Findings at a Glance

Comprehensive Care for Joint Replacement (CJR) Model

Evaluation of Performance Years 1 to 5 (2016 – September 2021)

MODEL OVERVIEW

The Comprehensive Care for Joint Replacement (CJR) model launched on April 1, 2016 to test whether an episode-based payment model for lower extremity joint replacements (LEJR) can lower payments while maintaining or improving quality.

Model Design Innovations

- Hospitals are financially accountable for the cost of the surgery and health care services for the following 90 days.
- A target pricing approach that considers performance relative to a hospital's regional peers and links payment to quality.
- A risk adjustment methodology that establishes higher quality-adjusted target prices for more complex episodes.

The model requires hospitals to focus efforts on:

1) Reducing overall hip and knee replacement costs; and
2) Improving quality of care by implementing a more collaborative approach with physicians, post-acute care providers, and other clinicians.

PARTICIPANTS

Report focuses on 205,893 joint replacements performed in 395 CJR mandatory hospitals located in 34 metropolitan statistical areas

HOSPITAL STRATEGIES

Hospitals invested in care coordination to achieve the goals of the CJR model.

Care coordination efforts typically required significant resources. As a result, 41% of hospitals hired additional staff or reassigned roles and 23% of hospitals dedicated additional staff or resources to care coordination due to the CJR model.

70% of care coordinators reported that the CJR model influenced…

Patient Care and Outcomes	Patient Engagement	Post-Acute Care Communication	Data Utilization
Tracking patient outcomes during the post-discharge period	Following up with patients after discharge	Communicating with post-acute care providers	Reviewing readmission data
Developing discharge or transition plans	Actively engaging patients in discharge planning	Monitoring patients discharged to post-acute care	Performing risk assessment or stratification

Survey data based on responses from care coordinators at 199 CJR hospitals.

This document summarizes the evaluation report prepared by an independent contractor. For more information about this model and to download the 5th annual evaluation report, visit https://innovation.cms.gov/initiatives/cjr.

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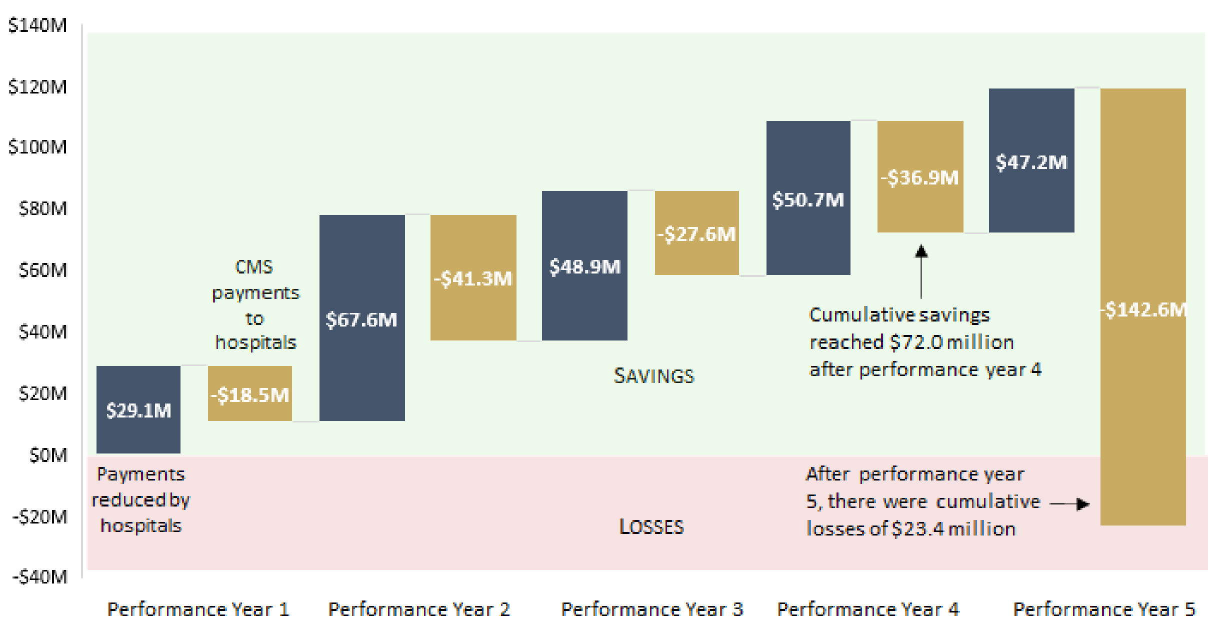
FINDINGS

$ Mandatory CJR hospitals generated Medicare savings until 2020, when savings were offset due to the COVID-19 public health emergency policy to remove downside risk



Performance year 5 included episodes ending between Jan. 2020 and Sep. 2021. For episodes starting between Jan. 31, 2020 and Mar. 31, 2021, CMS capped episode payments at the quality-adjusted target price for the purposes of calculating reconciliation during the pandemic.

Quality of care was improved or maintained

There was a relative improvement in the elective LEJR complications rate for CJR compared to control patients; otherwise, the CJR model did not impact quality.

CJR hip fracture patients reported similar functional recovery to control patients on our survey. This suggests that potential adverse effects on recovery observed previously may have dissipated.

We evaluated disparities under the CJR model for historically underserved populations

Before the CJR model, there were large disparities in elective LEJR rates, payments, institutional post-acute care use, and quality. The elective LEJR rate was 40% to 60% lower for historically underserved populations than reference populations.

The CJR model reduced payments for all underserved populations, by reducing institutional post-acute care use. We observed larger payment reductions and a lower mortality rate for Black or African American patients than White patients.

Under the CJR model, the disparity in elective LEJR rates widened for Black or African American and Black or African American dually eligible patients. No other changes to the pre-existing disparities were observed.

KEY TAKEAWAYS

The CJR model continues to be a promising approach for reducing episode payments. Through the first five years, participating mandatory hospitals responded to the model's financial incentives by reducing institutional post-acute care use, resulting in relative reductions in episode payments without compromising quality of care. This was observed for elective and fracture LEJR episodes, as well as all historically underserved populations. The CJR model did not impact the existing disparities between historically underserved populations and their reference populations in payments, utilization, and quality observed prior to the model. However, there was evidence suggesting that disparities in elective LEJR rates widened for some populations. CJR hospitals consistently generated savings until 2020 when smaller payment reductions and larger payments from CMS due to the pandemic offset cumulative savings and resulted in losses.