U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

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December 8, 2015

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Kevin Brady
Chairman
The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services*

Pursuant to section 801(a)(2)(A) of title 5, United States Code, this is our report on a major rule promulgated by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) entitled "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" (RIN: 0938-AS64). We received the rule on November 17, 2015. It was published in the *Federal Register* as a final rule on November 24, 2015. 80 Fed. Reg. 73,274. The rule has an effective date of January 15, 2016, and is applicable on April 1, 2016, when the first model performance period begins.

The final rule implements a new Medicare Part A and B payment model called the Comprehensive Care for Joint Replacement (CJR) model. Under this model, acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity. All related care within 90 days of hospital discharge from the joint replacement procedure will be included in the episode of care.

Enclosed is our assessment of CMS's compliance with the procedural steps required by section 801(a)(1)(B)(i) through (iv) of title 5 with respect to the rule. Our review of the procedural steps taken indicates that CMS complied with the applicable requirements.

If you have any questions about this report or wish to contact GAO officials responsible for the evaluation work relating to the subject matter of the rule, please contact Shirley A. Jones, Assistant General Counsel, at (202) 512-8156.

signed

Robert J. Cramer
Managing Associate General Counsel

Enclosure

cc: Ann Stallion
Deputy Director, ODRM
Department of Health and Human Services

ENCLOSURE

REPORT UNDER 5 U.S.C. § 801(a)(2)(A) ON A MAJOR RULE
ISSUED BY THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
CENTERS FOR MEDICARE & MEDICAID SERVICES
ENTITLED
"MEDICARE PROGRAM; COMPREHENSIVE CARE FOR
JOINT REPLACEMENT PAYMENT MODEL FOR
ACUTE CARE HOSPITALS FURNISHING
LOWER EXTREMITY JOINT REPLACEMENT SERVICES"
(RIN: 0938-AS64)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) described the economic effects of this final rule. CMS expects the Comprehensive Care for Joint Replacement (CJR) model to result in savings to Medicare of $343 million over the 5 performance years of the model. CMS noted that a composite quality score will be calculated for each hospital in order to determine (1) eligibility for a reconciliation payment and (2) whether the hospital qualifies for quality incentive payments that will reduce the effective discount percentage experience by the hospital at reconciliation for a given performance year.

More specifically, in performance year 1 of the model, CMS estimates the cost will be approximately $11 million, as hospitals will not be subject to downside risk in that year. As CMS introduces downside risk beginning in performance year 2 of the model, it estimates the savings will be approximately $36 million. In performance year 3 of the model, CMS estimates savings will be approximately $71 million. In performance years 4 and 5 of the model, CMS will move from target episode pricing that is based on a hospital's experience to target pricing based on regional experience, which it estimates will result in savings of $120 million and $127 million, respectively.

As a result, CMS estimates the net savings to Medicare will be $343 million over the 5 performance years of the model. CMS anticipates there will be a broader focus on care coordination and quality improvement for lower extremity joint replacement episodes among hospitals and other providers and suppliers within the Medicare program that will lead to both increased efficiency in the provision of care and improved quality of the care provided to beneficiaries.

(ii) Agency actions relevant to the Regulatory Flexibility Act (RFA), 5 U.S.C. §§ 603-605, 607, and 609

CMS determined that this final rule will not have a significant impact on a substantial number of small entities. CMS also determined that this final rule will not have a significant impact on the operation of a substantial number of small rural hospitals.

(iii) Agency actions relevant to sections 202-205 of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. §§ 1532-1535

CMS determined that this final rule does not include any mandate that would result in spending by state, local, or tribal governments, in the aggregate, or by the private sector in the amount of $144 million ($100 million adjusted for inflation) in any one year.

(iv) Other relevant information or requirements under acts and executive orders

Administrative Procedure Act, 5 U.S.C. §§ 551 et seq.

On July 14, 2015, CMS published a proposed rule. 80 Fed. Reg. 41,198. CMS received approximately 400 timely pieces of correspondences containing multiple comments on the proposed rule. Summaries of public comments that were within the scope of the proposed rule and CMS's response are included in this final rule. Comments which CMS deemed out of scope are mentioned but not addressed in the final rule.

Paperwork Reduction Act (PRA), 44 U.S.C. §§ 3501-3520

The Act does not apply to testing and evaluation of models or expansion of models under section 1115A of the Social Security Act. 42 U.S.C. 1315a(d)(3).

Statutory authorization for the rule

CMS promulgated this final rule under the authority of sections 1102, 1115A, and 1871 of the Social Security Act. 42 U.S.C. §§ 1302, 1315(a), 1395hh.

Executive Order No. 12,866 (Regulatory Planning and Review)

CMS determined that this final rule is economically significant under the Order as it surpasses the $100 million threshold. The rule was reviewed by the Office of Management and Budget.

Executive Order No. 13,132 (Federalism)

CMS stated that it does not believe this final rule will have a substantial direct effect on state or local governments, preempt state law, or otherwise have a federalism implication.