

## MODEL OVERVIEW

The Comprehensive Care for Joint Replacement (CJR) model is a five year model that launched on April 1, 2016 and tests whether a mandatory episode based payment approach for lower extremity joint replacement (LEJR) can incentivize hospitals to reduce costs while maintaining or improving quality. CJR participant hospitals are financially accountable for the quality and cost of health care services during the episode, which begins with the hospitalization for the surgery and extends for 90 days after the hospital stay.

At the end of each performance year, actual episode payments are compared to the hospital's quality-adjusted target price. Hospitals can earn a reconciliation payment if episode payments are below their target price and, starting in 2017, hospitals with episode payments above their target price repay Medicare.

## PARTICIPANTS

This evaluation report covers the first two performance years in which **147,923 LEJR episodes** were initiated by **733 hospitals** in **67 randomly selected metropolitan statistical areas (MSA)**. All hospitals in selected areas were required to participate. The mandatory, randomized design resulted in a diverse group of hospitals, with representation from a wide range of markets, hospitals, and patient types. The design of the model changed in the third performance year with hospitals in the 34 MSAs with the highest average historical episode payments remaining mandatory.

**77% of CJR participant hospitals earned reconciliation payments** in one or both performance years. All different types of hospitals were able to be successful under the CJR model.

## HOSPITAL STRATEGIES

Many hospital interviewees indicated the opportunity to prepare for future bundled payment models was a strong motivating factor in responding to the CJR model. Hospital representatives indicated that they focused on reducing institutional post-acute care (PAC) by emphasizing patient education and earlier discharge planning, speeding physical therapy after the surgery, and working with PAC providers on care protocols. These actions are consistent with the model's goal to improve care coordination. Here are some examples of what we heard:

*"And so now that we've been able to have that communication upfront with the patient and family, we have actually gone through and looked at what is each SNF's quality data and here are the ones that far outweigh the others. The patient, the family can still have their choice regardless, but it's a more well-informed decision for them."*

- Hospital director of quality

### Of the 196 hospital survey respondents:

**89%** reported implementing same day post-surgery ambulation and physical therapy

**81%** reported scheduling follow up appointments for all LEJR patients prior to discharge

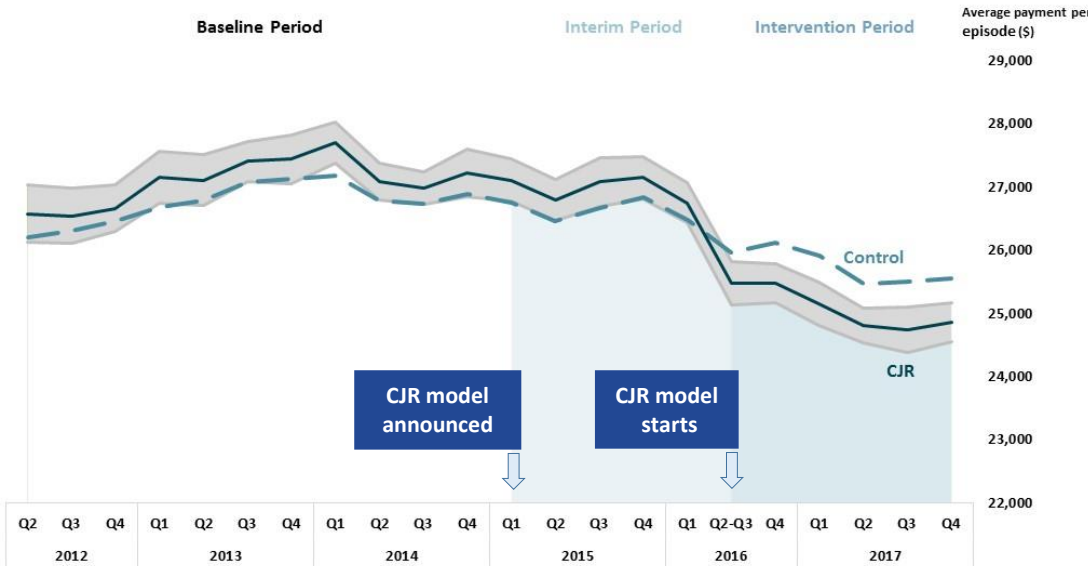
**65%** reported implementing repeated telephonic follow-up during the entire 90-day episode

**61%** felt that physician engagement in care redesign activities had improved since the CJR model

This document summarizes the evaluation report prepared by an independent contractor. For more information about this model and to download the 2<sup>nd</sup> annual evaluation report, visit <https://innovation.cms.gov/initiatives/cjr>.

### FINDINGS

Significant declines in average episode payments have persisted under the CJR model



CJR episode payments decreased by **3.7%** more in the first two years of the CJR model. This represents a **\$146.3 M** gross savings.

CMS distributed **\$128.9 M** in reconciliation payments to hospitals. After accounting for these payments, net savings to Medicare is estimated to be **\$17.4 M** or **0.5%** of baseline payments.

There were statistically significant payment reductions achieved across a variety of:

Markets		Hospitals		Patient Types	
<b>-4.2%</b>	high cost MSAs	<b>-3.7%</b>	high LEJR volume	<b>-3.7%</b>	most complex
<b>-2.8%</b>	low cost MSAs	<b>-4.2%</b>	medium LEJR volume	<b>-3.2%</b>	least complex
				<b>-4.1%</b>	elective surgery
				<b>-2.8%</b>	fracture surgery

### Payment reductions due to shifts in post-acute care

Changes in post-acute care use, suggesting shifts to less intensive sites of care, contributed the most to the decrease in episode payments. Discharges to inpatient rehabilitation facilities went down. The proportion of LEJR patients first discharged home with home health care rose. The proportion of LEJR patients first discharged to skilled nursing facilities remained constant, but the average length of stay decreased, which resulted in lower payments.

### Quality of care maintained under the model

The CJR model did not impact unplanned readmissions, emergency department visits, or mortality. CJR and comparison group patient survey respondents reported making similar gains in functional status from before their hospitalization to after the end of the episode, and reported similar satisfaction with their overall recovery, care management, and care transitions experiences. While the majority of patients reported needing some level of caregiver support, CJR patients reported needing slightly more help than comparison beneficiaries.

### KEY TAKEAWAYS

The CJR model continues to demonstrate promising reductions in Medicare payments, while maintaining quality of care. After two performance years, average episode payments decreased by 3.7% or \$146M, predominantly by changing PAC use. After accounting for reconciliation payments earned by participants, the CJR model likely resulted in net savings to the Medicare program of \$17.4M, although we cannot conclude this with statistical certainty. A range of hospitals, with a range of resources and circumstances, can and do respond to the incentives under a mandatory episode-based payment approach. In future reports, we will expand our understanding of how the changes to the model impacted payment, utilization and quality outcomes.