-finalruleext>

The Final Rule can be accessed in the Federal Register here:

<https://www.federalregister.gov/documents/2021/05/03/2021-09097/medicare-program-comprehensive-care-for-joint-replacement-model-three-year-extension-and-changes-to>

³ Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Medicare and Medicaid Programs; Policies and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 86 Fed. Reg. 23496-23576 (May 3, 2021) (to be codified at 45 CFR pt. 510) <https://www.federalregister.gov/d/2021-09097>