Comprehensive Care for Joint Replacement (CJR) Model Performance Years 6 through 8 Extension and Changes to Episode Definition and Pricing: Frequently Asked Questions

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***These Frequently Asked Questions (FAQs) have been updated to reflect several policy changes to the CJR model that have been finalized in the Medicare Program: Comprehensive Care for Joint Replacement Model Three Year Extension and Changes to Episode Definition and Pricing Final Rule published May 3, 2021.**

GENERAL MODEL QUESTIONS

Q: Where can I find a copy of the May 2021 CJR final rule?

A: The full text of the May 2021 final rule is available here: https://www.federalregister.gov/public-inspection/2021-09097/medicare-program-comprehensive-care-for-joint-replacement-model-three-year-extension-and-changes-to. This final rule contains revisions to certain CJR model policies including the episode of care definition, the target price calculation, the reconciliation process, the beneficiary notice requirements and the appeals process. In addition, for performance years (PY) 6 through 8, it eliminates the 50 percent cap on gainsharing payments, distribution payments, and downstream distribution payments for certain recipients. The final rule also extends the additional flexibilities provided to hospitals related to certain Medicare program rules consistent with the revised episode of care definition. Additionally, the final rule allows time to test the finalized changes by extending the length of the CJR model for an additional 3 years, through December 31, 2024, for certain participant hospitals.

Other regulations relevant to CJR are available via links listed under the Regulations and Notices section on the CJR website: https://innovation.cms.gov/initiatives/cjr.

The CJR regulations are codified under 42 CFR Part 510 and may be accessed via this link: https://ecfr.io/Title-42/pt42.5.510.

Q: When did the CJR model start and for how long does it last?

A: PY 1 for the CJR model began on April 1, 2016. Originally, PY 6 was scheduled to start on January 1, 2021. Due to the COVID-19 Public Health Emergency, PY 5 was extended until September 31, 2021, while PY 6 will start on October 1, 2021. The CJR model is scheduled to end after PY 8 on December 31, 2024.

The CJR model consists of 8 performance years, as shown below in Table 1.

Table 1. CJR Model Performance Years

Performance year	Episodes included in performance year
1	**Episodes that start on or after April 1, 2016, and end on or before December 31, 2016**
2	**Episodes that end between January 1, 2017, and December 31, 2017,**
3	**Episodes that end between January 1, 2018, and December 31, 2018,**
4	**Episodes that end between January 1, 2019, and December 31, 2019,**
5	**Episodes that end between January 1, 2020, and September 31, 2021**
6	**Episodes that end between October 1, 2021, and December 31, 2022,**
7	**Episodes that end between January 1, 2023, and December 31, 2023,**
8	**Episodes that end between January 1, 2024, and December 31, 2024,**

Q: Which providers and beneficiaries are affected by the CJR model?

A: As of October 1, 2021, nearly all acute care hospitals in selected geographic areas are required to participate in the model and have the opportunity to partner with surgeons, other physicians, and post-acute care providers to coordinate patient care more effectively. Medicare beneficiaries who have an inpatient hospitalization for a lower extremity joint replacement (LEJR) as designated by Medicare Severity Diagnosis Related Group (MS-DRGs) 469, 470, 521, or 522, or who receive an outpatient total knee replacement or total hip replacement as designated by CPT codes (27447 or 27130) at these participant hospitals are included in the model.

Q: Where is the CJR model implemented?

A: For PY 6 through PY 8, the CJR model will be implemented in 34 geographic areas defined by metropolitan statistical area (MSA). By definition, MSAs are counties associated with a core urban area that has a population of at least 50,000. Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection.

Q: Who is required to participate in the CJR model?

A: As of October 1, 2021, hospitals that are located in one of the 34 mandatory MSAs and not designated as low volume or rural will be required to participate in the CJR model 3-year extension.

Q: How will a hospital know if they are classified as rural for the start of PY6?

A: Hospitals who applied for rural reclassification and notified by CMS on or before July 4, 2021, that their application for rural status has been approved will no longer be participating in the model beginning in PY6. Participant hospitals reclassified as rural that are notified that their application for rural status has been approved after July 4, 2021, will continue to participate in the CJR model for PYs 6 through 8 and remain the financially accountable entities for PYs 6 through 8. Please note that the list of hospitals that are not continuing in the CJR model for the PY6 through 8 extension has been posted to the CJR website and will be updated accordingly.

Q: How many hospitals are included in the model?

A: As of October 1, 2021, there are currently 330 participants in the CJR model. The list of CJR participant hospitals is available on the CJR website: https://innovation.cms.gov/initiatives/cjr.

Q: Where can I find the list of hospitals included in the CJR model?

A: The list of CJR participant hospitals is posted on the model website at https://innovation.cms.gov/initiatives/cjr.

Q: Are hospitals that previously participated voluntarily able to opt-in to the CJR model for PY6-8?

A: No, hospitals that previously participated voluntarily are not being offered another opportunity to opt-in to the CJR model for PY 6-8. The Centers for Medicare and Medicaid (CMS) believes that reducing the scope of the model to only include those hospitals in the 34 mandatory MSAs required to participate in the CJR model will allow us to limit selection bias while evaluating the impact of the changes in the May 2021 final rule. Additionally, during the opt-in period previously provided in January 2018, a relatively small number of hospitals chose to opt-in. As we discussed in the May 2021 final rule, preliminary findings that will be included in CJR's 4th Evaluation Report shows that voluntary hospitals resulted in a significant net loss for the model. These hospitals typically chose to participate in the model because it was financially advantageous. Although this has led to improved clinical care in some settings evidence has shown that these hospitals could continue to reduce overall cost savings of the model.

Q: What is the close out process for hospitals that opted-in to the CJR model for PY 3-5?

A: Starting October 1st, 2021 all hospitals that are located in one of the 33 voluntary MSAs, designated low-volume, or designated rural will be excluded from PY's 6-8. Although these hospitals will no longer initiate episodes under the CJR model for PY 6-8, CMS will continue to communicate with these hospitals regarding model close out matters such as payment reconciliation for PY5.1 final and 5.2, appeals timelines, reconciliation payment or repayment information, Financial Arrangement and Clinician Engagement Lists, Hospital Monitoring Reports, and claims runout data. In addition, these hospitals will continue to have access to the CJR Data Portal and CJR Connect through approximately December 2022 to allow for an easy transition out of the model. They will also be notified before their access is removed from the CJR Data Portal and CJR Connect.

Q: Does CJR include only elective procedures?

A: No. The CJR model includes episodes for all Medicare fee-for-service (FFS) beneficiaries with an inpatient hospitalization assigned to MS-DRG 469, 470, 521, or 522 at discharge from a CJR participant hospital, or who receive an outpatient total knee arthroplasty (TKA) (CPT code 27447) or total hip arthroplasty (THA) (CPT code 27130) at a CJR participant hospital, when those beneficiaries meet the model's inclusion criteria. Target prices are set separately for each of the four MS-DRGs, to recognize the significant differences in spending and distinct clinical characteristics of patients across these four types of episodes. Beneficiaries otherwise meeting the inclusion criteria who have a hip fracture and receive an LEJR procedure at a CJR hospital are included in the model.

Q: How are providers and suppliers paid under the CJR model?

A: Providers and suppliers are paid under the existing FFS payment systems in the Medicare program for episode services throughout the year. For each participant hospital on an annual basis, the model sets Medicare target episode prices that include payment for all related services received by eligible Medicare FFS beneficiaries who have LEJR procedures at that hospital.

Following the end of a model performance year, actual episode spending for a participant hospital will be compared to the applicable Medicare target episode prices for that hospital. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or may need to repay Medicare for a portion of the episode spending.

Q: How will this model be evaluated?

A: There will be an independent evaluation of the CJR model that will assess whether the model was successful at achieving its intended aims of lower cost of LEJR procedures while maintaining or improving quality. Previous evaluation reports can be found on the CMS's CJR website.

Q: My hospital does not perform lower extremity joint replacements. Can we be excused from participation in the model or opt out of the model?

A: CMS recognizes that some acute care hospitals in the selected MSAs perform few, if any, LEJR procedures. In the November 2015 final rule, CMS defined a "low volume" hospital as one that performed fewer than 20 LEJR procedures in the initial CJR baseline period of 2012-2014. Those hospitals are no longer included in CJR for PY6-8. However, hospitals in the 34 mandatory MSAs that performed 20 or more episodes between 2012-2014 are technically still participants in the CJR model and must comply with all requirements of the CJR final rule, even if they furnish few, if any, LEJR procedures. For this reason, CMS maintains a point of contact and provides required model information, such as the beneficiary notification materials, to all IPPS hospitals that are required to participate in the CJR model, including those hospitals that do not typically furnish LEJR procedures.

Q: Our hospital recently merged with another entity. How should we communicate this to the CJR model team at CMS?

A: CJR hospitals that undergo mergers or other organizational changes should notify the CJR model team of such changes by emailing CJRSupport@cms.hhs.gov.

Q: What does a CJR episode mean?

A: A CJR episode includes 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, in the case of an inpatient episode, with the beneficiary's admission to an anchor hospitalization and ends on the 90th day after 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. In the case of an outpatient episode, the time period begins on the day that a beneficiary receives an anchor procedure and ends on the 90th day after the anchor procedure, with the date of the procedure itself being counted as both the first day of the episode and the first day of the 90-day post-discharge period.

Q: When do PY6, PY7, and PY8 episodes start?

A: Episodes are attributed to a given performance year based on the end date. This means that the first PY6 episodes, which end on 10/1/2021, will have been initiated 90 days earlier by a discharge from an anchor hospitalization or an anchor procedure. Episodes will be considered PY7 if they end between 1/1/2023 and 12/31/2023 and will be considered PY8 if they end between 1/1/2024 and 12/31/2024.

Q: How will you know if care is improving during the model?

A: As with all Center for Medicare and Medicaid Innovation (Innovation Center) models, during the CJR model we monitor and evaluate the impact of the model to assess the effects on beneficiaries and quality of care. The evaluation includes both quantitative and qualitative data and uses a variety of methods and measures in assessing quality. These include claims- based

measures such as increases in readmissions and emergency room visits, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) satisfaction and care experience measures, and functional performance change scores from the required patient assessment instruments in home health agencies and skilled nursing facilities. In addition, CMS includes a beneficiary survey that will be used to assess the impact of the CJR model on beneficiary perceptions of access, satisfaction, pain, mobility, and other relevant functional performance measures.

Beneficiaries who feel their care has been compromised should call 1-800-MEDICARE or contact their Quality Improvement Organization (QIO). CJR model participants will also be monitored for compliance with all existing rules and regulations.

LEARNING SYSTEM/CJR CONNECT

Q: What is the CJR Connect website?

A: CJR Connect provides an online knowledge management and collaboration forum for CJR participants to interact with one another and share resources. The site includes four key features: chatter, groups, events, and a library of resources. CMS posts information and documents to CJR Connect on a regular basis throughout the model. The site is intended for participant hospitals and their partners. CJR model documents can be found by navigating to the "Files" tab on CMMI Connect, selecting "Libraries", and then clicking on the "CJR Connect" folder.

Q: How do we access the CJR Connect website?

A: The CJR Connect site is located at https://app.innovation.cms.gov/CMMIConnect/IDMLogin. You must use CMS IDM credentials to enter the site. If you do not have CMS IDM credentials, you will need to register for IDM credentials through the Connect site. Individuals who would like to request access to CJR Connect should have their CJR model point of contact (POC) send an email to CJR@cms.hhs.gov. Access to the site takes approximately 5 – 10 business days. An email will be sent to the requester when access has been granted.

The requester will then have 24 hours during which they must enter the site and establish a password. If the 24-hour window is not met then requesters should contact the Innovation Center Salesforce Help Desk at 1-888-734-6433 (option 25) or email CMMIForceSupport@cms.hhs.gov.

Q: Where can I find the webinars from the CJR 101 series?

A: The CJR 101 webinar series materials are posted on the CJR Connect site. This webinar series was held at the beginning of the model and provides an overview of the aims and operational requirements of the model.

Q: Are only hospital employees allowed to use CJR Connect? Can external parties not directly employed by CJR hospitals also obtain access?

A: Employees of organizations directly participating in the CJR model can be granted access if authorized by their hospital's CJR model POC. If you have a consultant or other third party who requires access to CJR Connect in order to perform their duties in support of your hospital, please have them contact the hospital CJR model POC to submit the request through CJRSupport@cms.hhs.gov.

Q: If a health system includes participants in CJR as well as BPCI Advanced, can participant hospitals or other providers within the system access BPCI Advanced Connect and CJR Connect?

A: Yes. To receive access to CJR Connect, please contact your CJR participant hospital's POC and have them submit the request through CJRSupport@cms.hhs.gov.

PAYMENT AND PRICING

Q: Are hospitals and doctors paid differently in the CJR model?

A: The CJR model utilizes a retrospective reconciliation methodology. However, hospitals and other providers, as well as physicians and practitioners, continue to be paid through regular Medicare FFS for services furnished during a CJR episode.

CMS provides CJR hospitals with preliminary target prices prior to each performance year that represent the average spending within the participant's region for LEJR episodes based on historical spending data (i.e., the episode benchmark price) with a 3% discount applied. The 3% discount serves as Medicare's portion of the savings. The discount may be adjusted at reconciliation based on a hospital's composite quality score, so that the discount of 3% (based on a composite quality score that falls in the "acceptable" range) may be raised or lowered to incentivize quality. We calculate a separate preliminary target price for each of the four MS-DRGs in the model (469, 470, 521, and 522) due to the different levels of complexity and spending across the four MS-DRGs. The target price for MS-DRG 470 also includes outpatient (OP) TKA and THA episodes without hip fractures. At the conclusion of a performance year, CMS applies an episode-level risk adjustment methodology to the target price to account for a patient's age, dual-eligibility status (i.e., fully eligible for Medicaid benefits), and count of Hierarchical Condition Categories (HCCs), as well as a retrospective market trend factor. CMS then compares the target price at reconciliation, adjusted for risk, market trends, and quality, to actual episode spending to determine whether a hospital is eligible for a reconciliation payment or is responsible for making a payment to Medicare.

Hospitals with both LEJR episode spending below the target price at reconciliation and a minimum composite quality score for the required quality measures will be eligible to earn a reconciliation payment from Medicare for the difference between the target price at reconciliation and actual episode spending, up to a stop-gain limit. For PYs 6-8, the stop-gain limit is 20 percent of the difference between the target price at reconciliation and actual episode costs. Any net payment reconciliation amount (NPRA) greater than the stop-gain limit

will be capped at the stop-gain limit. Hospitals with LEJR episode spending that exceeds the target price at reconciliation will be financially responsible for paying a portion of the difference to Medicare, up to a stop-loss limit. For PYs 6-8, the stop-loss limit is also 20 percent of the difference between the target price at reconciliation and actual episode costs. Any reconciliation repayment amount that exceeds the stop-loss limit will be capped at the stop-loss limit.

Q: What spending amounts are included in the historical regional spending totals that are used to calculate episode benchmark prices?

A: The episode benchmark prices used to calculate target prices are based on regional hospital spending on LEJR episodes during a one-year baseline period. For PYs 6 – 8, benchmark prices are based on data for LEJR episodes beginning in calendar year 2019, 2021, and 2022, respectively.

Q: When do we receive the prospective target prices?

A: CJR participant hospitals can find the prospective target prices applicable to their region on the CJR website (https://innovation.cms.gov/innovation-models/cjr). For PYs 6-8, CMS updates these target prices once each year using more recent episode benchmark data. CJR hospitals will receive target prices for each episode type (i.e., MS-DRG 469, 470, 521, and 522) prior to the start of each PY. Since PY 6 begins on October 1, 2021, with episodes initiating on July 4, 2021, regional target prices and coefficients for the PY 6-8 risk adjustment variables will be posted on the CJR website by the end of June 2021. Since PYs 7 & 8 each start on January 1, and episodes for those PYs will begin initiating in early October of the previous year, regional target prices and coefficients for the risk adjustment variables will be posted by the end of September 2022 and 2023, respectively.

Q: Are the target prices risk-adjusted?

A: Separate regional target prices are calculated for each of the four included MS-DRGs (i.e., 469, 470, 521, and 522), with OP TKA and OP THA without hip fractures included in the target price for MS-DRG 470. These MS-DRGs are assigned based on the presence or absence of 1) major complications and comorbidities, and 2) a primary hip fracture. The regional target price for each MS-DRG thus reflects the different regional patterns of utilization and cost, both during the anchor hospitalization or procedure and in the 90 days post-discharge, that tend to occur based on these factors. At reconciliation, target prices are further risk adjusted based on a patient's age, dual-eligibility status, and count of Hierarchical Condition Category (HCC) conditions.

Q: How are hip fracture cases identified in CJR?

A: Inpatient hip fracture cases are identified by their assignment to MS-DRGs 521 and 522. CMS expects LEJR with hip fracture to almost always be performed in the inpatient setting. However, if an outpatient THA procedure is associated with a primary hip fracture, CMS will identify that case using the principal diagnosis code on the outpatient claim for the anchor procedure that initiates the CJR episode. The list of International Classification of Diseases, Tenth Revision,

Clinical Modification (ICD-10-CM) hip fracture codes is available on the public CJR website at https://innovation.cms.gov/initiatives/cjr. An OP THA with primary hip fracture would be assigned the target price for MS-DRG 522.

Q: Are the stop loss and stop gain limits applied to the quality- and risk-adjusted target price at reconciliation that incorporates the effective discount percentage based on the hospital's composite quality score?

A: The stop loss and stop gain limits are based on the quality- and risk-adjusted target price at reconciliation, which incorporates an effective discount based on the hospital's composite quality score for the performance year.

Q: Does the regional historical spending data used to calculate target prices include all episodes from all hospitals in a region (US Census Division) or only CJR hospitals? What about Bundled Payments for Care Improvement (BPCI) Advanced episodes?

A: The regional historical spending data used for target price calculations includes all LEJR episodes at acute care hospitals located in a given region (US Census Division), including BPCI Advanced episodes and both CJR and non-CJR episodes.

Q: Are the data in the CJR Data Portal standardized or unstandardized? What does standardized data mean?

A: The information in the hospital and regional summaries, including the MEAN_EPI_TOTAL, are in standardized dollars. Quality- and risk-adjusted target prices at reconciliation are expressed in "real" dollars (with wage factors applied). Standardized payments estimate the payment amount for a service in the absence of any payment adjustments, including wage factors or other CMS programs such as the Hospital Readmissions Reduction Program.

Q: What is included in the EPI_OTHER variable on my claims files?

A: The costs that are included in the EPI_OTHER category are payments made during the episode for services other than acute inpatient hospital services, inpatient rehab services, skilled nursing facility services, home health services, and physician and anesthesia services.

Q: What is the inpatient only list?

A: The Medicare inpatient-only (IPO) list includes procedures that are typically provided in the inpatient setting and not paid under the Hospital Outpatient Prospective Payment System (OPPS). Procedures on the IPO list are identified by Current Procedural Terminology (CPT) codes. Each year, CMS uses established criteria to review the IPO list and determine whether any changes to the list are necessary. In the CY 2020 OPPS/ASC final rule, CMS finalized a policy to phase out the IPO list entirely over a 3-year period.

Q: How will the removal of TKA and THA from the inpatient-only list affect CJR participant hospitals?

A: When the CJR model was originally designed, all LEJR procedures were on the inpatient-only list (IPO list), so the CJR episode definition included IP episodes only. Since then, the total knee arthroplasty (TKA) CPT code (27447) was removed from IPO list in the Calendar Year 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule, dated December 14, 2017. The total hip arthroplasty CPT code (27130) was subsequently removed from the IPO list in the CY 2020 OPPS and ASC final rule, dated November 1, 2019. To incorporate these procedures in the CJR model when performed in the OP setting, we expanded the definition of a CJR episode to include OP TKA and THA for PYs 6-8. This means that, beginning in PY6, both IP and OP TKA and THA will be included in the CJR model.

Q: How will the outpatient TKAs and THAs be incorporated into CJR target prices?

A: Beginning in PY6, OP TKA and OP THA episodes without hip fracture will be grouped with MS-DRG 470 episodes, which are IP TKA and IP THA episodes without major complications and comorbidities or a primary hip fracture. In the event a THA is performed on a beneficiary with a primary hip fracture in the OP setting, which we expect to happen rarely due to the complexity and generally emergent nature of such procedures, the episode would be grouped with MS-DRG 522 episodes, which represent IP THA episodes with a hip fracture, but without major complications and comorbidities.

Q: Does the "Two-Midnight" rule apply to TKAs and THAs done at CJR participant hospitals?

A: Yes, the "Two-Midnight" rule applies for TKA and THA procedures done at any acute care hospitals, including CJR participant hospitals. The "Two-Midnight" rule provides that, with certain exceptions, including an exception for procedures on the inpatient only list, Medicare Part A payment is generally appropriate for inpatient admissions when the admitting physician reasonably expects the patient to require hospital care that spans at least two midnights.

However, CMS recognizes that there may be cases where an inpatient admission should nonetheless be payable under Part A hospital care despite an expected length of stay that is less than two midnights. Thus, the "Two Midnight" rule provides that an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review. However, in finalizing the removal of the TKAs from the inpatient only (IPO) list as of January 1, 2018, CMS instituted a 2-year prohibition on Recovery Audit Contractor (RAC) review for TKA procedures performed in the inpatient setting in order to allow providers to gain experience with determining the most appropriate setting to perform these procedures and establishing patient selection criteria to assist in the determination. CMS instituted a similar 2-year prohibition on RAC review for THA procedures when THAs were removed from the IPO list as of January 1, 2020.

For more information on criteria that need to be documented to support a claim for inpatient stays not expected to span at least two midnights, please see the Medicare Learning Network (MLN) Matters document number MM10080.

Q: Where can I find background information on the Two-Midnight Rule?

A: A fact sheet on the Two-Midnight Rule, which was last revised in the CY 2016 OPPS final rule, is available here: https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0.

Q: What are the major changes to the episode methodology for the three-year extension?

A: The CJR three-year extension expands the episode definition from PY1-5 to include outpatient TKA and THA episodes. Outpatient episodes are identified using CPT codes 27447 (TKA) or 27130 (THA), and fracture status is based on the outpatient anchor claim's primary diagnosis. Outpatient anchor stays are defined as one-day stays based on the CPT code date of service.

Procedures with CPT codes 27447 or 27130 do not qualify as a potential anchor stay if they meet any of the following conditions: (1) the anchor begin date occurs prior to 7/4/2021; (2) claim lines contain a HCPCS modifier code that indicates a bilateral procedure, modified/discontinued procedure, or payment under the Medicare Physician Fee Schedule; (3) claim lines where the revenue center payment is zero; or (4) claim lines that were not paid through a comprehensive Ambulatory Payment Classification (APC) or do not indicate payment through the Hospital Outpatient Prospective Payment System (OPPS). The post-discharge period for outpatient episodes is 90 days, inclusive of the day of the anchor procedure.

Q: How does the model account for episode overlap between inpatient and outpatient episodes?

A: The episode overlap policy for PY6-8 extends the overlap criteria from PY1-5 to include outpatient episodes. If an inpatient or outpatient LEJR procedure is provided to a beneficiary at a participating hospital during an ongoing CJR episode initiated by an inpatient or outpatient anchor procedure for that same beneficiary, the ongoing episode initiated by the first anchor procedure is cancelled and a new episode is initiated.

Q: How do target prices differ in the three-year extension as compared to PY1-5?

A: Target prices differ in the three-year extension as compared to PY1-5 in the following key ways: (1) the inclusion of outpatient episodes in the baseline and target prices; (2) the addition of beneficiary-level risk adjustment; (3) reduction of the baseline period from three years to one year; (4) adjustment of target prices for geographic wage factors at reconciliation, rather than prospectively; (5) the addition of a market trend factor to better capture changes in service delivery patterns between the baseline and performance year; and (6) capping high-cost episodes at the 99th percentile of actual spending, rather than two standard deviations above the regional mean.

The beneficiary level risk adjustment categorizes beneficiaries by three types of risk factors. These include age brackets (<65, 65-74, 75-84, 85+), a count of HCCs (1, 2, 3, 4+), and dual eligibility for Medicare and Medicaid. The risk adjustment factor multipliers are available on the CJR website: https://innovation.cms.gov/initiatives/cjr.

Q: How does the model account for excess spending on high cost episodes, both in the baseline period and performance years?

A: For PY1-5, the CJR model set a high cost episode cap, or threshold, at two standard deviations above the mean episode spending for each target price period, region, MS-DRG, and fracture status combination. These high cost thresholds are used to cap episodes in the baseline episode period and to cap performance year episode spending. To determine target prices, episodes included in the three-year baseline period are capped at the high cost threshold. During reconciliation, the high cost thresholds are calculated based on regional episode spending during the associated performance period and episode spending is capped to determine the net payment reconciliation amount (NPRA).

For PY6-8, the high cost methodology was modified to set the high cost episode cap at the 99th percentile of episode spending for each target price period, region, MS-DRG, and fracture status combination. To determine target prices, the high cost thresholds are calculated based on regional episode spending during the one-year baseline period and applied to those episodes in the baseline period. During reconciliation, the high cost thresholds are calculated based on regional episode spending during the associated performance period, and episode spending is capped to determine the NPRA.

RECONCILIATION

Q: Please clarify the CJR reconciliation timeline.

A: CMS will perform a reconciliation calculation beginning six months after the conclusion of a performance year. CJR hospitals will receive reconciliation reports in the final quarter of the year following a given performance year. For example, the reconciliation calculation for PY 6 will begin in June 2023, and CJR hospitals will receive reconciliation reports with their results in the final quarter of 2023. The CJR regulations provide that participant hospitals may appeal these calculations by filing a Calculation Error (CE) form within 45 days from the date the report is issued. Reconciliation payments will be issued approximately 3 months after the appeals deadline expires for those not filing a Calculation Error form and approximately 6 months after the appeals deadline expires for those who do file a Calculation Error form.

Q: Does CJR conduct reconciliation on a quarterly basis or provide quarterly interim reconciliation reports to hospitals?

A: The CJR regulations require annual reconciliation. CMS does not conduct quarterly reconciliation for CJR hospitals or provide interim reconciliation reports.

Q: Do reconciliation reports include quality as well as financial results?

A: Yes. Reconciliation reports include the hospital's composite quality score, measure results and performance percentiles for the THA/TKA Complications measure and HCAHPS Survey measure, and whether or not the hospital successfully submitted voluntary patient-reported outcomes and limited risk variable data.

Q: What changes to reconciliation can we expect for the three-year extension?

A: In PY6-8, episodes will undergo one reconciliation, which will occur six months after the close of the performance year. This differs from PY1-5, which had both initial and final reconciliation for each performance year. As a result, the financial results for each PY6-8 reconciliation will be final and there will not be a true-up. PY5.2 final reconciliation and PY6 reconciliation will occur in 2023, however participants will receive two separate reconciliation reports to prevent a delay in reconciliation payments or repayments during the transition year.

Additionally, the following adjustments to target prices will take place during PY6-8 reconciliation: (1) adjustment for geographic wage factors; (2) adjustment for quality performance, with greater reductions in the discount factor for good and excellent performance; (2) adjustment of target prices using a market trend factor that trends target prices to the performance year; (3) adjustment of target prices based on new beneficiary-level risk adjustment factors, including age, dual-eligibility status, and beneficiary's number of clinical conditions defined using CMS HCC conditions; and (4) application of a normalization factor to remove the overall impact of adjusting for dual eligibility, age, and HCC counts on the national average target price. The normalization factor will be the national mean of the target price for all episode types divided by the national mean of the risk-adjusted target price.

EXTREME AND UNCONTROLLABLE CIRCUMSTANCES POLICY

Q: Why does CJR have an Extreme and Uncontrollable Circumstances Policy?

A: CMS recognizes that when emergency events such as hurricanes, wildfires, and the like impact CJR MSAs, it is likely that at least some CJR participant hospitals may experience episode cost escalation as a result of hurricane or fire damage and subsequent emergency evacuations. The Extreme and Uncontrollable Circumstances policy was implemented to provide CMS with some flexibility in determining episode spending for CJR participant hospitals located in areas impacted by extreme and uncontrollable circumstances.

Q: How will the CJR Extreme and Uncontrollable Circumstances Policy work?

A: For non-fracture episodes with dates of admission to the anchor hospitalization or anchor procedure dates on or within 30 days before the date that the emergency period begins, actual episode payments are capped at the target price determined for that episode under §510.300.

For fracture episodes with dates of admission to the anchor hospitalization on or within 30 days before or after the date that the emergency period begins, actual episode payments are capped at the target price determined for that episode under §510.300.

Q: When will the Extreme and Uncontrollable Circumstances Policy become effective?

A: This policy took effect on January 1, 2018 and will apply for the initial PY2 (2017) reconciliation process which will occur in the spring of 2018 (and subsequent performance years if and when the policy is triggered).

Q: Where will the Extreme and Uncontrollable Circumstances Policy be applied?

A: As of the PY 2 initial reconciliation, this policy will apply to CJR participant hospitals whose certification number (CCN) has a primary address located in a state, U.S. territory, or tribal government that is within an "emergency area" and "emergency period," as those terms are defined in section 1135(g) of the Act, for which the Secretary has issued a waiver under section 1135 of the Act and that is designated in a major disaster declaration under the Stafford Act that served as a condition precedent for the Secretary's exercise of the 1135 waiver authority.

Q: How will hospitals know if the policy applies to them?

A: CMS will notify CJR participant hospitals for whom this extreme and uncontrollable circumstances policy will apply for performance year 2 (and subsequent performance years if and when the policy is triggered) via the initial reconciliation reports CMS delivers to these providers.

Q: What is the Extreme and Uncontrollable Circumstance Policy for the COVID-19 public health emergency (PHE)?

A: CMS instituted financial safeguards to for the COVID-19 PHE by capping actual episode payments at the quality adjusted target price determined for that episode under § 510.300 from January 31, 2020 to March 31, 2021.

After March 31, 2021, actual episode payments are capped at the target price determined for that episode under § 510.300 for episodes that contain a COVID-19 Diagnosis Code as defined in § 510.2.

COVID-19 Diagnosis Code means any of the following ICD-10-CM diagnosis codes: B97.29; U07.1; or 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.

OVERLAP WITH THE BPCI ADVANCED MODEL

Q: What clinical episodes overlap between the two models?

A: The CJR model consists of only one type of episode of care, LEJR, while BPCI Advanced has various types of Clinical Episodes, one of which is the Major Joint Replacement of the Lower Extremity (MJRLE). LEJR and MJRLE refer to the same type of episode composed of MS-DRGs 469, 470, 521, and 522.

Q: If a hospital participating in both models is conducting an LEJR/MJRLE episode, which model would the clinical episode fall under?

A: The episode would fall under the CJR model. The BPCI Advanced Participation Agreement states that if a participant or, if applicable, a Downstream Episode Initiator (for example, an acute care hospital) is also participating in an Innovation Center model implemented via regulation, such as the CJR model, the participant will not be held accountable for any clinical episodes included in that model for purposes of BPCI Advanced. This means that any LEJR episodes that are triggered by a hospital participating in both BPCI Advanced and CJR models would be reconciled under the CJR model and not the BPCI Advanced model. This rule is also known as the "precedence rule".

Q: Do "precedence" rules apply to BPCI Advanced or CJR if the BPCI Advanced episode is not for LEJRs?

A: The precedence rules do not apply in these instances. For example, if a beneficiary is admitted to a CJR hospital for an LEJR procedure and later readmitted to the same or a different CJR hospital for a congestive heart failure episode under BPCI Advanced, each model would calculate episode spending and perform financial reconciliation as normal.

Q: Our hospital is in a CJR MSA but there is a physician group practice in the area that participates in BPCI Advanced for the LEJR episode and initiates episodes at our facility. Will those episodes be BPCI Advanced or CJR episodes?

A: If the LEJR/MJRLE episode is initiated at the CJR participant hospital, the episode would be included in CJR's reconciliation. Because CJR LEJR episodes have precedence over BPCI Advanced MJRLE episodes, in circumstances in which a physician (that is a member of a PGP participating in BPCI Advanced for the MJRLE episode) is the operating or attending physician on the inpatient claim, such episodes would be attributed to the CJR participant, not the BPCI Advanced participant.

Q: Our hospital is currently participating in CJR. Can we participate in BPCI Advanced for the LEJR episode and effectively opt-out of CJR?

A: No. BPCI Advanced participants that are also participating in any Innovation Center model implemented via regulation (e.g., CJR) are not permitted to participate in BPCI Advanced for the episodes included in those models. If a hospital is participating in CJR PY 6-8 that hospital may not drop out of CJR in order to participate in BPCI Advanced for the LEJR episode. A BPCI Advanced participant is able to terminate their participation in the BPCI Advanced Initiative for any reason with 90 days advanced notice to CMS.

OVERLAP WITH ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

Q: Will beneficiaries who are aligned or assigned to a Medicare Shared Savings Program or other ACO and undergo LEJR be included in CJR?

A: In most cases, yes. However, a beneficiary who is prospectively aligned with a Medicare Shared Savings Program ACO participating in the ENHANCED Track will not initiate a CJR episode.

Q: Can an ACO be a CJR collaborator?

A: Yes, an ACO can be a CJR collaborator.

Q: Can a Physician Group Practice (PGP) in an ACO be part of the CJR Model?

A: Yes, a PGP participating in an ACO can become a CJR collaborator by entering into sharing arrangements with a CJR participant hospital. In addition, a PGP participating in an ACO that is a CJR collaborator can become a collaboration agent by entering into a distribution arrangement with the ACO that has entered into a sharing arrangement with a CJR participant hospital.

QUALITY MEASURES

Q: What is the patient population for the CJR quality measures? Do the measures include only CJR patients?

A: The patient population for the HCAHPS Survey measure in the CJR model is not limited to Medicare beneficiaries and includes patients admitted in the medical, surgical, and maternity care service lines. The HCAHPS Survey measure evaluates patients' perceptions of their entire hospital experience, and is not specific to MS-DRGs 469, 470, 521, or 522 alone.

The Complications measure includes only elective THA/TKA patients and, therefore, excludes fractures. Please refer to page 73474 of the CJR 2016 final rule for more information specific to the inclusion and exclusion criteria for the Complications measure.

Q: When CMS determines a CJR participant hospital's performance percentile on the THA/TKA Complications measure, does CMS use the distribution of measure results from all hospitals, or the distribution of results from CJR participant hospitals only?

A: CMS will assign participant hospitals to a performance percentile for the THA/TKA Complications measure based on the distribution of measure results for all subsection (d) hospitals that are eligible for payment under IPPS, report the measure, and meet the minimum case count of 25 cases in the 3-year measurement period.

Q: What is the low volume threshold for the THA/TKA Complications measure? What if we do not meet it?

A: A participant hospital will not have a value for the THA/TKA Complications measure if the hospital does not meet the minimum case count of 25 cases in the 3-year measurement period.

CMS will assign any low volume participant hospitals without a reportable value through the Hospital Inpatient Quality Reporting (HIQR) Program to the 50th performance percentile of that respective measure when calculating the composite quality score.

Q: How do I access my risk-standardized complication rate (RSCR) for the THA/TKA Complications measure?

A: Hospitals can obtain their RSCR from their Hospital-Specific Report (HSR) available on QualityNet or from the Hospital Compare site at: https://data.medicare.gov/data/hospital-compare. Once on this site, select the "Complications" category, then the "Complications – Hospital" dataset. Next, hospitals should filter this dataset by the "Measure ID" column to only show "COMP_HIP_KNEE" data (or RSCRs).

Q: Does the HCAHPS Survey measure only include elective total knee and hip patients?

A: The patient population for the HCAHPS survey measure is not limited to Medicare beneficiaries and includes patients admitted in the medical, surgical, and maternity care service lines.

The HCAHPS Survey measure will evaluate patients' perceptions of their entire hospital experience, and is not specific to MS-DRGs 469, 470, 521, or 522 alone.

Q: Is it possible to obtain an exemption for HCAHPS to gather the data via secure email, text, or an online portal?

A: CMS only allows the approved modes of administration for the HCAHPS Hospital Survey at this time. For additional information, please refer to the resources on the HCAHPS website (http://www.hcahpsonline.org) or contact the HCAHPS Project Team at hcahps@HCQIS.org.

Q: How do I submit my HCAHPS score to CJR?

A: The HCAHPS score is already captured as part of the HIQR. Hospitals do not need to take any additional steps to submit HCAHPS data for the CJR model.

Q: What if I don't have more than 100 completed HCAHPS surveys?

A: A participant hospital will not have a reported value for the HCAHPS Survey measure if it does not meet the minimum of 100 completed surveys in a four-quarter period. These minimum thresholds are required to ensure reliability of the measure. These are the same thresholds that are used in the Hospital Value-Based Purchasing Program.

CMS will assign any low volume participant hospitals without a reportable value through the HIQR Program to the 50th performance percentile of that respective measure when calculating the composite quality score.

Q. What is the HCAHPS linear mean roll-up score?

A: The HCAHPS linear mean roll-up (HLMR) score summarizes performance across the 11 HCAHPS measures by taking an average of each of the linear mean scores (LMS) of the 11

HCAHPS measures using a weight of 1.0 for each of the 7 HCAHPS composite measures, and a weight of 0.5 for each of the single item measures (Cleanliness, Quietness, Overall Hospital Rating, and Recommend the Hospital).

To determine the HLMR score for the CJR model, CMS will take the average of the LMS for 10 of the 11 publicly reported HCAHPS measures. The CJR model HLMR score will summarize HCAHPS performance on all of the publicly reported measures, except for Pain Management.

Q: How do I calculate the HCAHPS linear mean roll-up score for the CJR model?

A: Hospitals can calculate their linear mean roll-up (HLMR) score by using the linear mean scores from their Hospital Compare Preview Report for the requisite time period. The linear mean scores summarize all survey responses for each of the 11 HCAHPS measures.

Because the CJR model HLMR score will summarize HCAHPS performance on all of the HCAHPS measures except for Pain Management, CJR participant hospitals will need to modify the formula for creating the HCAHPS Summary Star Rating, available in the HCAHPS Star Rating Technical Notes (http://www.hcahpsonline.org/en/hcahps-star-ratings/). To determine their HLMR score for the CJR model, hospitals should take an average of 10 of the 11 linear mean scores, using a weight of 1.0 for 6 of the HCAHPS composite measures (Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, Communication about Medicines, Discharge Information, and Care Transition), and a weight of 0.5 for each of the single item measures (Cleanliness, Quietness, Overall Hospital Rating, and Recommend the Hospital).

Q: What distribution of measure results does CMS use to determine a CJR participant hospital's performance percentile on the HCAHPS Survey measure?

A: CMS will assign participant hospitals to a performance percentile for the HCAHPS Survey measure based on the distribution of measure results for all subsection (d) hospitals that are eligible for payment under IPPS, report the measure, and meet the minimum of 100 completed surveys in a four-quarter period.

Q: Are there any changes to the quality methodology in PY6-8?

A: Yes, there will be reductions in the target price discount factor for good and excellent quality performance for PY6-8. Good quality performance (CQS >=6.9 and <=15) will reduce the discount factor by 1.5%, resulting in a 1.5% discount factor, and excellent quality performance (CQS >15) will reduce the discount factor by 3%, resulting in elimination of the target price discount factor entirely. Please note that the same quality measures used in PY1-5 will be used for PY6-8.

PATIENT-REPORTED OUTCOMES (PRO) AND LIMITED RISK VARIABLE DATA

Q: Is submission of patient-reported outcomes (PRO) and risk variable data required for the CJR model?

A: Submission of THA/TKA voluntary patient-reported outcomes and risk variable data is not required for reconciliation payment eligibility. However, CJR participant hospitals that successfully submit PRO data per the requirements on page 73548 of the CJR 2016 final rule may increase their financial opportunity under the model, since CJR participant hospitals that successfully submit PRO data can receive two points toward their composite quality score.

Q: What data must my hospital submit to meet the CJR requirements for voluntary PRO data collection?

A: Hospitals need to submit the Veterans RAND 12 Item Health Survey (VR-12) or Patient-Reported Outcomes Measurement Information System (PROMIS) Global-10 generic PRO survey; **and** the Hip disability and Osteoarthritis Outcome Score (HOOS)/Knee injury and Osteoarthritis Outcome Score (KOOS) Jr. **or** HOOS/KOOS subscales PRO survey for patients undergoing eligible elective primary THA/TKA procedures. The PRO surveys must be collected during both pre-operative and post-operative data collections. The PRO surveys that a given patient completes at the pre-operative data collection must be the same PRO surveys they complete at the post-operative data collection. In addition to the PRO surveys, hospitals should also submit the identifiers listed below so that pre- and post-operative data can be linked. Finally, hospitals must submit additional risk variables which are only collected at the pre-operative data collection. Table 2 summarizes the variables for the CJR voluntary PRO data collection.

For the data specifications for each variable, please refer to the PRO Data Dictionary available on CJR Connect or the CMS Measure Methodology Website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html, in the “Hip and Knee Arthroplasty Patient-Reported Outcomes” folder).

Table 2. Variables for CJR Voluntary PRO Data Collection

<table>
<tr><th colspan="11">Data Collection Requirements</th></tr>
<tr><th colspan="5">Pre-Operative Data Collection</th><th colspan="6">Post-Operative Data Collection</th></tr>
<tr><td colspan="2">VR-12</td><td>OR</td><td colspan="2">PROMIS-Global</td><td colspan="2">VR-12</td><td>OR</td><td colspan="3">PROMIS-Global</td></tr>
<tr><td colspan="5">AND</td><td colspan="6">AND</td></tr>
<tr><td colspan="2">HOOS/KOOS Jr.</td><td>OR</td><td colspan="2">HOOS/KOOS subscales</td><td colspan="2">HOOS/KOOS Jr.</td><td>OR</td><td colspan="3">HOOS/KOOS subscales</td></tr>
<tr><td>HOOS Jr</td><td>KOOS Jr.</td><td></td><td>HOOS subscales</td><td>KOOS subscales</td><td>HOOS Jr</td><td>KOOS Jr.</td><td></td><td>HOOS subscales</td><td>KOOS subscales</td></tr>
<tr><td>• Pain (2Qs)
• Function, daily living (4Qs)</td><td>• Stiffness (1Q)
• Pain (4Qs)
• Function, daily living (2Qs)</td><td></td><td>• Pain (10Qs)
• Function, daily living (17Qs)</td><td>• Stiffness (2Qs)
• Pain (9Qs)
• Function, daily living (17Qs)</td><td>• Pain (2Qs)
• Function, daily living (4Qs)</td><td>• Stiffness (1Q)
• Pain (4Qs)
• Function, daily living (2Qs)</td><td></td><td>• Pain (10Qs)
• Function, daily living (17Qs)</td><td>• Stiffness (2Qs)
• Pain (9Qs)
• Function, daily living (17Qs)</td></tr>
<tr><td colspan="5">AND</td><td colspan="6">AND</td></tr>
<tr><td colspan="2">Medicare Provider Number</td><td colspan="2">Mode of Collection</td><td>Body mass index (BMI) or height in cm and weight in kg</td><td colspan="2">Medicare Provider Number</td><td></td><td colspan="3">Mode of Collection</td></tr>
<tr><td colspan="2">Medicare Health Insurance Claim (HIC) number</td><td colspan="2">Person completing survey</td><td>Pre-operative Use of Narcotics</td><td colspan="2">Medicare Health Insurance Claim (HIC) number</td><td></td><td colspan="3">Person completing survey</td></tr>
<tr><td colspan="2">Date of Birth</td><td colspan="2">Patient-reported Pain in Non-operative Lower Extremity Joint(s)</td><td>Patient-reported Health Literacy Screening (SILS2) questionnaire</td><td colspan="2">Date of Birth</td><td></td><td colspan="3"></td></tr>
<tr><td colspan="2">Date of Collection</td><td colspan="2">Patient-reported Back Pain (Oswestry Index question)</td><td>Race and Ethnicity</td><td colspan="2">Date of Collection</td><td></td><td colspan="3"></td></tr>
</table>

Q: On which patients should my hospital collect PRO data?

A: Hospitals should collect data for Medicare patients who are aged 65 and older, and undergoing elective, primary THA/TKA procedure(s) (see Figure 3).

Of note, a hospital will need to assess a patient's eligibility for inclusion in the voluntary data collection on the day of or prior to the THA/TKA procedure (before billing codes are submitted). Therefore, hospitals will primarily use clinical criteria to exclude patients. While some discrepancies may occur, as the claims may not fully represent clinical status, CMS anticipates that the frequency of these discrepancies will be very low. Further, if providers document their assessment of the patient's eligibility in the medical record, the appropriate patients should be captured in administrative codes, increasing the concordance between the clinical determination and the billing codes claims data (see Table 3 for the THA/TKA ICD-10 codes relevant to the PRO collections).

Figure 3. Patient Selection Flowchart

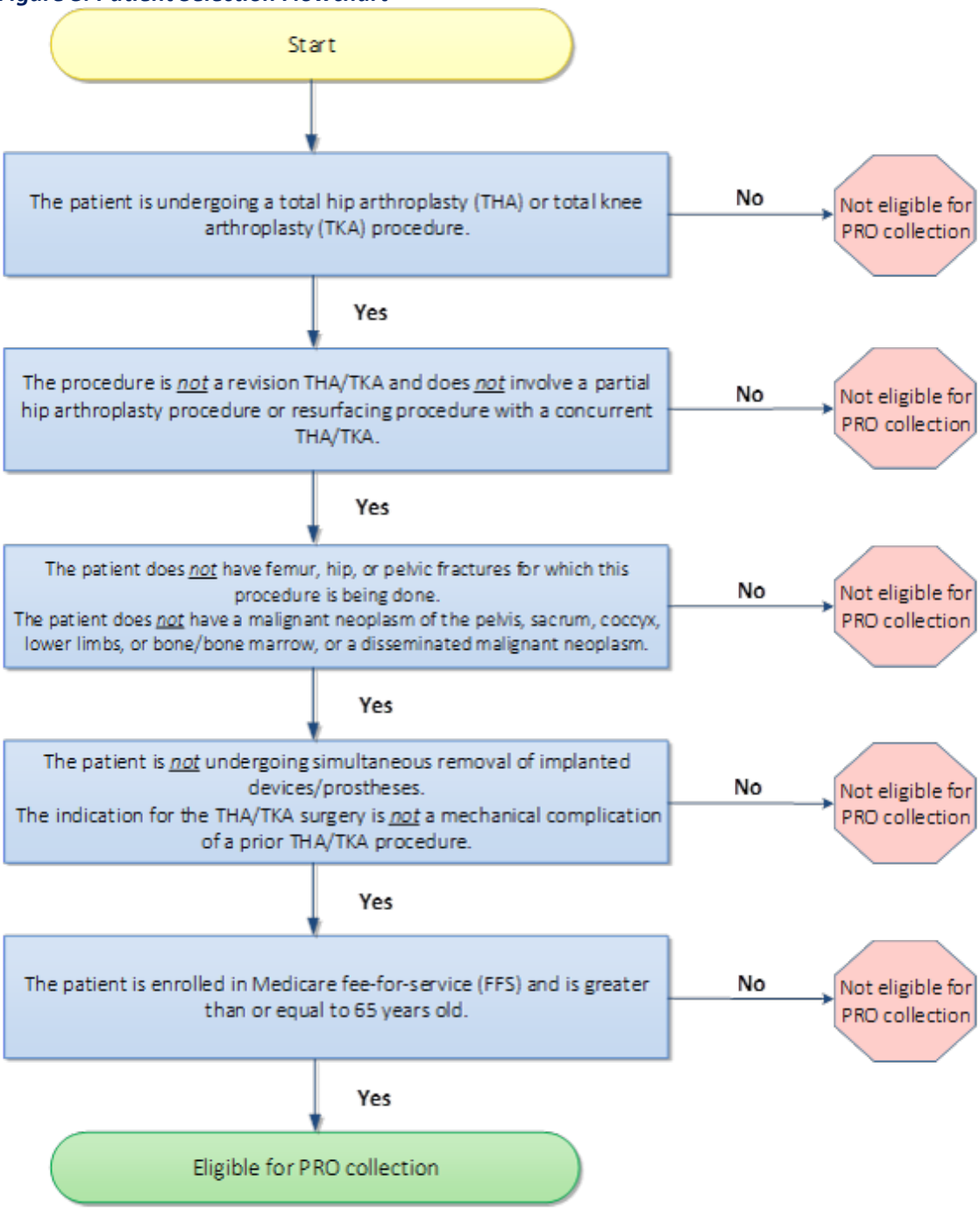


Table 3. THA/TKA ICD-10 Codes Relevant to PRO Collections

Code	Description
0SR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
0SRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
0SRC07Z	Replacement of Right Knee Joint with Autologous Tissue Substitute, Open Approach
0SRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
0SRC0KZ	Replacement of Right Knee Joint with Nonautologous Tissue Substitute, Open Approach
0SRD07Z	Replacement of Left Knee Joint with Autologous Tissue Substitute, Open Approach
0SRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach
0SRD0KZ	Replacement of Left Knee Joint with Nonautologous Tissue Substitute, Open Approach
0SRT07Z	Replacement of Right Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRT0JZ	Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRT0KZ	Replacement of Right Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRU07Z	Replacement of Left Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRU0JZ	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRU0KZ	Replacement of Left Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRV07Z	Replacement of Right Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
0SRV0JZ	Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
0SRV0KZ	Replacement of Right Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach
0SRW07Z	Replacement of Left Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
0SRW0JZ	Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
0SRW0KZ	Replacement of Left Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach

Q: How many patients do I need to capture to fulfill the PRO successful data collection criterion?

A: Participating hospitals must meet the requirements below in Table 4 for each performance year1 in order to fulfill the successful data collection criterion set forth in the CJR final rule. For example, in PY 1, a hospital with 20 eligible primary elective THA/TKA cases between July 1 and August 31, 2016 would need to submit data on at least 10 cases (50% of 20). In contrast, a hospital with 1,000 eligible cases between July 1 and August 31, 2016 would need to submit data on at least 50 cases in PY 1.

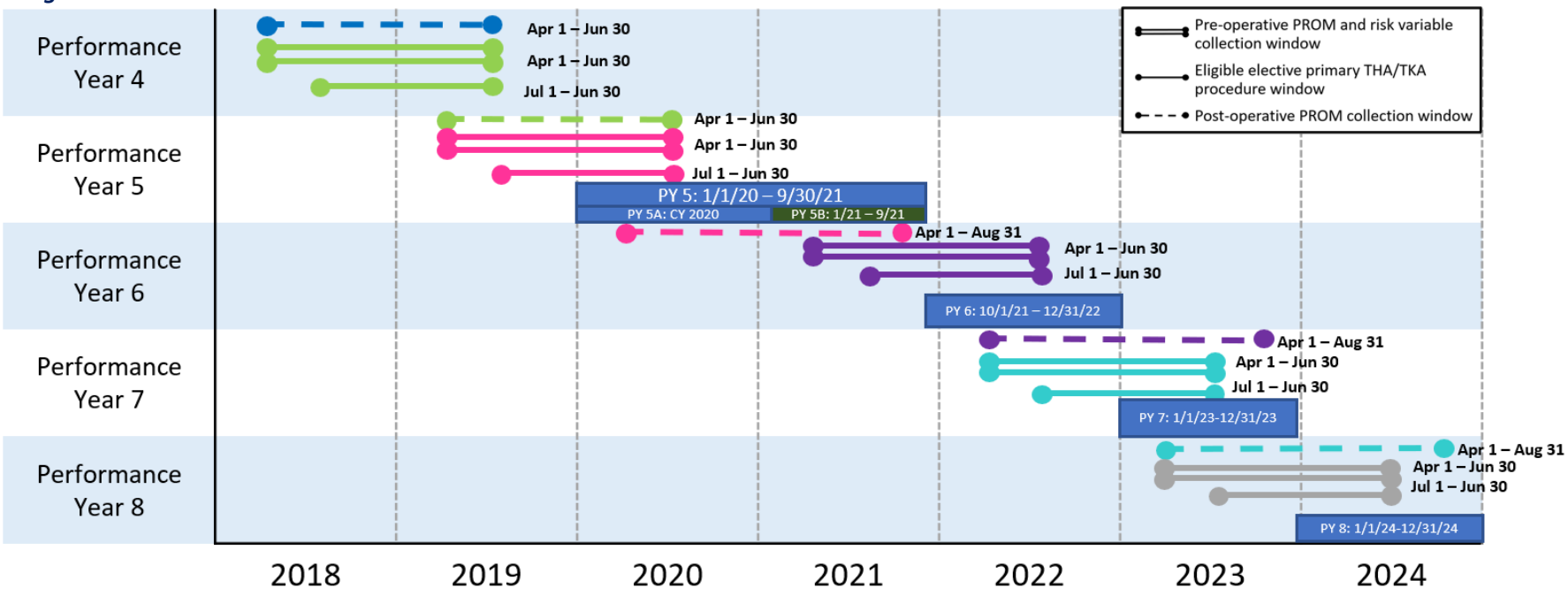
Table 4. Successful Criteria by CJR Performance Year

PY	Eligible THA/TKA Procedure Window	Pre-operative PRO and Risk Variable Submission Requirements
1	July 1, 2016 – August 31, 2016	≥ 50% or ≥ 50 eligible procedures
2	Sep 1, 2016 – June 30, 2017	≥ 60% or ≥ 75 eligible procedures
3	July 1, 2017 – June 30, 2018	≥ 70% or ≥ 100 eligible procedures
4	July 1, 2018 – June 30, 2019	≥ 80% or ≥ 200 eligible procedures
5	July 1, 2019 – June 30, 2020	≥ 80% or ≥ 200 eligible procedures
6	July 1, 2021 – June 30, 2022	≥ 80% or ≥ 300 eligible procedures
7	July 1, 2022 – June 30, 2023	≥ 85% or ≥ 400 eligible procedures
8	July 1, 2023 – June 30, 2024	≥ 90% or ≥ 500 eligible procedures

Q: When should my hospital collect the PRO data?

A: Hospitals should collect a patient's pre-operative data 90 to 0 days (3 months) prior to the patient's procedure. The hospital will then need to collect this patient's post-operative data 270 to 427 days (9-14 months) after the patient's procedure. The timeline for each performance year is presented in Figure 4 below.

Figure 4. PRO Submission Timeline



Q: What are the deadlines for PRO data submission?

A: The data submission deadlines for each performance year of CJR are shown in Table 5.

Table 5. Deadlines for CJR PRO Data Submission by Performance Year

	CJR Performance Year							
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	**Year 8**
Deadline	October 31, 2016	October 31, 2017	August 31, 2018	August 31, 2019	August 31, 2020	August 31, 2022	September 30, 2023	September 30, 2024
Data to be Submitted	Pre-Operative Data on Performance Year 1 Patients	Post-Operative Data on Performance Year 1 Patients *AND* Pre-Operative Data on Performance Year 2 Patients	Post-Operative Data on Performance Year 2 Patients *AND* Pre-Operative Data on Performance Year 3 Patients	Post-Operative Data on Performance Year 3 Patients *AND* Pre-Operative Data on Performance Year 4 Patients	Post-Operative Data on Performance Year 4 Patients *AND* Pre-Operative Data on Performance Year 5 Patients	Post-Operative Data on Performance Year 5 Patients *AND* Pre-Operative Data on Performance Year 6 Patients	Post-Operative Data on Performance Year 6 Patients *AND* Pre-Operative Data on Performance Year 7 Patients	Post-Operative Data on Performance Year 7 Patients *AND* Pre-Operative Data on Performance Year 8 Patients

Q: Is the PRO Data Collection Template available for download?

A: Yes. The CJR model PRO Data Collection Template, Data Collection Template User Guide, Data Dictionary, Data Dictionary User Guide, Data Collection Timeline, Data Collection Patient Selection Flowchart, and Data Collection Overview are available on CJR Connect. To access these materials, log on to CJR Connect and click on the Libraries tab. If you do not have access to CJR Connect, please have your hospital's CJR model POC send an email to CJR@cms.hhs.gov.

These resources are also available for download from the CMS Measure Methodology Website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html, in the "Hip and Knee Arthroplasty Patient-Reported Outcomes" folder).

COMPOSITE QUALITY SCORE

Q: How do the composite quality score and pay-for performance methodologies work?

A: The CJR model uses a composite quality score methodology to link quality to payment. The composite quality score for participant hospitals is determined by performance and improvement on two quality measures (THA/TKA Complications measure and the HCAHPS Survey measure), as well as successful submission of THA/TKA patient-reported outcomes and limited risk variable data.

CMS calculates a composite quality score for each participant hospital for each performance period, which equals the sum of:

- the hospital's quality performance points for the THA/TKA Complications measure;
- the hospital's quality performance points for HCAHPS Survey measure;
- any additional quality improvement points the hospital may earn as a result of demonstrating improvement on either or both of the quality measures; and,
- if applicable, 2 additional points for successful data submission of patient-reported outcomes and limited risk variable data.

The sum of the components above constitutes the composite quality score, which is capped at 20 points. For more information on how CMS determines the quality performance and improvement points, please refer to the CJR Model Quality Measures, Composite Quality Score, and Pay-for-Performance Methodology document available on the CJR model website: https://innovation.cms.gov/Files/x/cjr-qualstrat.pdf.

The composite quality score is incorporated into the pay-for-performance methodology, which assigns a participant hospital to one of four quality categories at the time of reconciliation for a performance year. While prospective quality-adjusted target prices will be provided before the conclusion of a performance year (based on a hospital's episode benchmark price incorporating a 3% discount), hospitals may experience a different effective discount percentage at reconciliation due to their assigned quality category.

Depending on whether a hospital is eligible for a reconciliation amount or responsible for a

repayment to Medicare, the effective discount varies by performance year and the participant hospital's quality category, as summarized in Table 6.

Table 6. Effective Discount Percentages by Performance Year (PY) and Quality Category

	Below Acceptable CQS <5		Acceptable CQS >=5 and <6.9		Good CQS >=6.9 and <=15		Excellent CQS >15	
PY	**Recon**	**Repay**	**Recon**	**Repay**	**Recon**	**Repay**	**Recon**	**Repay**
1	IN	NA	3.0	NA	2.0	NA	1.5	NA
2	IN	2.0	3.0	2.0	2.0	1.0	1.5	0.5
3	IN	2.0	3.0	2.0	2.0	1.0	1.5	0.5
4	IN	3.0	3.0	3.0	2.0	2.0	1.5	1.5
5	IN	3.0	3.0	3.0	2.0	2.0	1.5	1.5
6	IN	3.0	3.0	3.0	1.5	1.5	0.0	0.0
7	IN	3.0	3.0	3.0	1.5	1.5	0.0	0.0
8	IN	3.0	3.0	3.0	1.5	1.5	0.0	0.0

CQS = Composite Quality Score
Recon = Effective discount percentage for reconciliation payment
Repay = Effective discount percentage for repayment amount
IN = Ineligible

Participant hospitals must have a composite quality score greater than or equal to 5.0 in order to be eligible to receive a reconciliation payment. Participant hospitals with composite quality scores that place them in the "Good" or "Excellent" quality categories will either receive a higher reconciliation payment or have less repayment responsibility at reconciliation due to their quality performance. In other words, the change in effective (or applicable) discount percentage experienced at reconciliation will provide a potential benefit to hospitals.

Q: Is it possible that a hospital owes repayment to CMS at the 3% discounted target price, but, due to quality, may experience an effective discount at reconciliation that makes the hospital eligible to receive a reconciliation payment?

A: Yes. In rare instances, a participant hospital's quality incentive payment may change the effective discount factor applied at reconciliation in such a way that it could change whether a hospital qualifies for a reconciliation payment or has to make a repayment to Medicare.

For example, if a hospital's benchmark price is $20,000, its prospective quality-adjusted target price at the beginning of the performance year would be $19,400. If the hospital reduced spending to $19,600, but achieved a composite quality score in the "Excellent" category, then the hospital would not owe Medicare a repayment of $200. Instead, the hospital in the "Excellent" category would have a quality-adjusted target price of $19,700 at reconciliation.

Therefore, the hospital is eligible to receive a reconciliation payment of $100, even though the actual spending was more than the prospective quality-adjusted target price.

Q: When do CJR hospitals receive their composite quality scores?

A: CJR participant hospitals receive their composite quality scores in the second quarter of the year following the conclusion of a performance year. The composite quality score will be included on hospitals' reconciliation reports. Reconciliation reports also include the hospital's measure results and performance percentiles for the THA/TKA Complications measure and HCAHPS Survey measure, and whether or not the hospital successfully submitted patient-reported outcomes and limited risk variable data.

DATA SHARING

Q: How do CJR model participants access their data?

A: Upon receipt of a completed CJR Model Data Request and Attestation Form from a CJR hospital, we will send the two listed Data Primary Points of Contact instructions for signing up for the data portal. This is a multi-step process and these steps can be found below. Additional guidance may be provided by submitted questions to CJRsupport@cms.hhs.gov or on the CJR Connect Site under the data section.

1. First you will need to create a CMS Enterprise Portal ID or Enterprise Identity Management (EIDM) User ID. (If you already have a CMS EIDM User ID from a different CMS model, you may be able to skip this step).
2. Then once you have a CMS Enterprise Portal ID or EIDM ID, you will need to go through the Remote Identity (RIDP) and Multi-Factor Authentication (MFA) process to request access to the Innovation Center (IC) application where you will select the "Privileged User" role.
3. Finally, after you have been approved for the Innovation Center (IC) web application you will need to request access to the CJR Portal. (This is where you will eventually access the data).

In addition, on the CJR Connect Site you will also find:

- Information and FAQs surrounding Remote Identity Proofing (RIDP) and Multi- Factor Authentication (MFA)
- Instructions for Data Primary Points of Contact for Approving/Rejecting "Secondary Users" for CJR Data Portal access to their CCNs in the IC Application

Q: Can I open my CJR data using Microsoft Access?

A: The data files sent to CJR participants are flat files that can be read into Access, Excel, or other applications. Although we do not have specific instructions for Access, it is possible to upload our data into Access. Our recommended steps are:

1) Download the CJR data.
2) For each file, rename the files to have .csv extensions.
3) At this point, the files can be opened in spreadsheets like Excel.
4) To load into Access or other application, there are two general approaches:
   a) Save the data as an Excel file, then use the options in Access to import an Excel file.
   b) Use the Data Import function in Access to read-in a CSV file.

We encourage you to look at the file layout document that was included in your data to understand the contents in each file and which variables you need to use to merge files.

Q: What types of data can be requested in the CJR model?

A: Under the HIPPA privacy rule, participant hospitals may request the minimum necessary data to carry out healthcare operations in the CJR model. The data options include:

- Historical claims (includes enrollment, raw claim, and episode summary information) *Please note: These files contain personally-identifiable information (PII)
- Historical claim summaries (statistics on episodes for your hospital and region) In addition, all hospitals will receive:
- File layouts that describe the variables in each data file
- README files containing CJR episode and target pricing methodology

Q: Is a CJR participant hospital allowed to share the CJR data with its data analysts or consultants?

A: CJR participant hospitals should consult with their own legal counsel on this question.

Q: How can Business Associates of CJR participant hospitals request data from CMS?

A: Business Associates will use the same process as the two CJR Data Primary Points of Contact to register for EIDM, Innovation Center (IC), and CJR Data Portal access. They should follow the same instructions for accessing the CJR Data Portal that were provided to the CJR Data Primary Points of Contact.

However, per the CJR Data Request and Attestation Form, Business Associates must be approved in the CJR Data Portal by a CJR Data Primary Point of Contact (with current access) for each specific CCN for which they are applying before they are able to access the data. In addition, Business Associates and CJR participant hospitals are responsible for ensuring they are operating pursuant to a Business Associate Agreement that complies with the HIPAA Privacy Rule. See 45 C.F.R.§§164.502(a)(3) and 164.504(e)(2).

Q: Are CJR participant hospitals or Business Associates allowed to use the CJR data for

other research or studies?

A: CJR participant hospitals should consult with their own legal counsel on this question.

Q: Can CJR data be shared with academic colleagues or other research organizations associated with our hospital?

A: CJR participant hospitals should consult with their own legal counsel on this question.

Q: Is a participant hospital responsible for safeguarding all of the CJR data it receives (including data that are disseminated to Business Associates of the hospital)?

A: Yes. By signing the CJR Data Request and Attestation Form, the Data Requestor attests that the hospital will protect the requested data as required by applicable law, including the establishment of appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. Both covered entity hospitals and Business Associates are directly liable to the Department of Health and Human Services for compliance with the requirements of the HIPAA Security Rule.

Q: If there are any issues with data security or unauthorized access to the CJR data do we need to report them to CMS?

A: Yes. On the CJR Model Data Request and Attestation Form, the Data Requestor attests that he/she will immediately notify CMS of any actual access, use, or disclosure of the data requested that is not in accordance with applicable law, including, but not limited to, the HIPAA Privacy and Security Rules.

The CJR hospital should report any breach of personally-identifiable information (PII) from the CJR data files, loss of these data or disclosure to any unauthorized persons to the CMS Action Desk by telephone at (410) 786-2580 or by e-mail notification at CMS_IT_Service_Desk@cms.hhs.gov. In addition, CJR hospitals that experience a breach of protected health information must provide breach notification in accordance with all applicable laws, including the HIPAA Breach Notification Rule. See 45 C.F.R. Part 164, Subpart D.

Q: Can CJR participant hospitals publish research findings using CJR data?

A: CJR participant hospitals should consult with their own legal counsel on this question.

Q: Can multiple members of our organization share an EIDM ID to access the data in the CJR Data Portal?

A: No. Each user that needs to directly access the data portal will need to follow the CJR Data Portal Instructions to create their own accounts. Users who are not CJR Data Primary Points of Contact should select the "Standard User" role for the CJR Application. Additionally, organizations that are HIPAA covered entities must implement policies and procedures ensuring appropriate role-based access for staff who will access protected health information. 45 CFR §308(a)(4)(i).

Q: How can we obtain other CMS data for research purposes?

A: To obtain this type of data, you will need to contact the CMS Research Data and Assistance Center (ResDAC) to make an official request.

You can get more information on ResDAC or make an online request at: http://www.resdac.org/cms-data/request/cms-data-request-center.

You can find more general information on ResDAC from CMS at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/ResearchDataAssistanceCenter.html.

Email - resdac@umn.edu

Phone - 1-888-9-ResDAC (1-888-973-7322)

Q. What is required if any information on our CJR Model Data Request and Attestation Form changes over the course of the model such as the specific data requestor or data points of contact, or our hospital's minimum necessary data requests?

A: You will need to notify CMS immediately (via CJR@cms.hhs.gov) with details on the reasons for the changes and send us an updated version of the CJR Model Data Request and Attestation Form.

Q: Can we incorporate or comingle CJR data into our existing Electronic Health Record (EHR) or Electronic Medical Record (EMR) system?

A: CJR hospitals should consult with their legal counsel on this question.

Q: What needs to happen with the CJR data we received when the model is complete?

A: Per the CJR Data Model Data Request and Attestation (DRA) Form, upon the expiration of the CJR model, the Data Requestor asserts that all CJR data received over the course of the CJR model will generally be destroyed, but may be retained if protected by laws affording protections as least as stringent as those applicable to a HIPAA Covered Entity under HIPAA.

Q: How can we submit a DRA form?

A: Data Portal Submission (Preferred Method)

1. Log into the CJR Data Portal (https://portal.cms.gov/wps/portal/unauthportal/home/)
2. Under the CJR Application, navigate to the Upload Files tab
3. Complete the information on the Upload Files tab
    a. Use the Select Your CCN drop down menu to select the CCN under which you are submitting the DRA form.
    b. Use the File Type drop down menu to select "Supporting Document 11"
    c. Click the Select File button. A window will display, which will allow you to select your DRA form from your computer. Please note that your file name must not

include spaces. The suggested file name is CCN_HospitalName (Example: 123456_FictionalHospital).

d. You have the option to enter a comment in the File Upload Information textbox. If a comment is entered, it will be viewable in the Upload History table.

4. Select Upload to add the DRA form to the Upload History table. Any files queued for upload may be removed prior to upload if necessary.
5. After the file is successfully uploaded, a confirmation message will display. Once the Upload Files screen is refreshed, the uploaded document will display in the Upload History table.
6. Email CJRSupport@cms.hhs.gov to notify the CJR Support team that the DRA form is available for review and processing.

Email Submission (if your organization is unable to access the Data Portal)

1. Password encrypt your DRA form using software that is in compliance with Federal Information Processing Standards (FIPS), section 140-2. Currently, CMS recognizes two applications, WinZip and SecureZip.
2. Attach the password encrypted file to an email. Within the email, please include a name and phone number of a point of contact who can be reached to obtain the document password. Please note that, per CMS security requirements, passwords are not be submitted via email (this includes the original or any subsequent email).
3. Submit the email and secured form to CJRSupport@cms.hhs.gov
4. A CJR Support representative will reach out via the contact information provided to obtain the password in order to proceed with review and processing of the DRA form.

Upon completion of the DRA form review, you will receive a notification from CJRSupport@cms.hhs.gov confirming that the form has been processed or requesting revisions to the form in order to proceed.

FINANCIAL ARRANGEMENTS

Q: What are the amendments to the financial arrangement policies, and when are they effective?

A: Effective January 1, 2018, we:

- Added Non-Physician Provider Group Practices (NPPGP), ACOs, hospitals, and critical access hospitals (CAHs) as CJR collaborators;
- Deleted the term 'collaborator agreement' and revised requirements of a financial arrangement between a participant hospital and a CJR collaborator under sharing arrangements to streamline the requirements for participant hospitals;
- Added and revised several financial arrangements and payment terms in order to incorporate the addition of entities and individuals to the list of CJR

collaborators, collaboration agents and downstream collaboration agents;

- Added the term "CJR activities" to identify activities that collaborators and their partners undertake toward the CJR model's goals of improving the quality and efficiency of episodes; and
- Consolidated the requirements under the CJR model for access to records and record retention and apply them more broadly in the model.

Q: What entities or individuals may be a CJR collaborator?

A: CJR collaborator means an ACO in Medicare Shared Savings Program other than Track 3 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).

Q: What does CJR activities mean?

A: CJR activities means activities related to promoting accountability for the quality, cost, and overall care for CJR beneficiaries, including managing and coordinating care; encouraging investment in infrastructure enabling technologies and redesigned care processes for high quality and efficient service delivery; the provision of items and services during a CJR episode in a manner that reduces costs and improves quality; or carrying out any other obligation or duty under CJR.

Q: Can participant hospitals enter into new sharing arrangements after the start of the model?

A: Yes. Although participant hospitals who wish to engage in gainsharing are required to have sharing arrangements with its CJR collaborators which set forth the provisions between the parties regarding gainsharing payments and/or alignment payments, these arrangements did not have to be executed prior to April 1, 2016. We expect that participant hospitals will likely enter into sharing arrangements throughout the duration of the model, not only prior to April 1, 2016. While a participant hospital may enter into sharing arrangements throughout the duration of the model, the CJR regulations require that the sharing arrangement between the participant hospital and the CJR collaborator must be "entered into before care is furnished to CJR beneficiaries under the sharing arrangement." Therefore, CJR collaborators may only receive a gainsharing payment that includes funds from a reconciliation payment or from internal cost savings that were generated during the period that the sharing arrangement with the CJR collaborator was in effect.

Q: Do collaborators need to sign sharing arrangements by a particular date?

A: There is no requirement that CJR collaborators sign a sharing arrangement by a particular date. However, we note that parties must enter into a sharing arrangement before care is furnished to CJR beneficiaries under the terms of the arrangement. Thus, CJR collaborators may only receive a gainsharing payment that includes funds from a reconciliation payment or from internal cost savings that were generated during the period that the sharing arrangement with the CJR collaborator was in effect. In addition we note that, effective January 1, 2018, all sharing arrangements must meet the updated requirements for the CJR model in subpart F of the CJR regulations (https://ecfr.io/Title-42/pt42.5.510#sp42.5.510.f).

Q: Do CJR participant hospitals need to revise their current sharing arrangements to ensure compliance with the revised requirements?

A: CJR participant hospitals, and any other individual or entity involved in a financial arrangement under the CJR model should review and revise their financial arrangements, including any sharing arrangements, as necessary to reflect the regulations as revised as of January 1, 2018.

Please note, as of January 1, 2018, the term 'collaborator agreement' is deleted from CJR regulations.

Q. Have waivers of Fraud and Abuse Laws been issued for the CJR model?

A: Yes. On November 16, 2015 the HHS Office of Inspector General (OIG) and CMS issued a Notice of Waivers of Certain Fraud and Abuse Laws in Connection with the Comprehensive Care for Joint Replacement Model (2015 Notice) for specified arrangements and beneficiary incentives permitted under the CJR model. On December 5, 2017, the OIG and CMS jointly issued new waivers, effective January 1, 2018 (2017 Notice). The new waivers were issued because of certain programmatic changes made by CMS to the CJR Model. As of January 1, 2018, the new waivers in the 2017 Notice superseded the 2015 Notice. The 2017 Notice

discusses the implications of the new waivers on arrangements entered into on or before the effective date of the new waivers. The 2017 Notice and the 2015 Notice can be found here https://www.cms.gov/medicare/physician-self-referral/fraud-and-abuse-waivers#Comprehensive%20Care%20for%20Joint%20Replacement%20(CJR)%20Model.

Q: Is the cap on the amount of gainsharing payments made to physicians, nonphysician practitioners, physician group practices, and nonphysician provider group practices applicable gainsharing payments based upon internal cost savings as well as reconciliation payments?

A: For PY 6 through PY 8, we have eliminated the 50 percent cap on gainsharing payments for episodes that end on or after October 1, 2021.

Q: Is there a cap on the amount of distribution payments that a CJR collaborator may make to physicians, non-physician practitioners, physician group practices, and nonphysician provider group practices?

A: For PY 6 through PY 8, we have eliminated the 50 percent cap on distribution payments for episodes that end on or after October 1, 2021.

Q: Is there a cap on the amount of downstream distribution payments that a practitioner or nonphysician practitioner receives?

A: For PY 6 through PY 8, we have eliminated the 50 percent cap on downstream distribution payments for episodes that end on or after October 1, 2021.

Q: Can a participant hospital make gainsharing payments to their CJR collaborators if the participant hospital owes money to Medicare at reconciliation?

A: Yes, however the gainsharing payments in this case could not be based on reconciliation payments, and should be based solely on internal cost savings.

Q: Do alignment payments have amount restrictions?

A: Yes, there are several restrictions, specific to the participant hospital and the entity or individual providing the payment:

For a performance year, the aggregate amount of all alignment payments received by the participant hospital must not exceed 50 percent of the participant hospital's repayment amount.

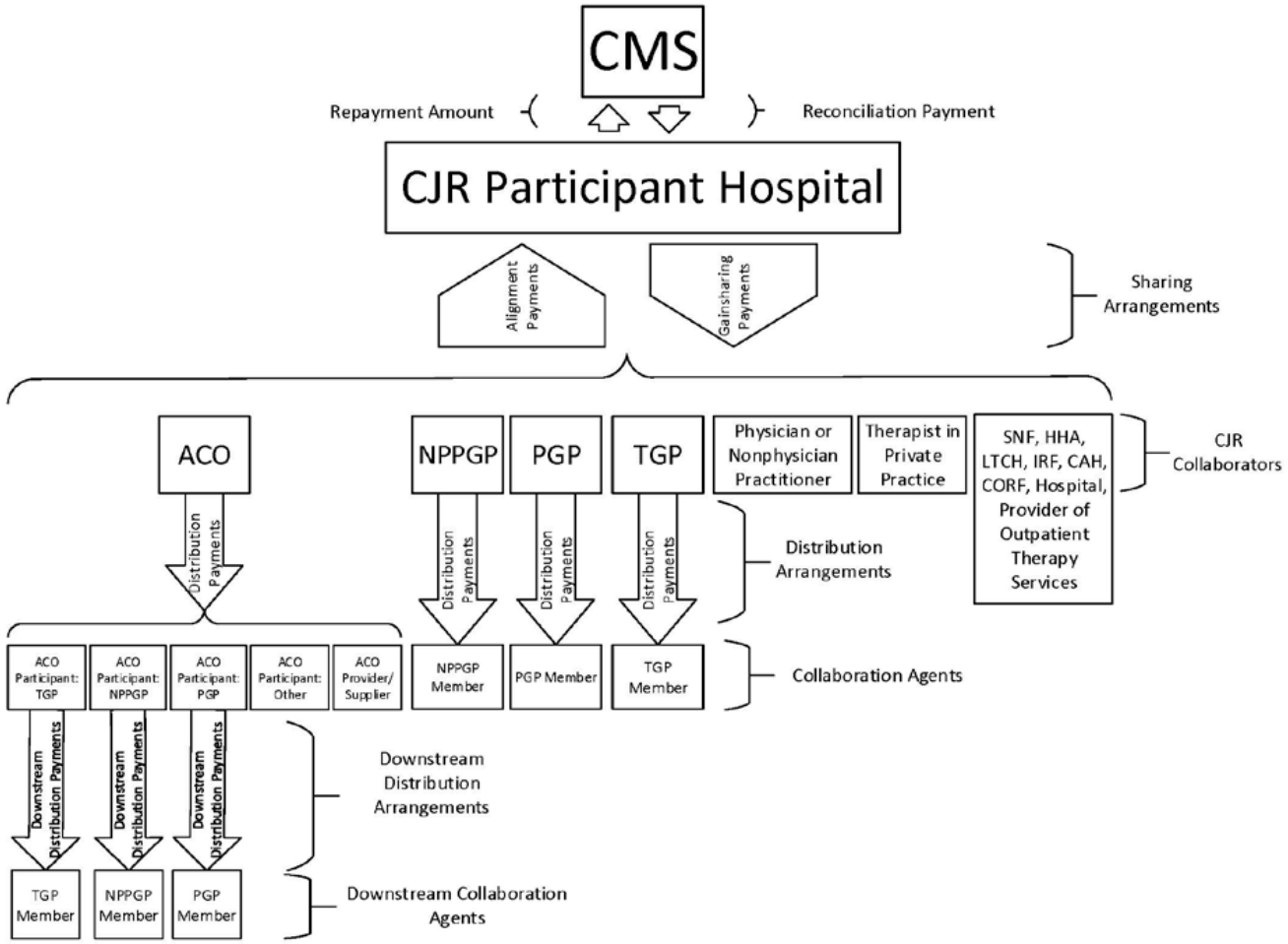
The aggregate amount of all alignment payments from a CJR collaborator that is not an ACO to the participant hospital may not be greater than 25 percent of the participant hospital's repayment amount.

Q: When can gainsharing payments from a participant hospital to its CJR collaborators take place?

A: Gainsharing payments from a participant hospital to its CJR collaborators may only take place on an annual basis, whether such payments are due to reconciliation payment amounts or internal cost savings. As providers and suppliers will continue to be paid according to the existing FFS processes throughout the duration of the model, CJR collaborators will continue to have sources of revenue other than gainsharing payments, which we believe makes distributions of gainsharing payments more often than once per year unnecessary.

As of January 1, 2018, Figure 5 below depicts the financial arrangements of the CJR Model.

Figure 5. CJR Model Financial Arrangements



BENEFICIARY INCENTIVES

Q: Can you provide examples of beneficiary incentives?

A: Post-surgical monitoring equipment not otherwise covered by Medicare is an example of a beneficiary incentive. This type of beneficiary incentive can track patient weight and vital signs for post-surgical patients discharged directly to home. Here, there is a reasonable connection between such equipment and the beneficiary's medical care, and this equipment advances a clinical goal for the CJR beneficiary.

An example of an item that is not a beneficiary incentive would be theater tickets, in that theater tickets bear no reasonable connection to the patient's medical care.

Q: Is there a limit to the amount of money a hospital can spend on beneficiary incentives?

A: There is no limit to the amount of money a hospital can spend on beneficiary incentives that are not technology-related. However, there is a limit for items or services involving technology provided to a beneficiary. The item or services may not exceed $1,000 in retail value for any one beneficiary in any one CJR episode.

Q: Do hospitals' costs for beneficiary incentive services or items count toward the calculation of episode spending?

A: No.

Q: Can a beneficiary incentive be provided to a beneficiary prior to initiating a CJR episode?

A: No. Participant hospitals may choose to provide in-kind patient engagement incentives only to beneficiaries currently in a CJR episode.

A CJR episode means most Medicare Part A and B items and services 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 the date of an anchor procedure, and ends on the 90th day after the date of discharge from the anchor hospitalization or the date of the anchor procedure, with the day of discharge or the date of the anchor procedure itself being counted as the first day of the 90-day post-discharge period.

Q: Does the hospital have to choose from a list of accepted technologies or services?

A: No. It is up to the CJR hospital as to whether a hospital chooses a particular product as a technology or service that could qualify as a beneficiary incentive.

Q: Will Medicare pay a CJR hospital separately for beneficiary incentives furnished to the beneficiaries?

A: All providers and suppliers caring for Medicare beneficiaries in CJR episodes will continue to bill and be paid as usual under the applicable Medicare payment systems. The CJR final rule does not change coverage requirements for technology or related items.

Q: Can hospitals give a beneficiary a technology item to keep after the CJR episode?

A: Items of technology exceeding $100 in retail value must be retrieved from the beneficiary by the participant hospital. Documentation regarding items of technology that exceed $100 in retail value must include contemporaneous documentation of attempts to retrieve technology. Further, the participant hospital must document all retrieval attempts, including the ultimate date of retrieval. Documented, diligent, good faith attempts to retrieve items of technology will be deemed to meet the retrieval requirement.

Q: When is a participant hospital required to document beneficiary incentives provided to CJR beneficiaries?

A: Hospitals must maintain a contemporaneous list of items and services furnished as beneficiary incentives, including the date the incentive was provided and identity of the beneficiary to whom it was provided. Though this requirement applies only to incentives with a retail value of $25 or greater, CMS encourages participant hospitals to document all beneficiary incentives as a good practice for showing compliance. Additionally, the CJR participant hospital must retain and provide access to the required documentation in accordance with § 510.110.

PROGRAM RULE WAIVERS

Telehealth Waiver

Q: Does the telehealth waiver allow for a telehealth visit to originate in a patient's home?

A: Yes, the CJR model includes a waiver of the geographic site requirement for any service on the Medicare-approved telehealth list and the originating site requirement only to permit telehealth visits to originate in the beneficiary's home or place of residence.

Q: How are services furnished under the telehealth waiver billed?

A: The telehealth services available under the CJR model program rule waiver for telehealth services are billed under the Medicare Physician Fee Schedule (MPFS) using the nine HCPCS G-codes listed in Table 27 on page 73450 of the CJR 2016 final rule.

Q: Can the telehealth waiver be used in conjunction with home health services?

A: The telehealth waiver is not intended to take the place of home health services. Telehealth visits under the waiver are not a substitute for in-person home health services paid under the home health prospective payment system.

Q: Is telehealth person-to-person communication or can it be vital signs only (transmitted via in-home devices)?

A: For Medicare payment to be made for telehealth services under the MPFS, several conditions must be met, as set forth under § 410.78. Specifically, the service must be on the Medicare list of telehealth services and meet all of the other requirements for payment. The service must be furnished via an interactive telecommunications system and must be furnished

to an eligible telehealth individual. The CJR final rule offers additional flexibilities to CJR hospitals through a waiver of the originating site and geographic site requirements for telehealth services.

Q: Do hospitals need to do any other recordkeeping in addition to following appropriate billing practices for the home visits and telehealth services provided to CJR beneficiaries to be in compliance with the post-discharge home visit and telehealth waivers?

A: The post-discharge home visits and telehealth visits furnished under the waivers must be billed using the appropriate G-Codes on the MPFS.
Hospitals must follow all requirements set forth in the CJR final rule when using the waivers.

Q: Can post-discharge home visits be furnished to a beneficiary that is also receiving home health services through the Medicare home health benefit?

A: No. Post-discharge home visits furnished under this waiver may not be furnished to a homebound beneficiary that is receiving home health services.

Q: How are the home visits under the waiver billed if the patients are not eligible for home health services under Medicare?

A: Services provided using the post-discharge home visit waiver are billed under the MPFS by the physician or non-physician practitioner, or by the hospital to which the supervising physician or non-physician practitioner has assigned his or her billing rights. The post- discharge home visits must be billed using the HCPCS codes found in Table 26 on page 73446 of the CJR 2016 final rule.

Q: Can any of the nine post-discharge home visits be provided by physical therapists and reimbursed by the hospital?

A: Physical therapy, occupational therapy and speech-language pathology services provided incident to a physician's professional services are subject to the provisions established in 42 CFR 410.59(a)(3)(iii), 410.60(a)(3)(iii), and 410.62(a)(3)(ii). These practitioners are subject to regulations that were not waived under the CJR final rule. Therefore, visits provided by these practitioners would not be reimbursed under the CJR post-discharge home visit waiver. The purpose of the post discharge home visit waiver is to allow a beneficiary the opportunity to benefit from physician/non-physician practitioner care that otherwise would only be available to them if they were homebound.

Q: Does the hospital need to follow CMS and/or Joint Commission requirements for home health services if they send staff members to the home?

A: The post-discharge home visit waiver allows clinical staff, such as nurses, either employed by the hospital or not, to furnish services under the general supervision of a physician or non-physician practitioner. This is only for those beneficiaries who are not homebound, meaning this is limited to those beneficiaries who would not be eligible for home health services. State and Joint Commission requirements still apply for all care given under the CJR model.

Q: What specifically does CMS mean by clinical staff or "auxiliary personnel"?

A: In 42 CFR 410.26, auxiliary personnel are defined as any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.

Q: What payment requirements has CMS waived for the telehealth wavier?

A: CMS waives the payment requirements under section 1834(m)(2)(A) so that the facility fee normally paid by Medicare to an originating site for a telehealth service is not paid if the service is originated in the beneficiary's home or place of residence. Starting January 1, 2018, CMS waives the payment requirements under section 1834(m)(2)(B) of the Act to allow the distant site payment for telehealth home visit HCPCS codes unique to this model.

SKILLED NURSING FACILITY WAIVER

Q: When can we begin utilizing the Skilled Nursing Facility (SNF) 3-day stay waiver?

A: The SNF waiver will not be available for use until January 1, 2017. The waiver will be available for use only for episodes that initiate on or after January 1, 2017.

Q: Where can we find the list of SNFs that meet the quality requirement (3 stars or higher for 7 of the last 12 months)?

A: The list will be updated and posted quarterly on the CMS public website at https://innovation.cms.gov/initiatives/cjr.

Q: What are the guidelines for discharge planning notices and potential liability for SNF stays when a beneficiary is discharged after less than 3 days to a SNF not meeting the quality requirements?

A: Beginning in January 2017 when the SNF 3-day stay waiver is available for CJR participant hospitals, CMS will cover services furnished under the waiver when the eligibility and enrollment information available to the provider at the time the services under the waiver were furnished indicated that the beneficiary was included in the model. In cases where the hospital does not provide the discharge planning notice, the hospital would be financially liable for the SNF stay.

If a CJR participant hospital discharges a beneficiary without a qualifying 3-day stay to a SNF that does not meet the quality requirements for waiver use, the hospital must provide a discharge planning notice to the beneficiary detailing any potential financial liability for the SNF stay. Participant hospitals must provide a discharge planning notice to a beneficiary to provide written notice of potential financial liability associated with non-covered services

recommended or discussed as a part of discharge planning. This must be provided no later than at the time that post-acute care is discussed or at the time of discharge, whichever occurs earlier. For example, if a participant hospital discharges a beneficiary to a SNF that would not qualify under the 3-day stay waiver, then the hospital must notify the beneficiary that he or she may be responsible for costs associated with that SNF stay, except those which would be covered by Medicare Part B during a non-covered inpatient SNF stay.

Q: When we give the beneficiaries a list of SNFs eligible for waiver use can we include their star ratings?

A: Yes, as long as there is no patient steering and the star ratings match what CMS has posted on the CJR public website. The CJR participant hospitals can also point beneficiaries to the Nursing Home Compare website, which is listed on the beneficiary notification template.

Q: What if there are no SNFs meeting the quality requirement in close proximity to the CJR hospital or a SNF meeting the quality requirement refuses to admit a CJR beneficiary?

A: Beneficiaries may choose any SNF; the CJR model does not limit beneficiary choice of any provider or supplier. However, the SNF 3-day stay waiver may only be utilized for discharge to a SNF meeting the quality requirement. Please note that CJR hospitals are not required to use the SNF 3-day stay waiver; beneficiaries in CJR episodes may be discharged to any SNF (assuming other Medicare coverage rules are met) after a qualifying 3-day inpatient stay.

Q: If a hospital elects to use the SNF waiver for a beneficiary who initially falls under the CJR episode, but during reconciliation, the CJR episode is cancelled, who is responsible for the SNF stay that occurred?

A: If the waiver is used correctly, that is, in accordance with 42 CFR 510.610, it can be used for beneficiaries who are eligible for inclusion in a CJR episode of care at the time of SNF admission, even if the episode is later cancelled.

Q: Do beneficiaries not meeting the criteria for SNF-level care have the right to appeal the decision?

A: A beneficiary has the right to contact 1-800-Medicare to raise any concerns. Beneficiaries also retain all existing Medicare appeal rights. Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) help Medicare beneficiaries access high-quality health care. They review beneficiary complaints about the quality of care and conduct quality of care reviews based on reviews from other sources (e.g., other QIOs, CMS, etc.) in a manner to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. They also handle cases in which beneficiaries want to appeal a healthcare provider's decision to discharge them from the hospital or discontinue other types of institutional services.

Q: How do Critical Access Hospitals' (CAH) Swing Beds fit under the SNF waiver rule? Currently CAHs do not have a star rating.

A: The SNF 3-day stay waiver may only be utilized for discharge to a SNF that meets the quality requirements laid out in the CJR final rule.

Q: Do you have any requirement for selecting Home Health Agencies like the SNF requirement of three stars or greater?

A: No, the CJR final rule does not institute any new requirements for selecting home health agencies.

Q: If a SNF is participating in the BPCI Advanced Model for major joint replacement of the lower extremity but does not have a 3-star rating for 7 out of the last 12 months, can it still accept patients discharged under the CJR SNF 3-day waiver?

A: The CJR model does not limit beneficiaries' choice of post-acute care setting. However, the SNF 3-day stay waiver may only be utilized for discharge to a SNF meeting the quality requirement. The SNF quality requirement for use of the waiver states that the facility must have an overall rating of three stars or better in the Five-Star-Quality Rating System for SNFs on the Nursing Home Compare website for at least 7 of the past 12 preceding months. CMS will post on the public website a list of SNFs that meet this requirement to hospitals participating in the CJR model prior to the waiver becoming available for CJR hospitals on or after January 1, 2017. The SNF quality requirement for use of the CJR SNF 3-day stay waiver applies regardless of a SNF's current or prior participation in BPCI Advanced Model.

Q: How does the revised episode of care definition effect the SNF waiver?

A: The definition of an episode of care has been changed to include outpatient procedures. Additionally, we added the definition of anchor procedure to mean a TKA or THA procedure that is permitted and reimbursable by Medicare when performed in the outpatient setting and billed through the OPPS. Therefore, when we use the term "discharge" under the Medicare Program Rule waivers, we intend for this term to apply to both anchor hospitalizations and anchor procedures. In the event that a participant hospital performs an LEJR procedure in the outpatient setting and due to unforeseen circumstances, the beneficiaries needs a SNF stay, the SNF 3 –day waiver will also apply in the outpatient setting.

Q: What are the requirements for participant hospitals to use the SNF 3-day waiver in PY 6 through PY 8?

A: For episodes being conducted in PY 6 through 8 of the CJR model, CMS waives the SNF 3-day rule for coverage of a SNF stay within 30 days of the date of discharge from the anchor hospitalization or anchor procedure for a CJR beneficiary on the date of discharge from the anchor hospitalization or anchor procedure. This policy will only be applicable if the SNF is listed on the current calendar quarter list of qualified SNFs at the time of the CJR beneficiary's admission to the SNF.

BENEFICIARY NOTIFICATION

Q: Does the beneficiary notification have to be given in writing or can it be given verbally?

A: Beneficiary notifications must be given to beneficiaries in writing for both inpatient and outpatient procedures. As stated at 42 CFR 510.405, each participant hospital must provide written notice to any Medicare beneficiary that meets the criteria in § 510.205 for inclusion in the CJR model. The beneficiary notice can also be mailed to the CJR beneficiary.

Q: Where can the CJR beneficiary notification documents be found?

A: These documents can be found on the public CJR website at https://innovation.cms.gov/initiatives/cjr and on the CJR Connect site.

Q: Can the beneficiary notice be given to the beneficiary prior to admission for an elective LEJR procedure?

A: Yes. The participant hospital must provide a beneficiary notification prior to discharge from the anchor hospitalization, or prior to discharge from the anchor procedure, as applicable.

Q: Will beneficiaries receive multiple notification letters during a CJR episode?

A: Participant hospitals are required in all circumstances to provide written notice to beneficiaries concerning the CJR model. If a participant hospital does not have any collaborator agreements, neither the physicians, or other providers of services would need to provide written notice to beneficiaries of the CJR model. CMS provided, and has made available on the CJR model's website, beneficiary notices for use by the participant hospitals, as well as physicians, physician group practices, and post-acute care providers collaborating with participant hospitals.

Q: How are CJR hospitals expected to provide beneficiary notification materials to patients undergoing an urgent or emergent LEJR procedure as a result of a hip fracture? Can a family member receive this notification on behalf of the beneficiary?

A: The notification must be provided to the beneficiary no later than discharge from the CJR participant hospital accountable for the CJR episode.

Q: How do we prove that beneficiaries received notification materials? Does the notice need to be signed and dated by the patient/beneficiary? How will CMS measure hospitals' compliance with the notification requirement? Does it need to be documented in the EMR that the patient was given the beneficiary notification?

A: Beginning January 1, 2018, participant hospitals, all CJR collaborators, collaboration agents, or downstream collaboration agents, and the ACO, PGP, NPPGP, or TGP must be able to generate upon request a list of all beneficiaries who have received the required notices, including the date the notice was delivered. Lists of beneficiaries that receive notifications must be retained and provided access to CMS, or its designees, in accordance with § 510.110.

Q: Is the beneficiary notification presented to the patient only once per episode? For example, if a CJR beneficiary is readmitted to the hospital for a complication, must the CJR hospital provide an additional notification letter to the beneficiary?

A: No, participant hospitals do not need to give a second written notice if a CJR beneficiary is readmitted for a complication.

Q: What does CMS mean when they state that the beneficiary notification letters are non-modifiable?

A: CMS provided CJR hospitals with the notification letters to aid hospitals in compliance with the requirements of the CJR final rule. If they are modified they may not be referred to as CMS model documents.

Q: Will you be providing the beneficiary notification letters in Spanish or any other languages? If not, can hospitals have the notification documents translated themselves or use an interpreter?

A: Yes, CMS provides the beneficiary notification documents in English and Spanish. Beneficiary notices may be translated into other languages, so long as their content meets the requirements in §510.405.

Q: Do CJR hospitals need to provide CJR beneficiary notification materials to beneficiaries for whom Medicare is a secondary payer?

A: No. As stated in the November 2015 CJR final rule, each participant hospital must provide written notice to any Medicare beneficiary that meets the criteria in § 510.205 of his or her inclusion in the CJR model. Under these criteria, only beneficiaries with Medicare FFS as their primary payer are included in the CJR model.

Q: If a participant hospital does not have any sharing arrangements, do hospitals still have to give the physicians and post-acute care (PAC) providers the beneficiary letter that they would hand out to beneficiaries?

A: In this situation, neither the physician nor the PAC provider would need to provide written notice to beneficiaries of the CJR model. It is still the responsibility of the participant hospital to provide beneficiaries with written notice of the model as required in § 510.405.

Q: If the surgeon is employed by the hospital, does this mean the beneficiary notification has to be provided by the hospital and the surgeon?

A: As stated in the January 2017 CJR final rule, each participant hospital must provide written notice to any Medicare beneficiary that meets the criteria in § 510.205 of his or her inclusion in the CJR model. The participant hospital and any CJR collaborator must provide the CJR beneficiary with notification. If the physician is not a CJR collaborator, the notice requirements in §510.405 do not apply to that physician.

Q: Do CJR hospitals with orthopedic surgeons initiating LEJR episodes in the BPCI initiative still need to provide the beneficiary notification letter to patients receiving a LEJR procedure?

A: The requirement that physicians provide notice to CJR-eligible beneficiaries applies only to CJR collaborators.

Q: Do hospitals have to provide beneficiary notifications to patients in an outpatient setting?

A: Yes. Patients taking part in both inpatient and outpatient settings must be provided with beneficiary notifications as listed in 42 CFR 510.405 of the May 2021 CJR final rule.

DISCHARGE PLANNING NOTICE

Q: Where can we find information concerning the discharge planning notice in the final rule?

A: Pages 73516 through 73520 of the CJR 2016 final rule describe the discharge planning requirements included in the CJR model. A participant hospital must provide the beneficiary with a written notice of any potential financial liability associated with non-covered services recommended or presented as an option as part of discharge planning, no later than the time that the beneficiary discusses a particular post-acute care option or at the time the beneficiary is discharged from an anchor procedure or anchor hospitalization, whichever occurs earlier.

Q: How is the discharge planning notice under CJR different from what is currently required?

A: The CJR discharge planning notice is in addition to other discharge planning materials currently provided to beneficiaries at CJR hospitals. CJR hospitals must provide beneficiaries with a discharge planning notice that contains notice of any potential financial liability, associated with non-covered services recommended or presented as an option during discharge planning. If the participant hospital knows or should have known that the beneficiary is considering or has decided to receive a non-covered post-acute care service or other non-covered associated service or supply, the participant hospital must notify the beneficiary that the service would not be covered by Medicare.

Q: Can the financial liability portion of the discharge planning notice be given verbally during the regular discharge process in the hospital or does it have to be given in a written notice?

A: The discharge planning notice must be given in writing.

Q: When and how will the hospitals be provided the discharge planning notice?

A: CMS does not provide a template for these materials.

Q: Can you clarify that the discharge planning notice is only required if the beneficiary is discharged to a SNF without a qualifying 3-day stay?

A: CJR participant hospitals must provide beneficiaries with a written notice of any potential financial liability, associated with non-covered services recommended or presented as an option as part of discharge planning.

For example, if a CJR hospital discharges a beneficiary after a two-day stay to a SNF that does not meet the quality requirements laid out in the CJR final rule for use of the SNF 3-day stay waiver, the hospital must provide the beneficiary with notice of potential financial liability prior to discharge. This is to allow for beneficiary choice and awareness of the potential financial liability due to the decisions or recommendations presented as part of the discharge process. Also, as part of discharge planning and referral, participant hospitals must inform beneficiaries of all Medicare participating post-acute care providers in an area and must identify those post-acute care providers with whom they have sharing arrangements.

Q: On the beneficiary notification letter where the hospital is required to notify beneficiaries of all PAC providers in the area, how is area defined?

A: Area means, as defined in 42 CFR § 400.200, 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.

MONITORING AND BENEFICIARY PROTECTIONS

Q: How will participant hospitals receive information about CMS monitoring efforts?

A: The 2017 Q1 Hospital Monitoring report (which was packaged with reconciliation reports providers received in April of 2017) was the first monitoring report provided to participant hospitals. The data included in the monitoring report is separated into the following categories: access to care, compliance, and quality. Hospitals will continue to receive these reports on a quarterly basis.

Q: Is there a way to aggregate data files by hospital system? We have multiple hospitals participating in CJR.

A: Unfortunately, we cannot provide aggregate data files at this time for hospital systems with multiple CJR hospitals. CMS data security policies prevent us from providing data from one hospital to another or from providing multiple individual hospitals' data to one entity.

Q: Is CJR model quality measure data included in the monitoring reports? Where can I find the quality data that is used in determining reconciliation payments?

A: Because CJR model quality measure performance and improvement are determined annually at reconciliation, these data are not included in the quarterly monitoring reports. CJR model quality measure data for your hospital, which is available on an annual basis along with reconciliation information, can be downloaded from the CJR data portal under "Final

Reconciliation File." The quality measure data in that ZIP file is in "QM.csv" and in the HTML report ("CJR_Reconciliation_Report_H[CCN]_PY[#].html").

Q: Does the CJR model restrict beneficiaries from receiving certain types of services?

A: Medicare beneficiaries retain their freedom to choose their providers and services, and providers may continue to provide any medically necessary covered services. The model will not require beneficiaries to receive services from certain providers, nor will it limit them to certain types of services. All providers and suppliers will continue to be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year.

Q: Does CJR limit beneficiaries' ability to choose their preferred hospital or other provider or supplier?

A: No. Beneficiaries retain the ability to choose any hospital or provider that they wish. The model does not limit a beneficiary's freedom of choice to choose providers and suppliers.

Q: I am a beneficiary living in one of the selected areas. What can I do if I do not want to participate in the CJR model?

A: The care of Medicare beneficiaries meeting certain criteria who have either an inpatient hospitalization for lower extremity joint replacement (as designated by MS-DRGs 469, 470, 521, or 522) or an outpatient TKA or THA (as designated by CPT codes 27447 or 27130) at participant hospitals will be included in the model. Beneficiaries who are cared for at a participant hospital will receive care that must meet the current standards as required by the Medicare program. Beneficiaries retain their right to choose any provider or supplier.

Q: Will this new payment system for hospitals affect the way doctors provide care to beneficiaries?

A: Physicians and hospitals are expected to continue meeting current standards required by the Medicare program. The model creates incentives for hospitals and physicians to improve quality and decrease the cost of care for lower extremity joint replacements. Hospitals may redesign care pathways to increase coordination among providers, making care safer and more efficient. Physicians can provide telehealth visits to CJR beneficiaries in their homes, and CJR beneficiaries who are not homebound may be able to receive home visits.

Q: What safeguards have you put in place to make sure that patient care is not adversely affected?

A: All existing safeguards to protect beneficiaries and patients remain in place. If a beneficiary believes that his or her care has been adversely affected, he or she can call 1-800-MEDICARE or contact his or her state's QIO. CMS will also conduct additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services. If concerns are identified, CMS can initiate audits and corrective action under existing authority.

Q: How will patient data be protected?

A: Patient data will continue to be protected under the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy laws. Under the CJR model, CMS only shares data with participant hospitals and only based on a request by the hospital for data that meets the requirements of the HIPAA Privacy Rule. Participant hospitals are that are covered entities are responsible for compliance with the requirements of the HIPAA Privacy and Security Rules.

Q: How will beneficiaries be notified about their rights within the CJR model?

A: Beneficiary notification must include an explanation of the model and how it will impact patient care, information that patients retain the freedom of choice to choose providers and services, an explanation of how patients can access care records and claims data, and reaffirmation that existing Medicare beneficiary protections remain in place. Notification must occur by participant hospitals and the providers and suppliers who are collaborating with them.

Q: If CMS discovers that a hospital participant is non-compliant with the requirements of the CJR model, what actions will CMS take?

A: CMS may take several actions against the participant hospital including but not limited to issuing a warning letter to the participant hospital, requiring the participant hospital to develop a corrective action plan (CAP), and reducing or eliminating a participant hospital's reconciliation payment.

ADVANCED APM TRACKS

CJR Participant Hospital CEHRT TRACK REQUIREMENTS

Clinician Financial Arrangement List

Q: What are the two different track options for the CJR model? Is CJR an Advanced APM?

A: Track 1 of the CJR model is an Advanced APM and the participation of eligible clinicians in track 1 will be considered in the determination of eligibility for an APM incentive payment. Track 2 of this model is an APM, but does not meet the Advanced APM criteria in the Quality Payment Program.

Q. What is a Clinician Financial Arrangement List?

A: CJR participant hospitals that choose CEHRT use must submit to CMS a clinician financial arrangements list on a no more than quarterly basis. The list must include specific information on affiliated CJR collaborators, collaboration agents, and downstream collaboration agents.

If there are no individuals that meet the requirements to be reported, the CJR participant hospital must attest that there are no individuals to report on the clinician financial

arrangements list. CMS reaches out to all participant hospitals during a performance year to facilitate collection of the clinician financial arrangements list.

Q: Why is CMS collecting Financial Arrangement lists with CEHRT Track information?

A: In an effort to minimize burden to the extent possible, CMS is combining the collection of information on participant hospitals' track selection and CEHRT use and on financial arrangements. If a participant hospital chooses CEHRT use (Track 1), the CJR model team will use the information provided for financial arrangements for the clinician financial arrangement list.

Q: If a CJR participant hospital selected Track 1 participation and submitted a clinician financial arrangement list, where can physicians check to see if they received QP status?

A: Eligible clinicians can use the Qualifying APM Participant (QP) Look-up Tool at https://data.cms.gov/qplookup.

Q: Should a hospital resubmit the clinician financial arrangement list each time a collaborator, collaboration agent, or downstream collaboration agent changes?

A: No. The hospital can update their clinician financial arrangement when the CJR model team requests this information.

Clinician Engagement List

Q: What is the Clinician Engagement List?

A: Physicians, nonphysician practitioners, or therapists who are not CJR collaborators during the period of the CJR model performance year specified by CMS but who have a contractual relationship with the Track 1 participant hospital based at least in part on supporting the hospital's quality or cost goals under the CJR model are considered eligible clinicians for QP determinations. These physicians, nonphysician practitioners, and therapists' information would be included on a clinician engagement list submitted to CMS.

CMS will collect information for the clinician financial arrangement list and the clinician engagement list together to reduce burden on participant hospitals. The clinician engagement list and the clinician financial arrangement list will be considered together an Affiliated Practitioner List, which is used by CMS to identify eligible clinicians for the Qualified Practitioner (QP) determination under the Quality Payment Program.

CMS will notify hospitals when these lists must be submitted.

Q: What does the term 'contractual relationship' mean?

A: The term contractual relationship encompasses the wide range of relationships whereby a participant hospital engages a clinician to perform work that at least in part supports the cost and quality goals of the CJR model.