

Comprehensive Care for Joint Replacement (CJR) Model

Hip and knee replacements are the most common medical procedures for Medicare beneficiaries. Even with modern advancements, these procedures still require lengthy rehabilitation periods and are costly. Although these procedures are the most common, the cost of care and the length of recovery varies greatly among patients. For instance, the rate of complications like infections or implant failures after surgery can be more than three times higher for procedures performed at some hospitals than others.

Although there are many reasons for these variations in the cost, quality of the surgery, and length of recovery of the joint replacement, one reason is due to the lack of coordinated care before, during, and after surgery. This lack of care coordination has led to more complications after surgery, higher readmission rates, protracted rehabilitative care, and variable costs. Incentives to coordinate the whole episode of care – from surgery to recovery – are not strong enough, and a patient’s health may suffer as a result.

To address the discrepancy in care in lower extremity joint replacements (LEJR), including total hip, knee, and ankle replacements for Medicare beneficiaries, the Centers for Medicare and Medicaid Services (CMS) created the Comprehensive Care for Joint Replacement (CJR) model. Beginning April 1, 2016, the model has helped provide incentives for healthcare providers to increase coordination with other healthcare providers throughout the episode of care. In the five years since CJR’s implementation, the increased coordination has helped improve quality of care, while working to decrease the cost of joint replacements for Medicare beneficiaries.

As the most recent annual evaluation report shows, measures of quality either improved or were maintained in the first three years of the model for mandatory CJR hospitals. Specifically, unplanned readmission rate and complication rate for elective surgeries improved, and emergency department use and mortality remained unchanged. Also, CJR patients and control survey respondents reported similar improvements in functional status and pain from before their episode and similar satisfaction with their overall recovery and care management.

In addition, the CJR model showed a statistically significant decrease in average episode spending due to decreased utilization of post-acute care (PAC). In the first three years of the model, mandatory CJR hospitals achieved a statistically significant decrease in average payments for all LEJR compared to a control group. In total, the model has achieved \$61.6 million net savings, or 2% of savings compared to the baseline period, after accounting for reconciliation payments to participant hospitals.

Reasons for the CJR Model:

- LEJR are the most commonly performed Medicare inpatient surgery, and utilization

has continued to grow since 2016.

- This model drives significant movement toward new payment and care delivery models in various areas of care for Medicare beneficiaries.
- This model supports HHS efforts to focus on quality care, smarter spending, and healthier people through care transformation and payment reform.

How the CJR model helps—and protects—beneficiaries:

- Coordination of care leads to better outcomes, better experiences, and fewer complications. Recent evaluation reports show improved coordination of care has helped decrease preventable readmissions, infections, and prolonged rehabilitation and recovery.
- Benefits from CJR protections include: additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services. Also, beneficiaries have continued protection of patient data under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable privacy laws; and patient notification by providers and suppliers. Further, all existing safeguards to protect beneficiaries and patients will remain in place. If a beneficiary believes that his or her care has been adversely affected, he or she can call 1-800-MEDICARE or contact his or her state’s Quality Improvement Organization (QIO) by going to <http://www.qioprogram.org>. If concerns are identified, CMS will initiate audits and corrective action under existing authority.
- As before, patients can continue to choose their doctor, hospital, skilled nursing facility, home health agency, and other providers, but now the CJR model provides incentives for care providers to better coordinate their care with other medical professionals.

How the CJR Model works:

- Under this model, the hospital that performs the LEJR is accountable for the costs and quality of related care from the time of the surgery through 90 days after hospital discharge or 90 days after the procedure for outpatient procedure — what is called an “episode” of care. With knee and hip replacements being removed from the inpatient only list in January 2018 and January 2020, the definition of an episode of care in the CJR model is updated for PY6 to include permitted hip or knee replacement procedures in the hospital outpatient setting.
- Hospitals in the model are provided access to additional tools – such as spending and utilization data and sharing of best practices – to improve the effectiveness of care

coordination. The model also gives providers additional flexibilities that are not otherwise available under Medicare so they can better manage the care of patients.

- Depending on the hospital's quality and cost performance during the episode, the hospital either earns a financial reward or is required to repay Medicare for a portion of the spending above an established target. This payment structure gives hospitals an incentive to work with physicians, home health agencies, skilled nursing facilities, and other providers to make sure beneficiaries receive the coordinated care they need. The goal of this payment structure is to reduce avoidable hospitalizations and complications.
- By "bundling" payments for an episode of care, hospitals, physicians, and other providers have an incentive to work together to deliver more effective and efficient care.
- As of October 1, 2021, approximately 330 hospitals are participating in the model in 34 mandatory metropolitan statistical areas (MSA's) throughout the country, excluding rural and low-volume hospitals.

Key Takeaways from the Evaluation

- Mandatory CJR hospitals reduced average episode payments in each of the first three performance years, while maintaining or improving performance on quality measures
- Reductions in average episode payments were driven by fewer patients going to inpatient rehabilitation facilities and patients spending fewer days in skilled nursing facilities.
- Hospital interviewees reported strategies to coordinate care throughout the episode, however the amount of control hospitals had over care redesign was influenced by hospital resources and market conditions.

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