

February 21, 2020

CMS Proposes Changes to Hip and Knee Bundled Payment Program

The Centers for Medicare & Medicaid Services (CMS) Feb. 20 issued a [rule](#) proposing changes to the Comprehensive Care for Joint Replacement (CJR) model, which bundles payment to acute care hospitals for hip and knee replacement surgery. Under this model, hospitals in which a joint replacement has taken place are held financially accountable for episode quality and costs.

Among other proposals, CMS would extend the CJR model for an additional three years, through Dec. 31, 2023, beyond its current five-year timeline. However, this extension would apply only to hospitals in the 34 metropolitan statistical areas (MSAs) in which participation was mandatory. Hospitals participating in the 33 “voluntary” MSAs, as well as all low-volume and rural hospitals that have elected to participate, will continue to see the model end on Dec. 31, 2020.

AHA Take: The AHA has long been supportive of voluntary participation in alternative payment models as a pathway to potentially improve care coordination and efficiency. As such, we are disappointed that CMS is not proposing to extend voluntary participation options in the CJR model.

A summary with highlights of the proposed rule follows.

Key Takeaways

- CMS proposes to extend the CJR model for an additional three years, through Dec. 31, 2023.
- This extension would apply only to hospitals participating on a mandatory basis.
- CMS would add outpatient procedures to the CJR model, and, as a result, add additional risk adjustment as well.
- The agency proposes to increase shared savings thresholds to hospitals with higher quality scores.
- CMS would use one year of data — the most recent available — to set hospital pricing targets as compared to the current three years of data.
- CMS proposes to retain the same quality measures for the extension of the model.
- The proposed rule will be published in the Feb. 24 *Federal Register*, and CMS will accept comments for 60 days after it is published.

HIGHLIGHTS OF THE PROPOSED RULE

Episode of Care: Currently, a CJR episode begins with a beneficiary's admission to an inpatient prospective payment system hospital for a procedure assigned to either Medicare-severity diagnosis-related group (MS-DRG) 469 or 470.¹ However, CMS proposes a change to this definition to address the fact that total knee arthroplasty (TKA) and total hip arthroplasty (THA) procedures were recently removed from the inpatient-only list and are now being performed in both outpatient and inpatient settings. Specifically, CMS would include outpatient TKAs and THAs as episode "triggers" for CJR.

For purposes of calculating episode "target prices," CMS proposes to group outpatient TKA and non-hip fracture THA procedures together with the generally less severe MS-DRG 470 non-hip fracture episodes. Outpatient THA procedures with a hip fracture would be grouped with MS-DRG 470 hip-fracture episodes.

Payment Methodology. CMS currently uses three years of historical data to calculate hospital target prices. It set this policy because it was concerned that using less data would not generate stable target prices. However, as of performance year four of the program, target prices are based entirely on historical data across an entire region, rather than across individual hospitals, which has mitigated CMS's concerns about low volume. Thus, it proposes to use one year of data — the most recent available — to set target prices.

In addition, as a means of risk adjustment for the model, CMS currently sets four separate target prices for each hospital: for MS-DRGs 469 and 470, for patients with and without hip fractures. However, the agency states that given its proposal to include outpatient THA and TKA procedures in the model, it believes additional risk adjustment is warranted. Thus, it proposes to also incorporate data on CMS hierarchical condition category (HCC) condition count and beneficiary age into the target price calculation. CMS proposes to use five CMS-HCC condition count variables to account for the expected marginal cost of treating beneficiaries with zero, one, two, three or four or more CMS-HCCs. It proposes four age categories: less than 65, 65 to 74, 75 to 84 and 85 or older.

In order to determine any shared savings, CMS currently compares a hospital's actual spending to its target price minus a percent discount that varies depending on its quality score. Hospitals keep any savings they achieve in excess of this percent discount, again subject to quality performance. For the extension of the model (performance years six through eight), CMS proposes changes to the discount amounts, which would provide more favorable factors for higher quality scores (see Table 1 below).

¹ MS-DRG 469 is Major Joint Replacement or Reattachment of Lower Extremity with Major Complications or Comorbidities (MCC) and MS-DRG 470 is Major Joint Replacement or Reattachment of Lower Extremity without MCC.

Table 1: Discount Factor by Performance Year

Quality Score	Year 5	Proposed Years 6-8
Below acceptable	N/A	N/A
Acceptable	3.0%	3.0%
Good	2.0%	1.5%
Excellent	1.5%	0.0%

Reconciliation. CMS proposes to change the high-episode spending cap used at reconciliation. Specifically, the agency implemented a high-episode spending cap policy to prevent hospitals from being held responsible for catastrophic episode spending that they could not have reasonably been expected to prevent. Under this policy, CMS caps the spending amount of episodes at two standard deviations above the mean. However, CMS now proposes to change the methodology to cap episode spending at the 99th percentile. The agency believes this change would more accurately represent the cost of infrequent and potentially non-preventable complications.

CMS also proposes to move from two reconciliation periods (conducted two and 14 months after the close of each performance year) to one reconciliation period conducted six months after the close of each performance year. The agency has determined that the full 14 months is not necessarily required to sufficiently capture claims run out and overlap with other models. Rather, CMS believes that six months is adequate for capturing episode costs, and that one less reconciliation would reduce administrative burden for the agency and hospitals alike.

Quality Measurement. CMS proposes to retain the same quality measures for the extension of the model. The two mandatory quality measures would remain the hip/knee complications and Hospital Consumer Assessment of Providers and Systems measures that hospitals already report for the inpatient quality reporting program. In addition, CMS would retain an optional patient-reported outcome (PRO) measure that enables hospitals to increase their composite quality score. However, CMS proposes to increase the data completeness thresholds for the PRO measure such that by the last year of the extension, hospitals must report on 100% of eligible cases. For all measures, performance periods and reporting deadlines would remain consistent with prior years.

NEXT STEPS

The proposed rule will be published in the Feb. 24 *Federal Register*. CMS will accept comments for 60 days after the rule is published. AHA staff will continue to review and analyze it.

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