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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: May 5, 2021

Re: **Final Rule Summary – Medicare Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing**

On April 29, 2021, the Centers for Medicare & Medicaid Services ("CMS") released a final rule ("Final Rule") extending the length of the Comprehensive Care for Joint Replacement ("CJR") Model for an additional 3 performance years ("PYs"). CMS previously issued a proposed rule on the CJR Model in February 24, 2020, and subsequently issued two interim final rules with comment periods ("IFCs") in response to the COVID-19 public health emergency ("PHE") that also addressed the CJR Model. The Final Rule will go into effect on July 2, 2021.

The following summarizes key provisions of the Final Rule and AAHKS comments on the IFCs, including changes to the episode of care definition, the target price calculation, the reconciliation process, the beneficiary notice requirements, and the appeals process of the CJR Model. The Final Rule eliminates the 50 percent cap on gainsharing payments, distribution payments, and downstream distribution payments for certain recipients and extends additional flexibilities to certain Medicare program rules consistent with the revised episode of care definition. The Final Rule also finalizes certain policies from the two previous IFCs.

I. CMS Extended the Duration of the CJR Model for an Additional 3 PYs and Excluded Certain Participants from the Extension

CMS added 3 performance years to extend the CJR model through December 31, 2024.

PY 6	Oct. 1, 2021 – Dec. 31, 2022
PY 7	Jan. 1, 2023 – Dec. 31, 2023
PY 8	Jan. 1, 2024 – Dec. 31, 2024

CMS sought comments on the duration of the current PY 5 through September or December of 2021 and therefore whether PY6 should consist of 15 or 12 months. AAHKS supported the extension of CJR PY 5 to December 31, 2021 in recognition of the burden of the COVID-19 pandemic, and to allow more time to resume normal volume of elective procedures. Instead, CMS will conclude the pandemic-extended PY5 on September 30, 2021 and a 15-month PY6 will then commence.

The extension of the CJR model only applies to participant hospitals located in the 34 mandatory metropolitan statistical areas ("MSAs") for whom participation has been mandatory since the beginning of the model in 2016. The review excludes rural and low-volume hospitals in the 34 mandatory MSAs and any voluntary hospitals in 33 voluntary MSAs that opted into the model for PYs 3 through 5. As a result, 330 hospitals in the 34 mandatory MSAs will be participating in PYs 6 to 8.

II. CMS Revised the Definition of an "Episode of Care" to Include Outpatient TKA and THA and Finalized its Proposal to Freeze the Hip Fracture List and Episode Exclusions List

Consistent with AAHKS' requests, CMS added outpatient TKA and THA to the CJR model "episode of care" definition with a blended inpatient/outpatient target price to address the recent removal of the TKA and THA procedure codes from the IPO list.[1] CMS also revised the definition "anchor procedure" to include a TKA or THA procedure that is permitted and payable by Medicare when performed in the outpatient setting and billed through the OPPS. CMS also finalized a freeze on the hip fracture list and episode exclusions list given the relative stability of the ICD-10-CM code set used to determine hip fractures and exclusions and will discontinue the annual sub-regulatory process to update the hip fracture list and episode exclusions list.

III. CMS Revisions to Target Price, Updates, and High Episode Spending Cap

Changed to 1 Year of Baseline Data. As earlier proposed by CMS the PY6 target prices will be based on episode baseline data from 2019. PY7 target prices will be based on episode baseline data from 2021, and PY8 target prices will be based on episode baseline data from 2022. CMS determined that 1 year of data, rather than 3 years of data, would be sufficient to calculate target prices for all participant hospitals and that the most recently available 1 year of data would be a more appropriate baseline period on which to set target prices given the removal of TKA from the IPO list and the national shift in lower extremity joint replacements ("LEJR") spending. CMS anticipates that the corrective mechanisms of PYs 6 through 8 payment methodology and market trend factors will reduce potential distortions caused by the COVID-19 PHE.

Removed Anchor Factor and Weights, and Prospective Payment System Target Pricing Updates. As proposed, CMS removed the anchor factor and weights and updates to the target prices as a result of prospective payment system changes. The use regional episode spending data only and no hospital-specific data to calculate target prices for PY6 through 8 addresses CMS' concerns that a lack of volume of data for certain participant hospitals may limit the predictability of the target price calculation. The removal of hospital-specific ratios of MS-DRG 469 to 470 episodes for PY4 and 5 from the target price calculation addressed CMS' concern that a participant hospital's ratio of MS-DRG 469 to 470 episodes might skew the pooled historical

[1] CMS noted that its internal claims data showed that 25% of Medicare fee-for-service TKA procedures were performed during an outpatient admission.

average episode payment. CMS will stop using the national anchor factor calculation and the subsequent regional and hospital weighting steps in the CJR model target price calculation method for PY6 through 8. CMS also will not continue the annual updates to the target prices since the new market trend adjustment for target prices at reconciliation will adjust for the 2-year percent change in prices at the regional/MS-DRG level.

Shifted to Using the 99th Percentile for Determining the High Episode Spending Cap Amount in Initial Target Price Calculation. As proposed, CMS will use the 99th percentile of historical costs when capping episodes prior to calculating the target prices. The high episode spending cap calculation would utilize the national summary of episode data to calculate the 99th percentile of each MS-DRG and hip fracture combination for each region and total episode. Costs above the 99th percentile would be capped prior to calculating target prices for each MS-DRG and hip fracture combination for each region. AAHKS recommended that CMS set the high episode spending cap at the 90th percentile so that hospitals and surgeons would not be punished for taking the risk of treating the most vulnerable and complex patients. CMS argued that this method will "more accurately represent the cost of infrequent and potentially non-preventable complications for each category of episode the participant hospital could not have reasonably controlled." CMS maintains that the risk adjustment methodology, with the addition of the dual-eligibility status variable, will adjust target prices to account for characteristics of certain LEJR patients that are associated with higher costs.

IV. Reconciliation, Risk Adjustment, Trend Factors, and Quality Adjustments

Shifted to one reconciliation period instead of two. CMS will move from two reconciliation periods (conducted 2 and 14 months after the close of each performance year) to one reconciliation period conducted 6x months after the close of each performance year to reduce hospital and administrative burdens. The post-episode spending calculation will be applied at the single reconciliation for PYs 6 through 8. Episodes that are subject to a PY 5.2 target price but are reconciled in PY 6 will not be subject to the additional risk and market trend adjustments that will otherwise apply at the first reconciliation for PY 6. CMS did not finalize its proposal to extend previous overlap calculations and post-episode spending calculations to PYs 6 through 8, since the calculations had been applied at the subsequent reconciliation.

Added episode-level risk adjustments to adjust the target price at reconciliation using three patient-level risk factors. CMS initially proposed adding to the CJR a risk adjustment factor for a beneficiary's age and Hierarchal Condition Category ("HCC") count. AAHKS thanked CMS for finally adding risk adjustment to the program as has been requested since 2015. AAHKS added that CMS should include further risk adjustment for beneficiary socioeconomic status. In response to comments from AAHKS and other stakeholders, CMS will add a third risk adjustment factor for dual eligible beneficiaries (those enrolled in both Medicare and Medicaid) which is commonly understood as a proxy for socioeconomic status. The data used to calculate all risk adjustment coefficients for PY6 will be derived from Medicare claims data from January 1, 2019, to December 31, 2019, and the coefficients will be held constant and used for PY7. The

coefficients for PY8 will be derived from Medicare claims data from January 1, 2021 to December 31, 2021.

Changes to the Trend Factor Calculation. CMS finalized a market trend factor that will be the regional/MS-DRG mean cost for episodes occurring during the performance year divided by the regional/MS-DRG mean cost for episodes occurring during the target price base year. CMS will make a minor adjustment to this methodology to calculate PY6 target prices for MS-DRGs 521 and 522 to align the methodology with the addition of the new MS-DRGs to the CJR episode definition. In those instances, CMS will only adjust the IPPS portion of episode costs for baseline episodes initiated by MS-DRG 469 and 470 with fracture. CMS will make this adjustment prior to the application of the market trend factor for PY6 target prices for episodes initiated by MS-DRGs 521 and 522.

Quality Adjustment Increases. CMS increased to 1.5 percentage point, from 1.0, the reduction to the applicable discount factor for participant hospitals with "good" quality performance and increased to a 3 percentage point, from 1.5, the reduction for participant hospitals with "excellent" quality performance for the composite score adjustment.

V. Modified Dates of Publicly Reported Data Use for Quality Measures and Patient-Reported Outcomes (PROs)

CMS modified the PRO and Risk Variable Submission Requirements to reduce the percentage and procedure PRO data submission thresholds for PYs 6 through 8 as noted in Table 5a. Stakeholders expressed challenges reaching current benchmarks in PY5 (≥80% or ≥200 eligible procedures) and commented that requiring 100 percent submission was neither feasible nor realistic for participant hospitals.

TABLE 5a. REVISED PERFORMANCE PERIODS FOR PRE- AND POST-OPERATIVE THA/TKA VOLUNTARY DATA SUBMISSION

Model Year	Performance Period	Patient Population Eligible for THA/TKA Voluntary Data Submission	Requirements for Successful THA/TKA Voluntary Data Submission
2021	July 1, 2019 through June 30, 2020.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2019 and June 30, 2020.	Submit POST-operative data on primary elective THA/TKA procedures for >80% or ≥200 procedures performed between July 1, 2019 and June 30, 2020.
2022.....	July 1, 2021 through June 30, 2022.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2021 and June 30, 2022.	Submit PRE-operative data on primary elective THA/TKA procedures for >80% or ≥300 procedures performed between July 1, 2021 and June 30, 2022.
2023.....	July 1, 2021 through June 30, 2022.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2021 and June 30, 2022.	Submit POST-operative data on primary elective THA/TKA procedures for ≥80% or ≥300 procedures performed between July 1, 2021 and June 30, 2022.
2023	July 1, 2022 through June 30, 2023.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2022 and June 30, 2023.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥85% or ≥400 procedures performed between July 1, 2022 and June 30, 2023.
2024.....	July 1, 2022 through June 30, 2023.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2022 and June 30, 2023.	Submit POST-operative data on primary elective THA/TKA procedures for ≥85% or ≥400 procedures performed between July 1, 2022 and June 30, 2023.
2024	July 1, 2023 through June 30, 2024.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2023 and June 30, 2024.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥90% or ≥500 procedures performed between July 1, 2023 and June 30, 2024.

CMS extended the post-op collection window for PYs 6 through 8 an additional 2 months, totaling 14 months. The start of post-op collection window for PY6 will remain unchanged, but will extend an additional 2 months (April 1, 2020 through August 31, 2021). CMS will shift the PY6 pre-op collection window 1 year later than originally proposed to April 1, 2021 through June 30, 2022. CMS made additional technical updates to the language. CMS also finalized its proposal to advance the Complications and HCAHPS performance periods for PYs 6 through 8 in alignment with the performance periods used for PYs 1 through 5.

VI. Eliminated the 50 Percent Cap on Gainsharing Payments, Distribution Payments, and Downstream Distribution Payments.

In response to long standing requests by AAHKS and other stakeholders, CMS eliminated the 50 percent cap on gainsharing payments, distribution payments, and downstream distribution payments when the recipient of these payments is a physician, non-physician practitioner, physician group practice, or non-physician practitioner group practice for episodes that end on or after October 1, 2021, to account for the new end date of PY5.

VII. Collected Comments on New LEJR-Focused Models Incorporating ASCs

CMS received comments regarding how a new model might better recognize the role of surgeons and clinicians in LEJR episodes, but will continue to seek input from stakeholders as they consider future models that incorporate ASCs. In responding to the proposed rule, AAHKS recommend against a separate bundled payment model for ASCs. If there were separate models for ASCs and hospitals it would exacerbate the existing problem of drawing low-cost, low-complexity outpatient TJA episodes out of hospitals, thereby skewing target prices and performance. Rather, AAHKS advocated for a single site-neutral LEJR model that encompasses ASCs and inpatient and outpatient hospitals procedures.

VIII. CMS Finalized Policies in Two Interim Final Rules with Comment (IFCs)

CMS finalized that, within PY5, CMS would separately perform the reconciliation processes for PY subsets 5.1 and 5.2 because providing two reconciliation periods allows participant hospitals the opportunity to receive a reconciliation payment, if applicable, on a timelier schedule rather than having an extended gap between reconciliation payments.

CMS finalized that as of October 1, 2020, the CJR model includes episodes when the MS-DRG assigned at discharge for an anchor hospitalization is one of two new MS-DRGs: MS-DRG 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with Major Complications and Comorbidities (MCC) and MS-DRG 522 (Hip Replacement with Principal Diagnosis of Hip Fracture, without MCC) to monitor MS-DRG 469 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC) and MS-DRG 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC).

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