Comprehensive Care for Joint Replacement Model
Frequently Asked Questions

July 9, 2015

Q1: Where can I find a copy of the proposed rule and how can I comment?
A1: You can read the proposed rule in the Federal Register at https://www.federalregister.gov/public-inspection and can be viewed at https://www.federalregister.gov starting July 14, 2015.

We encourage all interested parties to submit comments electronically through the CMS e-Regulation website at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking or on paper by following the instructions included in the proposed rule. Submissions must be received by September 8, 2015.

Q2: How would the Comprehensive Care for Joint Replacement (CCJR) model support the HHS delivery system reform goals of better care, smarter spending, and healthier people?
A2: The proposed CCJR model is an alternative payment model and would contribute to the Medicare goals set by the Administration of having 30 percent of all Medicare payments made via alternative payment models by 2016 and 50 percent by 2018. Effective implementation of CCJR would improve the quality and efficiency of care for Medicare beneficiaries, which is essential to creating a health care system that delivers better care, spends our dollars more wisely, and leads to healthier Americans.

Q3: Who would be affected by the CCJR model?
A3: We propose that most hospitals in select geographic areas would be required to participate in the model and would have the opportunity to partner with surgeons, other physicians, and post-acute care providers to coordinate patient care more effectively. The care of Medicare beneficiaries meeting certain criteria who have an inpatient hospitalization for lower extremity joint replacement (LEJR) as designated by MS-DRG 469 or 470 at participant hospitals would be included in the model. These MS-DRGs primarily include single-joint total hip and total knee replacement procedures.

Q4: Where would the CCJR model be implemented?
A4: The proposed model would be tested in 75 geographic areas defined by metropolitan statistical areas (MSAs) across the United States. A complete list of proposed MSAs can be found on our website. By definition, MSAs are counties associated with a core urban area of at least 50,000 in population. Counties that are not in an MSA (no urban core area or urban core area of less than 50,000 in population) are not included.

Q5: How were hospitals chosen to participate in the model?
A5: We propose that all hospitals paid under the Inpatient Prospective Payment System (IPPS) in selected MSAs and not currently participating in Model 1 or Phase II of Models 2 or 4 of the Bundled Payments for Care Improvement initiative for the lower extremity joint replacement clinical episode be included in the model. Proposed MSAs were selected using a stratified randomized method. First, MSAs were classified into groups according to their historic LEJR episode payments and their population size. Next, we randomly selected MSAs within these groups. Only hospitals physically located in the selected MSAs would participate in the CCJR model. Hospitals outside these geographic areas cannot participate. There is no application process for this model.

Q6: Why are hospitals required to participate in the CCJR model?
A6: With the proposed CCJR model, CMS would test a model implemented at the geographic regional level. We believe it is important to test this alternative payment model among a wide range of hospitals, including those who would not necessarily apply to participate. We believe that by requiring the participation of a large number of hospitals with diverse characteristics, the proposed model would result in a robust data set for evaluation of this bundled payment approach, and would stimulate the rapid development of new evidence-based knowledge. Testing the model in this manner would also allow us to learn more about patterns of inefficient utilization of health care services and how to incentivize the improvement of quality for common LEJR procedure episodes. This learning potentially could inform future Medicare payment policy.

Q7: Why are you testing the CCJR model?
A7: We believe that there is an opportunity to improve care for Medicare beneficiaries who undergo lower extremity joint replacement. Lower extremity joint replacements are common, expensive procedures with a significant recovery period. There is substantial regional variation in care patterns and episode spending. The CCJR model would test bundled payment and quality measurement for an episode of care associated with hip and knee replacements to better align incentives for hospitals, physicians, and post-acute care providers to improve quality and coordination of care from the initial hospitalization through discharge and recovery. We anticipate that this model would improve care coordination and care transitions between medical settings and produce better outcomes for Medicare beneficiaries.

Q8: When would the CCJR model start and for how long would it last?
A8: The proposed CCJR model would be implemented on January 1, 2016, and would consist of five performance years.

Q9: How would the CCJR model improve the quality of care for patients?
A9: The proposed CCJR model may improve quality in three ways. First, the model would adopt a quality first principle where hospitals must achieve quality performance requirements before receiving reconciliation payments when episode spending is below the target price. Second, quality performance requirements would increase over the lifetime of the model in order to incentivize continuous improvement on these measures. Third, CMS would provide additional tools to improve the effectiveness of care coordination by participant hospitals in selected MSAs. Proposed activities include providing hospitals with relevant spending and utilization data, waiving certain Medicare requirements to encourage flexibility in the delivery of care, and facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.

Q10: How would providers and suppliers be paid under the CCJR model?
A10: Every year, the model would set a Medicare episode price for each participant hospital that includes payment for all related services received by eligible Medicare fee-for-service beneficiaries who have LEJR procedures at that hospital. Providers and suppliers would be paid under the existing payment systems in the Medicare program for episode services throughout the year. Following the end of a model performance year, actual episode spending for a participant hospital would be compared to the Medicare episode price for that hospital. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or, beginning in the second year of the model, may need to repay Medicare for a portion of the episode spending.

Q11: How would this model be evaluated?
A11: Like all models tested by CMS, there would be a formal, independent evaluation using quantitative and qualitative data. Outcomes evaluated would include both quality and costs of care.

Q12: Would this model restrict beneficiaries from receiving certain types of services?
A12: Medicare beneficiaries would retain their freedom to choose their providers, and providers may continue to provide any medically necessary covered services. The model proposes to change the payment methodology for providers in select geographic regions that furnish LEJR services, but it would not require beneficiaries to receive services from certain providers, nor would it limit them to certain types of services.

Also, patient data would continue to be protected under the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy laws. Under the CCJR model, CMS would only share data with participant hospitals and only in response to a request by the hospital for data that meets the requirements of the HIPAA Privacy Rule. Participant hospitals would be subject to all existing HIPAA restrictions and consequences where provisions are violated. Those beneficiaries who do not wish to have their data shared can contact 1-800-Medicare to make their preference known.

For more information, visit: http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-09.html

Additional information can be found at http://innovation.cms.gov/initiatives/ccjr/