AUTHORITY: 42 U.S.C. 1302, 1315a, and 1395hh.

SOURCE: 80 FR 73540, Nov. 24, 2015, unless otherwise noted.

Subpart A—General Provisions

§510.1 Basis and scope.

(a) *Basis.* This part implements the test of the Comprehensive Care for Joint Replacement model under section 1115A of the Act. Except as specifically noted in this part, the regulations under this part must not be construed to affect the payment, coverage, program integrity, or other requirements (such as those in parts 412 and 482 of this chapter) that apply to providers and suppliers under this chapter.

(b) *Scope.* This part sets forth the following:

(1) The participants in the Comprehensive Care for Joint Replacement model.

(2) The episodes being tested in the model.

(3) The methodology for pricing and payment under the model.

(4) Quality performance standards and quality reporting requirements.

(5) Safeguards to ensure preservation of beneficiary choice and beneficiary notification.

§510.2 Definitions.

For the purposes of this part, the following definitions are applicable unless otherwise stated:

ACO means an accountable care organization, as defined at §425.20 of this chapter, that participates in the Shared Savings Program and is not in Track 3.

ACO participant has the meaning set forth in §425.20 of this chapter.

ACO provider/supplier has the meaning set forth in §425.20 of this chapter.

Actual episode payment means the sum of standardized Medicare claims payments for the items and services that are included in the episode in accordance with §510.200(b), excluding the items and services described in §510.200(d).

Age bracket risk adjustment factor means the coefficient of risk associated with a patient's age bracket, calculated as described in §510.301(a)(1).

Alignment payment means a payment from a CJR collaborator to a participant hospital under a sharing arrangement, for the sole purpose of sharing the participant hospital's responsibility for making repayments to Medicare.

Anchor hospitalization means the initial hospital stay upon admission for a lower extremity joint replacement, for which the institutional claim is billed through the IPPS. Anchor hospitalization also includes an inpatient hospital admission within 3 days after an outpatient Total Knee Arthroplasty (TKA) or Total Hip Arthroplasty (THA).

Anchor procedure means a TKA or THA procedure that is permitted and paid for by Medicare when performed in a hospital outpatient department (HOPD) and billed through the OPPS, except when the beneficiary is admitted to an inpatient hospital stay within 3 days after the TKA or THA.

Applicable discount factor means the discount percentage established by the participant hospital's quality category as determined in § 510.315 and that is applied to the episode benchmark price for purposes of determining a participant hospital's Medicare repayment in performance years 2 and 3.

Area means, as defined in § 400.200 of this chapter, the geographical area within the boundaries of a State, or a State or other jurisdiction, designated as constituting an area with respect to which a Professional Standards Review Organization or a Utilization and Quality Control Peer Review Organization has been or may be designated.

BPCI stands for the Bundled Payment for Care Improvement initiative.

BPCI Advanced stands for the Bundled Payments for Care Improvement Advanced Model.

CCN stands for CMS certification number.

CEC stands for Comprehensive ESRD Care Initiative.

CEHRT means certified electronic health record technology that meets the requirements of 45 CFR 170.102. .

CJR beneficiary means a beneficiary who meets the beneficiary inclusion criteria in § 510.205 and who is in a CJR episode.

CJR collaborator means an ACO or one of the following Medicare-enrolled individuals or entities that enters into a sharing arrangement:

(1) SNF.
(2) HHA.
(3) LTCH.
(4) IRF.
(5) Physician.
(6) Nonphysician practitioner.
(7) Therapist in private practice.
(8) CORF.
(9) Provider of outpatient therapy services.
(10) Physician Group Practice (PGP).
(11) Hospital.
(12) CAH.
(13) Non-Physician Provider Group Practice (NPPGP).
(14) Therapy Group Practice (TGP).

CJR–HCC condition count risk adjustment factor means the coefficient of risk associated with a patient's total number of CMS Hierarchical Condition Categories, calculated as described in § 510.301(a)(1).

CJR reconciliation report means the report prepared after each reconciliation that CMS provides to each participant hospital notifying the participant hospital of the outcome of the reconciliation.

Collaboration agent means an individual or entity that is not a CJR collaborator and that is either of the following:

(1) A member of a PGP, NPPGP, or TGP that has entered into a distribution arrangement with the same PGP, NPPGP, or TGP in which he or she is an owner or employee, and where the PGP, NPPGP, or TGP is a CJR collaborator.

(2) An ACO participant or ACO provider/supplier that has entered into a distribution arrangement with the same ACO in which it is participating, and where the ACO is a CJR collaborator.

Composite quality score means a score computed for each participant hospital to summarize the hospital's level of quality performance and improvement on specified quality measures as described in § 510.315.

Core-based statistical area (CBSA) means a statistical geographic entity consisting of the county or counties associated with at least one core (urbanized area or urban cluster) of at least

10,000 population, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core.

CORF stands for comprehensive outpatient rehabilitation facility.

COVID–19 Diagnosis Code means any of the following ICD–10–CM diagnosis codes:

(1) B97.29;

(2) U07.1; or

(3) Any other ICD–10–CM diagnosis code that is recommended by the Centers for Disease Control and Prevention for the coding of a confirmed case of COVID–19.

Critical access hospital (CAH) means a hospital designated under subpart F of part 485 of this chapter.

Distribution arrangement means a financial arrangement between a CJR collaborator that is an ACO, PGP, NPPGP, or TGP and a collaboration agent for the sole purpose of distributing some or all of a gainsharing payment received by the ACO, PGP, NPPGP, or TGP.

Distribution payment means a payment from a CJR collaborator that is an ACO, PGP, NPPGP, or TGP to a collaboration agent, under a distribution arrangement, composed only of gainsharing payments.

DME stands for durable medical equipment.

Downstream collaboration agent means an individual who is not a CJR collaborator or a collaboration agent and who is a PGP member, an NPPGP member, or a TGP member that has entered into a downstream distribution arrangement with the same PGP, NPPGP, or TGP in which he or she is an owner or employee, and where the PGP, NPPGP, or TGP is a collaboration agent.

Downstream distribution arrangement means a financial arrangement between a collaboration agent that is both a PGP, NPPGP, or TGP and an ACO participant and a downstream collaboration agent for the sole purpose of distributing some or all of a distribution payment received by the PGP, NPPGP, or TGP.

Downstream distribution payment means a payment from a collaboration agent that is both a PGP, NPPGP, or TGP and an ACO participant to a downstream collaboration agent, under a downstream distribution arrangement, composed only of distribution payments.

Dual-eligibility risk adjustment factor means the coefficient of risk associated with beneficiaries that are eligible for full Medicaid benefits or beneficiaries that are not eligible for full Medicaid benefits, calculated as described in §510.301(a)(1).

EFT stands for electronic funds transfer.

Episode benchmark price means a dollar amount assigned to CJR episodes based on historical episode payment data (3 years of historical Medicare payment data grouped into CJR episodes according to the episode definition as described in §510.200(b)) prior to the application of the effective discount factor or applicable discount factor, as described in §510.300(c).

Episode of care (or Episode) means all Medicare Part A and B items and services described in §510.200(b) (and excluding the items and services described in §510.200(d)) that are furnished to a beneficiary described in §510.205 during the time period that begins with the beneficiary's admission to an anchor hospitalization or, on or after July 4, 2021, the date of admission to an anchor hospitalization or the date of the anchor procedure, as applicable, and ends on the 90th day after the following, as applicable:

(1) The date of discharge from the anchor hospitalization (with the day of discharge itself being counted as the first day of the 90-day post-discharge period); or

(2) The date of service for the anchor procedure.

ESRD stands for end stage renal disease.

Gainsharing payment means a payment from a participant hospital to a CJR collaborator, under a sharing arrangement, composed of only reconciliation payments or internal cost savings or both.

HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems.

HCPCS stands for Healthcare Common Procedure Coding System.

HHA means a Medicare-enrolled home health agency.

Historical episode payment means the expenditures for historical episodes that occurred during the historical period used to determine the episode benchmark price.

Hospital means a provider subject to the prospective payment system specified in § 412.1(a)(1) of this chapter.

ICD–CM stands for International Classification of Diseases, Clinical Modification.

Inpatient prospective payment systems (IPPS) means the payment systems for subsection (d) hospitals as defined in section 1886(d)(1)(B) of the Act.

Internal cost savings means the measurable, actual, and verifiable cost savings realized by the participant hospital resulting from care redesign undertaken by the participant hospital in connection with providing items and services to beneficiaries within specific CJR episodes of care. Internal cost savings does not include savings realized by any individual or entity that is not the participant hospital.

IPF stands for inpatient psychiatric facility.

IRF stands for inpatient rehabilitation facility.

Low-volume hospital means a hospital identified by CMS as having fewer than 20 LEJR episodes in total across the 3 historical years of data used to calculate the performance year 1 CJR episode target prices.

Lower-extremity joint replacement (LEJR) means any procedure that is within MS–DRG 469 or 470, or, on or after October 1, 2020, MS–DRG 521 or 522, including lower-extremity joint replacement procedures or reattachment of a lower extremity.

LTCH stands for long-term care hospital.

Mandatory MSA means an MSA designated by CMS as a mandatory participation MSA in accordance with § 510.105(a).

Medicare severity diagnosis-related group (MS–DRG) means, for the purposes of this model, the classification of inpatient hospital discharges updated in accordance with § 412.10 of this chapter.

Medicare-dependent, small rural hospital (MDH) means a specific type of hospital that meets the classification criteria specified under § 412.108 of this chapter.

Member of the NPPGP or *NPPGP member* means a nonphysician practitioner or therapist who is an owner or employee of an NPPGP and who has reassigned to the NPPGP his or her right to receive Medicare payment.

Member of the PGP or *PGP member* means a physician, nonphysician practitioner, or therapist who is an owner or employee of the PGP and who has reassigned to the PGP his or her right to receive Medicare payment.

Member of the TGP or *TGP member* means a therapist who is an owner or employee of a TGP and who has reassigned to the TGP his or her right to receive Medicare payment.

Metropolitan Statistical Area (MSA) means a core-based statistical area associated with at least one urbanized area that has a population of at least 50,000.

Net payment reconciliation amount (NPRA) means the amount determined in accordance with § 510.305(e) or (m).

Nonphysician practitioner means (except for purposes of subpart G of this part) one of the following:

(1) A physician assistant who satisfies the qualifications set forth at § 410.74(a)(2)(i) and (ii) of this chapter.

(2) A nurse practitioner who satisfies the qualifications set forth at § 410.75(b) of this chapter.

(3) A clinical nurse specialist who satisfies the qualifications set forth at § 410.76(b) of this chapter.

(4) A certified registered nurse anesthetist (as defined at § 410.69(b)).

(5) A clinical social worker (as defined at § 410.73(a)).

(6) A registered dietician or nutrition professional (as defined at § 410.134).

NPI stands for National Provider Identifier.

NPPGP means an entity that is enrolled in Medicare as a group practice, includes at least one owner or employee who is a nonphysician practitioner, does not include a physician owner or employee, and has a valid and active TIN.

OIG stands for the Department of Health and Human Services Office of the Inspector General.

OP THA/OP TKA means a total hip arthroplasty or total knee

arthroplasty, respectively, for which the institutional claim is billed by the hospital through the OPPS.

OPPS stands for the outpatient prospective payment system.

PAC stands for post-acute care.

Participant hospital means one of the following:

(1) During performance years 1 and 2 of the CJR model and the period from January 1, 2018 to January 31, 2018 of performance year 3, a hospital (other than a hospital excepted under §510.100(b)) with a CCN primary address located in one of the geographic areas selected for participation in the CJR model in accordance with §510.105.

(2) Between February 1, 2018 and September 30, 2021 a hospital (other than a hospital excepted under §510.100(b)) that is one of the following:

(i) A hospital with a CCN primary address located in a mandatory MSA as of February 1, 2018 that is not a rural hospital or a low-volume hospital on that date.

(ii) A hospital that is a rural hospital or low-volume hospital with a CCN primary address located in a mandatory MSA that makes an election to participate in the CJR model in accordance with §510.115.

(iii) A hospital with a CCN primary address located in a voluntary MSA that makes an election to participate in the CJR model in accordance with §510.115.

(3) Beginning October 1, 2021, a hospital that is not a rural hospital or a low-volume hospital as defined in §510.2, as of July 4, 2021 (based on the date of the CMS notification letter and not the effective date of the rural reclassification, if applicable) with a CCN primary address located in a mandatory MSA.

PBPM stands for per-beneficiary-per-month.

Performance year means one of the years in which the CJR model is being tested. Performance years for the model correlate to calendar years with the exceptions of performance year 1, which is April 1, 2016 through December 31, 2016, performance year 5, which is January 1, 2020 through September 30, 2021, and performance year 6 which is October 1, 2021 through December 31, 2022. For reconciliation purposes, performance year 5 is divided into two subsets, performance year subset 5.1 (January 1, 2020 through December 31, 2020) and performance year subset 5.2 (January 1, 2021 through September 30, 2021).

PGP stands for physician group practice.

Physician has the meaning set forth in section 1861(r) of the Act.

Post-episode spending amount means the sum of Medicare Parts A and B payments for items and services that are furnished to a beneficiary within 30 days after the end of the beneficiary's episode.

Provider of outpatient therapy services means an entity that is enrolled in Medicare as a provider of therapy services and furnishes one or more of the following:

(1) Outpatient physical therapy services as defined in §410.60 of this chapter.

(2) Outpatient occupational therapy services as defined in §410.59 of this chapter.

(3) Outpatient speech-language pathology services as defined in §410.62 of this chapter.

Quality-adjusted target price means the dollar amount assigned to CJR episodes as the result of adjusting the episode benchmark price by the participant hospital's effective discount factor or applicable discount factor based on the participant hospital's quality category, as described in §§510.300(c) and 510.315(f).

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 for performance years 2 through 4 and 6 through 8, or for performance year subsets of performance year 5, increases from the previous performance year or performance year subset by at least 2 deciles on the performance percentile scale, as described in §510.315(d). For performance year 1, CMS adds quality improvement points 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 corresponding time period in the previous year by at least 2 deciles

on the performance percentile scale, as described in § 510.315(d).

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.

Reconciliation payment means a payment made by CMS to a CJR participant hospital as determined in accordance with § 510.305(f) or (l).

Reconciliation target price means, for performance years 6 through 8, the target price applied to an episode at reconciliation, as determined in accordance with § 510.301.

Region means one of the nine U.S. census divisions, as defined by the U.S. Census Bureau.

Repayment amount means the amount owed by a participant hospital to CMS, as reflected on a reconciliation report.

Rural hospital means an IPPS hospital that meets one of the following definitions:

(1) Is located in a rural area as defined under § 412.64 of this chapter.

(2) Is located in a rural census tract defined under § 412.103(a)(1) of this chapter.

(3) Has reclassified as a rural hospital under § 412.103 of this chapter.

Rural referral center (RRC) has the same meaning given this term under § 412.96 of this chapter.

Sharing arrangement means a financial arrangement between a participant hospital and a CJR collaborator for the sole purpose of making gainsharing payments or alignment payments under the CJR model.

SNF stands for skilled nursing facility.

Sole community hospital (SCH) means a hospital that meets the classification criteria specified in § 412.92 of this chapter.

TGP means an entity that is enrolled in Medicare as a therapy group in private practice, includes at least one owner or employee who is a therapist in private practice, does not include an owner or employee who is a physician or nonphysician practitioner, and has a valid and active TIN.

Therapist means one of the following individuals as defined at § 484.4 of this chapter:

(1) Physical therapist.

(2) Occupational therapist.

(3) Speech-language pathologist.

Therapist in private practice means a therapist that—

(1) Complies with the special provisions for physical therapists in private practice in § 410.60(c) of this chapter;

(2) Complies with the special provisions for occupational therapists in private practice in § 410.59(c) of this chapter; or

(3) Complies with the special provisions for speech-language pathologists in private practice in § 410.62(c) of this chapter.

TIN stands for taxpayer identification number.

TKA/THA stands for total knee arthroplasty/total hip arthroplasty.

Voluntary MSA means an MSA designated by CMS as a voluntary participation MSA in accordance with § 510.105(a).

[80 FR 73540, Nov. 24, 2015, as amended at 82 FR 610, 611, Jan. 3, 2017; 82 FR 57103, Dec. 1, 2017; 85 FR 19292, Apr. 6, 2020; 85 FR 71198, Nov. 6, 2020; 86 FR 23569, May 3, 2021]

Subpart B—Comprehensive Care for Joint Replacement Program Participants

§ 510.100 Episodes being tested.

(a) *Initiation of an episode.* An episode is initiated when, with respect to a beneficiary described in § 510.205—

(1) The participant hospital admits the beneficiary for an anchor hospitalization; or

(2) On or after July 4, 2021, an anchor procedure is performed at the participant hospital.

(b) *Exclusions.* A hospital is excluded from being a participant hospital, but only so long as any of the following conditions apply:

(1) The hospital is an episode initiator for an LEJR episode in the risk-bearing period of Models 2 or 4 of BPCI.

(2) The hospital is participating in Model 1 of BPCI.

(3) These exclusions cease to apply as of the date that the hospital no longer