

**CJR Model: Three-Year Extension and Changes to Episode Definition and Pricing
and Additional Relevant Rulemaking Webinar**

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Alicia Goroski: Welcome to the “CJR Model: Three-Year Extension and Changes to Episode Definition and Pricing and Additional Relevant Rulemaking” recorded webinar. We acknowledge that this is a challenging time for the entire healthcare system, and we thank you for your time and attention. We are grateful for your dedication and your ongoing efforts.

This webinar will provide an overview of the recently published proposed rule, which aims to extend the length of the CJR model for an additional three years. It will also contain an overview of the interim final rule with comment period and the IPPS fiscal year 2021 proposed rule.

The agenda begins with a quick overview of logistics, followed by the proposed rule presentation. This will be followed by a presentation on the interim final rule with comment period. Then we will have a short presentation on the inpatient prospective payment system proposed rule, followed by a review of the public comment submission instructions. Then we will wrap up with a few announcements and reminders.

Just a quick reminder. If you would like to enlarge the slides as you are viewing today's recording, click on the four outward facing arrows that you will find as you hover your mouse toward the top of the slide, and that will enlarge the slides to take up your full screen. To return to the original view, click on the four arrows that will now be facing inward.

On slide four, we have a reminder for how to download the materials for today's session from the event resources pod. You should find these to the right of the slides, and to download a file, select the file and click the download file button, which will open a pop-up window that will allow you to save the document to your computer.

We have three presenters for today's recorded webinar. All presenters are from the Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services. Today you will be hearing from Heather Holsey, Matt Fox and Sarah Mioduski.

I would like to read the disclaimer: This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference. This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Now, I will turn today's recording over to Heather Holsey.

Heather Holsey: Thank you, Alicia. The proposed rule is currently available for public comment on the federal register site, and we will have additional information on the last slide of this presentation on how to submit comments and where to go for more information. Please note that the public comment period has been extended and now closes June 23, 2020 at 5pm ET.

The proposed rule proposes several changes to the CJR Model. Most notably, it proposes to extend the CJR Model for an additional 3 performance years, performance year 6 through performance year 8. The proposed rule also proposes to make changes to the definition of a CJR episode to include outpatient knee and hip replacements. We are proposing this episode definition change in order to address changes to the inpatient-only list that now allow for total knee and total hip replacements to be treated in the outpatient setting.

Additionally, the rule proposes changes to the CJR target price calculation. Specifically, CMS has proposed to change the basis for the target price from three years of claims data to the most recent one year of claims data, to remove the national update factor and twice yearly update to the target price that accounts for prospective payment system and fee schedule updates, to remove anchor weights, to incorporate additional risk adjustment to the target pricing, and to change the high episode spending cap calculation methodology.

Additionally, CMS has proposed several changes to the CJR reconciliation process. Specifically, the proposed rule has proposed to move from two reconciliation periods to one reconciliation period that will be conducted 6 months after the close of each performance year, and to add an additional episode-level risk adjustment beyond fracture status such that the target price will be further adjusted at the episode level based on the individual beneficiary's age and HCC count condition. The proposed rule proposes to make conforming changes to the beneficiary notification, gainsharing caps, appeal process, and waiver sections to align with the proposed model extension as well as the proposed changes to episode definition.

The CJR Model is a CMS CMMI model that aims to reduce Medicare expenditures while preserving or enhancing quality of care for Medicare beneficiaries. The model tests whether bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the inpatient hospitalization through recovery. Under the CJR Model, these participant hospitals receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity. Currently, a CJR episode begins with an inpatient admission for MS-DRG 469 or 470 and includes, with limited exceptions, all care for 90 days following discharge.

Originally established to run for five performance years, the CJR Model was designed to further CMS' goals of improving the efficiency and quality of care for Medicare beneficiaries. Additional information and background materials regarding the CJR Model are available on our website.

In the November 2015 Final Rule, participant hospitals were located in 67 MSAs, with limited exceptions. The MSAs were randomly selected from 294 eligible MSAs and presented in the final rule. In the December 2017 Final Rule, rural and low-volume hospitals selected for participation in the CJR model, as well as those hospitals located in 33 of the 67 MSAs, were given a one-time option to choose whether to continue their participation in the model through December 31, 2020. The remaining 34 MSAs were required to continue participating in the model. This proposed rule will apply only to those participant hospitals with a CCN primary address in the 34 mandatory MSAs. The model changes and extension will exclude participant hospitals in those mandatory MSAs that are low-volume hospitals or that have received a notification from CMS dated prior to October 4, 2020 that they have been designated as rural hospitals and that voluntarily elected to participate in the CJR model for performance years 3 through 5.

Currently, CJR model episodes are initiated by an inpatient MS-DRG 469 or 470 discharge of an eligible Medicare beneficiary from a CJR participant hospital. The proposed rule proposes to change this episode definition in order to address the removal of TKA and THA from the inpatient-only list, which allows these procedures to be reimbursed by Medicare when performed in the outpatient setting. We are proposing that TKA and THA procedures performed in the outpatient setting will also trigger a CJR episode. Outpatient TKA episodes will be reconciled against the MS-DRG 470 without hip fracture target price, while outpatient THA episodes will be reconciled against either the MS-DRG 470 with hip fracture or without hip fracture target price, as applicable.

Now I will turn the presentation over to Matt Fox to discuss payment and pricing, and financial arrangements.

Matt Fox: Thank you, Heather. While there are a number of proposed changes to the CJR payment and pricing methodology, the general concept remains the same. Participant hospitals are provided with prospective episode target prices based on historical episode spending, and those hospitals have the opportunity to achieve a reconciliation payment if their performance year spending is below the applicable target price or they may owe a repayment if their spending is above the applicable target price.

New payment methodology provisions in the proposed rule relating to target pricing are listed here. Specifically, instead of using 3 years of historical data to calculate target prices, we are proposing to use the most recently available one year of historical data. Therefore, we propose to base performance year 6 target prices on episode baseline data from 2019, performance year 7 target prices on episode baseline data from 2020, and performance year 8 target prices on episode baseline data from 2021. We believe that using only the most recently available one year of baseline data will provide the best available picture of spending patterns we would expect to see during the performance period, which will allow us to calculate more accurate target prices.

Since we propose to continue using 100% regional pricing data to calculate target prices and no longer use hospital-specific data, we propose to remove the use of anchor factors and weights in the target price calculation.

Lastly, while we propose to use regional data for the target price calculation, we seek comment on the appropriateness of moving to a national pricing approach in future years of the CJR model.

We have proposed a number of changes to the reconciliation process as well. First, in an effort to recognize the greater needs of certain beneficiaries that are beyond a participant hospital's control, we are proposing to incorporate episode-specific risk adjustment factors for performance years 6 through 8. Specifically, we propose to adjust target prices at reconciliation using two patient-level risk factors: the number of CMS-Hierarchical Condition Category, or HCC, conditions of a beneficiary and the age of a beneficiary. We propose to incorporate these risk adjustment factors in combination with the existing factor related to the presence or absence of a hip fracture.

Next, we propose to replace the CJR methodology of twice yearly updates for fee schedule changes with a retrospective trend adjustment factor during reconciliation. We anticipate the proposed trend adjustment factor will ensure that target prices better capture spending trends and changes.

Lastly, we propose to no longer conduct a second CJR reconciliation 14 months after the end of each performance year. Instead, we propose to conduct one CJR reconciliation 6 months after the end of a performance year. This change is intended to reduce the administrative burden of an additional reconciliation for Medicare and CJR participant hospitals.

The Composite Quality Score, or CQS, determines whether a participant is eligible for a reconciliation payment, that is, if savings are achieved beyond the quality-adjusted target price, and what effective discount percentage is applied to the CJR-episode specific benchmark price for reconciliation payment. A participant hospital's quality performance determines their rating for each performance year of acceptable, unacceptable, good, or excellent. Currently, participants with unacceptable quality are not eligible for reconciliation payments and have an effective discount percentage of 3%. The proposed rule does not propose to change this.

Currently, those hospitals with acceptable, good, or excellent quality are eligible for reconciliation payment and have an effective discount percentage of 3%, 2%, or 1.5%, respectively. The proposed rule proposes to move to a 0% quality withhold for participants with excellent quality scores and a 1.5% withhold for participants with good quality scores. CJR participants with a higher level of quality performance would generally experience a lower effective discount percentage at reconciliation, resulting in greater financial opportunity for the CJR participant.

The last change to the payment methodology relates to our strategy to limit the impact of extremely high cost episodes. The high episode spending cap policy is designed to prevent participant hospitals from being held responsible for catastrophic episode spending amounts that they could not reasonably have been expected to prevent, by capping those costs for those episodes. We currently apply a cap at 2 standard deviations above the regional mean, also known as the high episode payment ceiling, when calculating initial CJR target prices and when comparing actual CJR episode payments to CJR episode benchmark and quality adjusted target prices at reconciliation.

The proposed rule proposes to set the cap at the 99% percentile of arrayed actual costs for each episode type for each region. We anticipate this proposed approach to capping high cost episodes will more accurately apply to true outlier episodes than the previous method.

Consistent with applicable law and regulations, CJR participant hospitals may currently engage in financial arrangements under the model. Specifically, CJR participant hospitals may share reconciliation payments and internal cost savings with collaborators, such as certain Accountable Care Organizations, hospitals, Critical Access Hospitals, non-physician provider group practices, and therapy group practices.

Collaborators may then share gainsharing payments as distribution payments to collaboration agents, such as physician group practice members, non-physician group practice members, ACO participants, or ACO providers or suppliers. Collaboration agents that are PGPs or NPPGPs apart of a collaborator ACO may share distribution payments as downstream distribution payments to downstream collaboration agents who are physician group practice members or non-physician group practice members.

In regards to physicians or non-physician practitioners, the CJR model has always included a cap on gainsharing payments, distribution payments, and downstream distribution payments. However, we are proposing to eliminate the 50% cap on Gainsharing Payments, Distribution Payments, and Downstream Distribution Payments. It was determined that the existing cap is arbitrary, limiting, and its burdens

outweigh its benefits, and the elimination of the cap is consistent with BPCI Advanced policy. Additionally, we believe that participant hospitals, CJR collaborators, collaboration agents, and downstream collaboration agents are now accustomed to the episode-based CJR payment methodology and that administrative burden should be reduced and further flexibility should be offered to allow hospitals to share internal cost savings or earned reconciliation payments by removing the gainsharing cap.

I will now turn it over to Sarah to discuss waivers, beneficiary notifications, and other aspects of the proposed rule, as well as regulations affecting the CJR model.

Sarah Mioduski: Thanks, Matt. Currently, the CJR model waives the SNF 3-day rule for coverage of a SNF stay for a CJR beneficiary, if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of the CJR beneficiary's admission to the SNF.

As we discussed previously, in this CJR Extension proposed rule we are proposing to change the episode of care to include outpatient procedures for TKA and THA. Therefore, based on this proposal, we are proposing for performance years 6 through 8 to extend the SNF 3-day waiver to include beneficiaries who initiate CJR episodes in the outpatient setting.

We do not anticipate that a beneficiary who receives a LEJR procedure in the outpatient setting will need a SNF stay. However, in the event that a participant hospital performs an LEJR procedure in the outpatient setting and due to unforeseen circumstances, the beneficiary needs a SNF stay and has not had a qualifying 3-day inpatient stay, we do not want the beneficiary to be held financially liable for these costs. Beneficiaries would still need to be discharged pursuant to the waiver and must be admitted to SNFs rated 3-stars or higher on the CMS Nursing Home Compare website.

We are also proposing to update the direct supervision requirement in the proposed rule. Currently, in Section 510.600 of the CJR regulations, CMS waives the direct supervision requirement to allow clinical staff to furnish certain post-discharge home visits under the general, rather than direct, supervision of a physician or non-physician practitioners. We propose in this rule that this waiver will apply for LEJR procedures performed in the outpatient setting as well.

Given our proposal to add to the definition of anchor procedure to mean a TKA or THA procedure that is permitted and reimbursable by Medicare when performed in the outpatient setting and billed through the OPPS, we believe that the beneficiary should be notified of his or her inclusion in the CJR model whether the procedure takes place in an inpatient or outpatient setting. Therefore, we propose changes for the participant hospital detailed notification to clarify that if the anchor procedure or anchor hospitalization is scheduled in advance, then the participant hospital must provide notice as soon as the anchor procedure or anchor hospitalization is scheduled.

While initial evaluation results for the first and second year of the CJR model indicate that the CJR model is having a positive impact on lowering episode costs when CJR participant hospitals are compared to non-CJR hospitals, changes in program payment policy and national care delivery patterns have occurred since the CJR model began. With our proposal to extend the model for an additional 3 years, we can better evaluate the model while addressing these changes.

The evaluation will assess the impact of the CJR model on the aims of improved care quality and efficiency, as well as reduced health care costs. Some focus areas of the evaluation are payment and utilization impact, quality of care and outcomes, unintended consequences, referral patterns and market impact, and potential for extrapolation of results.

On March 13, 2020 the President of the United States declared the 2019 Novel Coronavirus or COVID-19 outbreak a national emergency. Following, Secretary Azar issued a waiver of reimbursements under Section 1135 of the Social Security Act. The waivers and modifications issued here have a retroactive effect to March 1, 2020, nationwide. The interim final rule with comment period, or IFC, gives individuals and entities that provide services to Medicare beneficiaries needed flexibility to respond effectively to the serious public health threats posed by the spread of COVID-19. Recognizing the immense impact of this pandemic, we are making programmatic changes to the CJR model.

Though regulations in the IFC are applicable March 1, 2020, the public can provide comment on these regulations. Instructions for submitting comments can be found in the proposed rule. To be assured consideration, comments must be received no later than 5 p.m. on June 1, 2020.

We are implementing two changes to the model to support the continuity of model operations and to ensure that CJR participant hospitals do not unfairly suffer financial consequences from the impact of COVID-19 due to their participation in CJR. First, we are implementing a 3-month extension to CJR performance year 5 such that the model will now end on March 31, 2021, rather than ending on December 31, 2020. Secondly, we are also implementing a change to the extreme and uncontrollable circumstance policy in this IFC such that it will be applicable to episodes impacted by the COVID-19 pandemic. We are also broadening the extreme and uncontrollable circumstances policy by applying certain financial safeguards to participant hospitals that have a CCN primary address that is located in an emergency area for episodes that overlap with the emergency period, as those terms are defined in Section 1135(g) of the Social Security Act. Accordingly, all participant hospitals are located in the emergency area and qualify for the financial safeguards during the emergency period.

As for the financial safeguards, we are proposing that for a fracture or non-fracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before the date that the emergency period begins or that occurs through the termination of the emergency period, actual episode payments are capped at the target price determined for that episode under section 510.300. March 1 is the effective date of the emergency period.

Again, you will see on this slide, it references what I previously said about the financial safeguards and it does apply to all hospitals during the emergency period. Again, March 1 is the effective date of the emergency period and the policies will start on or within 30 days before the March 1 date.

For Fiscal Year 2021, CMS is proposing to create new MS-DRG 521, which is Hip Replacement with Principal Diagnosis of Hip Fracture with major complication or comorbidity, and new MS-DRG 522, Hip Replacement with Principal Diagnosis of Hip Fracture without a major complication or comorbidity.

Given the proposal to create MS- DRG 521 and 522, we are soliciting comments on the effects this proposal would have on the CJR model and whether to incorporate it, if finalized, into the CJR model's proposed extension to December 31, 2023. Please refer to that rule for submitting instructions of public comments.

We want to share this slide containing information on the submission of public comments. Please note that it is not possible to include all of the policies included in the proposed rule in this presentation. Please refer to the proposed rule published on the Federal Register, as all of the policies are outlined in detail there. Additional information can be found at our website, listed at the bottom of this slide. As in all rulemaking, only those comments submitted through the official process summarized on this slide by the close of the comment period will be considered and responded to in the final rule finalizing the policies for these models. For those who wish to submit comments on the IFC or the IPPS proposed rule, please refer to those rules for commenting instructions and deadlines.

We want to thank you very much for taking the time for our presentation today, and we hope that this has been very helpful. We look forward to reviewing any comments you submit through [regulations.gov](https://www.regulations.gov). I will now turn the presentation back to Alicia for some housekeeping items.

Alicia Goroski: Thank you Sarah, Matt and Heather. Yes, I would like to just do a couple reminders before we wrap up today's recording. First, all of the materials from this event are available on CJR Connect in the CJR Connect libraries. If you do not have a CJR Connect account, you may navigate to the URL that you see on slide 31. You can also click up in the right-hand corner of your screen on web links, to CJR Connect, and that will take you right to that site.

A recent change to CJR Connect policy does mean that users who have not been active for 60 days or more will have their accounts suspended. Therefore, to avoid suspension, users must be logging in at least once every 60 days. If your CJR Connect account has been suspended and you would like to regain access, follow the instructions at the bottom of slide 31. This includes emailing or calling the CMMI helpdesk.

Finally, just another reminder that the public comment period for the CJR proposed rule closes at 5 PM Eastern on June 23, 2020, and the public comment period for the interim final rule with comment closes at 5 PM Eastern on June 1, 2020. Feedback from this event will not be considered as formal comments on the aforementioned rule. Please follow the process to submit your final comments.

You may send any questions or CJR model point of contact updates directly to CJRsupport@CMS.HHS.gov. And again, you will find the link on slide 32 to request a CJR Connect account or to login to CJR Connect.

And again I would like to thank our presenters for this recording, and I would encourage everyone to please take a few minutes to respond to the post-event survey, which should have just popped up on your screen. You may need to disable your pop-up blockers.

Thank you everyone for your time and attention, and I hope you have a good rest of your day.