TOP STORY—Out with the old models, CJR model gets revamped, (Aug. 16, 2017)

Changes to participation and refinements to payment are proposed for the Comprehensive Care for Joint Replacement (CJR) model under a Proposed rule announced on August 15, 2017. The Proposed rule also aims to cancel the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) incentive payment model and to rescind regulations at 42 CFR part 512. All models were created under Soc. Sec. Act sec. 1115A by the Center for Medicare and Medicaid Innovation, an initiative rising out of the Affordable Care Act (ACA) (P.L. 111-148) sec. 3021. Comments on the rule must be received no later than October 15, 2017.

Background of CJR model. The CJR model’s goal is to provide more efficient, better quality care and improve care coordination for Medicare beneficiaries undergoing hip and knee replacements throughout recovery. The model holds participating hospitals accountable for the quality and cost of the replacements and incentivizes increased coordination among the providers. At the beginning of the performance year, CMS sets the target prices for specific MS-DRGs and providers and suppliers are paid under the usual payment system throughout the year. At the end of the year, the actual spending for the replacements is compared to the target price, and depending on the level of quality and episode spending achieved by the hospital, it may receive an additional payment or may be required to repay a portion of its payment.

Proposed changes to CJR model. Among the proposed changes are the following:

1. Make the CJR model voluntary to eligible hospitals in 33 of the 67 geographic areas selected for participation and for low volume and rural hospitals in all 67 areas. The program would remain mandatory for non-low volume and non-rural hospitals the other 34 areas. Specific election procedures must be followed for voluntary participants.
2. Add provision of 42 CFR 510.410(b)(1)(i)(G) to allow CMS to take remedial action if a participating hospital does not meet evaluation activities.
3. Clarify that participating hospitals must use applicable ICD-CM code set that is updated and released each year.
4. Clarify that when a reorganization results in a hospital receiving a new CMS Certification Number (CCN), that separate reconciliation calculations would be performed for episodes before and after the reorganization (42 CFR 510.305(d)(1)).
5. Adjust pricing calculation for telehealth HCPCS codes to include facility practice expense (PE) values.
6. Clarify that subsequent reconciliation of amended composite quality score methodology during performance year 1 will differ.
7. Make clarifying and technical changes for the use of CMS price standardization detailed methodology.

EPMs and CR models. The EPMs were created to improve efficiency and quality of care for Medicare beneficiaries and to better coordinate care from the initial hospitalization through recovery. There are four EPMs: the acute myocardial infarction (AMI) model, coronary artery bypass graft (CABG) model, surgical hip and femur fracture treatment (SHFFT) model, and the CR model. The CR model requires acute care hospitals in certain areas to participate in incentive payments for having Medicare beneficiaries in cardiac rehabilitation/intensive cardiac rehabilitation (CR/ICR) for 90 days following an AMI or CABG episode. The cancellation of these models is proposed because CMS believes: (1) requiring participation in additional EPMs is not in the best interest of CMS or providers; (2) reducing the number of providers required to participation in the CJR model will allow for
evaluation of that model while limiting the effect of other mandatory models; (3) a different method of solicitation would be used in the future, and (4) allows CMS with greater flexibility to design and test other models.