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Summary and Analysis of CMS Proposed and Final Rules versus AAOS Comments:
Comprehensive Care for Joint Replacement Model (CJR)

The table below summarizes the specific provisions noted in the **Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Proposed Rule [CMS-5516-P]** for which the American Association of Orthopaedic Surgeons (AAOS) submitted comments to CMS in September, 2015 and related/corresponding provisions stated in the **Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Final Rule [CMS-5516-F].** Notably, the language listed under "Proposed Rule Provisions" and "Final Rule Provisions" do not necessarily represent the proposals or final rules issued by CMS in their entirety but rather reflect those provisions for which AAOS provided comment. An Executive Summary inclusive of all major provisions reflected in the final rule will follow in a separate document.

You may access the Proposed and Final Rules at: http://www.gpo.gov/fdsys/pkg/FR-2015-08-25/pdf/2015-20994.pdf and http://www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf, respectively. AAOS' comment letter on the Proposed Rule can be found at: http://www.regulations.gov/#!documentDetail;D=CMS-2015-0082-0002

Proposed Rule Provisions	AAOS Comments/Recommendations	Final Rule Provisions
Mandatory Participation for Providers, Facilities Included in Assigned MSAs		
• As opposed to CMMI's Bundled Payment for Care Improvement (BPCI) models, the Comprehensive Joint Replacement (CJR) program would require participation of all hospitals throughout selected geographic areas, resulting in a model containing various hospital type. • Model mandates participation for all surgical episodes in 75 assigned Metropolitan Statistical Areas (75). • MSAs were included in the proposal by stratifying MSAs nationwide according to specified characteristics.	***Comments*** • Strongly support *voluntary* bundled and episode-of-care pilot projects. • Believe mandated participation for all surgical episodes in 75 assigned MSAs flawed, should be replaced by voluntary approach for providers/facilities. • Mandating all practicing providers designated MSAs to participate will be force surgeons and facilities (lacking experience/proper infrastructure) to support care redesign efforts into bundled payment system.	• Model continues to be mandatory, will now include participant hospitals in 67 MSAs: http://www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf. • All Inpatient Prospective Payment System (IPPS) hospitals in selected MSA *not* participating in BPCI Model 1 or Phase II of Models 2 or 4 for LEJR episodes to be included in CJR model.

	• Mandatory participation will disadvantage those without proper infrastructure to optimize patient care under episodes-of-care payment models and/or lack patient volumes to create sufficient economies of scale. ***Recommendations*** • Revise mandatory nature of the proposal, create incentives for interested participants to reward innovation and high quality care. • Create nationwide voluntary program for any surgeons, facilities, other providers to collaborate to bring higher quality, improved care coordination, lower costs for musculoskeletal care. • Ensure infrastructure necessary to carry out an episode of care approach to payment and delivery. • ***Specifically,*** AAOS recommended that CMS require participating entities have verifiable interoperability, infrastructure, and agreements between all necessary entities.	
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Immediate and Full Program Implementation		
• In the PR, CMS proposed to initiate the program on January 1, 2016 for all 75 MSAs. • Any changes made by CMS to the proposal would be implemented immediately with no transition time between implementation and the deadline for comments on the FR.	***Comments*** • Period of 60 days far too brief to implement and transition into this model. • Brief implementation and transition compounded by mandatory participation requirement. • If full program implementation is not extended, participants face startup and	• Full implementation is delayed by three months, set to begin April 1, 2016. • CMS plans to make participating hospitals' baseline data available upon request prior to the April 1st start date to allow participants to assess their baseline data as they consider changes to their practices prior to the model's start date.

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• Medicare participants and patients in these MSAs would have only 60 days from final rule publication to make this transition.	integration problems, increasing difficulty in achieving improvements in patient care quality and costs. ***Recommendations*** • Postponement of mandatory implementation feature until at least 85% of providers attain Meaningful Use (MU) or another metric of infrastructure readiness. • Infrastructural readiness will provide CMS time to monitor progress, determine what is and is not working within voluntary BPCI program.	• An episode will last for 90 days with five model performance years, April 1, 2016 through December 31, 2020 and the first lasting nine months.
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Lack of Physician Leadership		
• CMS proposed to make acute care hospitals the responsible party for managing the episode of care. • Proposed rule would allow the hospital to choose to enter arrangements with other providers and facilities to share potential savings and risk.	***Comments*** • AAOS stated that CMS' proposal to make acute care hospitals responsible for managing the episode of care requires change to designate that physicians – specifically orthopaedic surgeons – be the primary responsible party or at least equivalent in status to the hospital. • It is the orthopaedic surgeon who is involved in the patient's care throughout the episode of care from pre-op to the surgery to inpatient and outpatient rehabilitative post-op care – no other party is as involved in the patient's care nor as important to the patient's final outcome. • All episodes treated under the program should be overseen by an orthopaedic surgeon, who bears the most risk throughout the episode of care.	• The acute care hospital – the site where surgery takes place – will be held accountable for spending throughout the episode of care. • Many hospitals aligning resources, efforts under other CMS models and programs, including Accountable Care Organization (ACO) initiatives such as the Medicare Shared Savings Program, and the Hospital Readmissions Reduction Program (HRRP). • The services of providers and suppliers other than that of the acute care hospital where hospitalization for the lower extremity joint replacement (LEJR) procedure occurs would not necessarily be furnished in every LEJR episode. • Physician leadership for episodes of care not included, may not have the

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	Recommendations • Revise proposal to afford operating surgeons and physician groups ability to lead the bundle, or create mechanism allowing the surgeon or group to participate with facility or third party to manage episode, collect payments, recoup overpayments, return "shared savings" across care spectrum. • Explicitly placing a surgeon as head or co-head of episodes would significantly reduce patient quality outcome barriers. • Hospitals should be explicitly prohibited in rulemaking from restricting providers or from engaging in provider credentialing to limit physician ability to perform TJRs, essential to ensure beneficiaries have ability to choose any surgeon or provider for required services.	procedure volume, resources to invest in care coordination.
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Lack of Infrastructure Support		
No Provision	***Comments*** • Full scale implementation within 60 days of FR publication unrealistic, likely to disrupt patient-access-to-care patterns. • May potentially cause financial harm to physicians and facilities. • Proposal timing exacerbated by concurrent mandatory ICD-10 adoption. • Incomplete infrastructural support, MU attestation at 18 and 48% for physicians and hospitals, respectively.	• Full-scale implementation and other requirements finalized as proposed. • States most hospitals have some infrastructure in place related to interoperable health information technology (HIT) and qualified electronic health records (EHRs). • CMS' timeline ignores multiple competing mandates (ICD-10-CM implementation, EHR Meaningful Use, other quality-related programs), current state of interoperable infrastructure.

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	• EHR vendors plagued practices with lack of interoperability, errors in 2014 PQRS program. ***Recommendations*** • Until issues addressed and reliable systems in place, no further mandates should be initiated. • Must further strengthen better analytics and support, best practices and ease-of-reporting tools, patient risk assessment measures, data sharing with physicians via transparency between hospitals, payers in place and prior to adding programs requiring additional infrastructure investment and development.	• Voluntary BPCI participants provided at least one year to consider baseline episode data.
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Lack of Risk Adjustment		
• CMS proposed to base adjustments for quality on current Inpatient Prospective Payment System (IPPS) quality measures and future outcome measures for DRGS 469 and 470. • These measures are not risk-stratified, nor risk-adjusted.	***Comments*** • Basing adjustments for quality on current IPPS quality measures and future outcome measures for DRGs 469 and 470 results in large post-acute care cost variation as measures not risk-stratified or risk-adjusted. • Reliance on current DRG categories to differentiate patient risk inadequate for stratifying patients for entire episode of care. • Relying on only the two MS-DRGs to differentiate hospital payments do not incorporate functional status measures and cannot be used to adjust for longer episodes.	• CJR hospitals will receive separate episode target prices for MS-DRGs 469 and 470, reflecting differences in spending for episodes initiated by each MS-DRG. • CMS will implement a specific pricing methodology for hip fracture patients due to significantly higher spending associated with these complex procedures. • CMS to utilize a simple risk stratification methodology to set different target prices for patients with hip fractures within each MS-DRG. • CMS will NOT be risk-adjusting measures for socio-demographic

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	• Unclear if variation reflects legitimate differences in patient needs and not "unnecessary" care. • Patients with chronic illnesses/functional or cognitive limitations require rehabilitation for longer periods of time in more expensive settings. • CMS acknowledges need for risk adjustment beyond DRGs, concludes no best approach to risk-adjustment, not to be performed under program. ***Recommendations*** • Lack of risk-adjustment standard flawed, recommend implementation delay to also develop and test appropriate risk-adjustment model over time and work with stakeholders to develop optimal risk-adjustment system for program. • Program should enable teams of providers to redesign care to reduce or eliminate avoidable spending, yet ensure patients with greater needs can access increased levels of care. • Program should not financially penalize providers who perform joint replacements on high acuity patients and discourage providers from performing procedures on such patients or encourage providers to stint in needed care. • Episode payment amounts must be risk-adjusted or risk-stratified based on patient characteristics, expected to require disparate service types or amounts during episode.	variables at this time, awaiting research findings from APSE, NQF.

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	• Patient functional status important in determining post-acute care spending, differentiating patients and associated payments by functional status essential.	
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Inappropriate Proposed Patient Reported Outcomes and Risk Variables		
• "Quality performance points" are points that CMS adds to a participant hospital's composite quality score for a measure based on the performance percentile scale and for successful data submission of patient reported outcomes; and "Quality improvement points" are points that CMS adds to a participant hospital's composite quality score for a measure if the hospital's performance percentile on an individual quality measure increases from the previous performance year by at least three deciles on the performance percentile scale.	• The AAOS suggested CMS amend and clarify the sections of the proposal that deal with patient-reported outcomes and risk variables. The AAOS participated in a one-day summit convened by the American Association of Hip and Knee Surgeons (AAHKS) and attended by entities involved in developing and utilizing hip and knee arthroplasty patient-reported outcomes and risk variables. The participants in that summit had several specific comments related to the CJR proposal that were captured in a joint letter from said participants.	• CJR model includes voluntary submission of patient-reported outcomes (PRO), risk-variable data associated with primary elective THA/TKA procedures, financial incentives for hospitals participating in voluntary submission. • Voluntary data submission initiative to allow CMS to assess post-op functional outcomes and collect data from patient's perspective to help finalize, test specifications of a hospital-level, risk-adjusted patient-reported outcome performance measure (PRO-PM) for primary elective THA/TKA procedures. • CMS to integrate as mandatory measure in CJR model in years 4 and 5, proposed details in future rulemaking, public to be informed. • If adopted, would be added to existing set of quality measures within CJR and tied to payment.
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Inappropriate Conditions Included in the Program		
• CMS proposed to include all lower extremity joint arthroplasty procedures within DRGs 469 and 470.	• The AAOS strongly recommended that CMS revise the conditions included in the program and specifically exclude all arthroplasty procedures for fracture	• The inclusion of all lower extremity joint arthroplasty procedures within DRGs 469 and 470 in the final rule remains unchanged.

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• These include elective hip and knee arthroplasty procedures (total or partial) caused by osteoarthritis or similar conditions, but also include ankle arthroplasty, as well as arthroplasty for fracture repair such as hip hemiarthroplasty or total hip arthroplasty for hip fracture.	conditions as well as any conditions for ankle replacement. • AAOS argued that the program should be limited to truly elective hip and knee arthroplasty procedures and that to include other conditions would only increase the burden on systems and exacerbate the likelihood of adverse selection. • This program revision would not be complicated as CMS is able to track patients by ICD-10 diagnosis code and could easily structure the program to exclude fracture or acute diagnoses or any diagnosis codes below the knee. • We proposed the program should be limited to truly elective hip and knee arthroplasty procedures and to include other conditions only increases the burden on systems and exacerbates the likelihood of adverse selection. The inclusion of higher cost and more variable conditions like hip fracture also increases the possibility of significant variation both longitudinally and geographically.	
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Retrospective Payment Approach		
• CMS proposed to pay all surgeons, facilities, other physicians and non-physicians, and other entities across the episode of care in a normal fashion, and then retrospectively apply a "total target expenditure" and seek to reconcile actual expenditures against the target expenditures.	• The AAOS was supportive of the retrospective approach as proposed, as the prospective bundles under BPCI (Model II) for total joint arthroplasty faced significant logistical difficulties administering the prospective payments. • Retrospective episode-of-care payments are akin to "virtual" bundles, and help	• CMS will provide participant hospitals with Medicare episode (target) prices prior to the start of each performance year. • Target prices for episodes anchored by MS-DRG 469 vs. MS-DRG 470 and for episodes with hip fractures vs. without

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	minimize many of the legal hurdles inherent in contracting across a diverse spectrum of care providers. • AAOS contends CMS is correct to apply the experiences under BPCI Model II for total joint arthroplasty, whereby all four of the sites that started under Model II ultimately either dropped out of the BPCI initiative, or converted to the retrospective bundled model (Model IV). • This demonstrates why it is critical the program be executed voluntarily and based on rigorous analysis of the results for patients, providers, and payers. As drafted, the proposal lacks the evidence-based approach necessary to truly leverage best practices in managing payments and delivery across the healthcare system.	hip fractures will be provided to participant hospitals. • The target price to include discount over expected episode spending, combine blend of historical hospital-specific spending, regional spending for LEJR episodes, with regional component increasing over time. • All providers, suppliers furnishing LEJR episodes of care to beneficiaries throughout the year will be paid under existing Medicare payment systems.
Proposed Rule Provisions	**AAOS Comments/Recommendations**	**Final Rule Provisions**
Lack of Patient Protections and Incentives		
No provision	• CMS' current proposal doesn't address the role of the patient in the process, does not propose methods to empower patients to seek out the highest quality joint care. • AAOS stated that we believe this is a missed opportunity and that CMS should revise the proposal to add incentives and pathways for patients to be more actively involved in the care process. • There are numerous ways CMS could provide incentives to patients, from reducing or waiving deductibles to	• Beneficiaries retain freedom of choice in selecting services, providers. • Physicians and hospitals expected to continue to meet current standards required by the Medicare program. • The rule describes additional monitoring of claims data from participant hospitals, ensuring hospitals continue to provide all necessary services. • As hospitals in selected geographic areas will be required to participate in the model, individual beneficiaries unable to opt out of the CJR model.

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	providing benefits for accelerated recovery and participation in therapy. • AAOS believes the best way to provide real choice to patients is to give them the benefit of meaningful choices regarding where/with whom they receive joint care. • In light of this important consideration, a voluntary approach would provide patients with much stronger signals about which facilities and physicians are seeking new models of care and delivery and further reinforces the need for the program to be voluntary rather than mandatory.	• Once PRO-PM implemented, patients likely to have increased input in evaluating CJR model and care quality.

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