

# Comprehensive Care for Joint Replacement (CJR) Model 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; Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation (CR) Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement (CJR) Payment Model Final Rule and Interim Final Rule with Comment published December 1, 2017.\***

## **GENERAL MODEL QUESTIONS**

**Q: Where can I find a copy of the CJR final rules?**

**A:** The full text of the November 2015 CJR model final rule is available here: <http://federalregister.gov/a/2015-29438>. This final rule contains a comprehensive discussion of CJR model policies.

The full text of the December 2017 final rule and interim final rule with comment period is available here: <https://www.federalregister.gov/documents/2017/12/01/2017-25979/medicare-program-cancellation-of-advancing-care-coordination-through-episode-payment-and-cardiac>. This rule contains revisions to certain CJR model policies and establishes a new policy for increased flexibility in determination of episode costs for participant hospitals located in areas impacted by extreme and uncontrollable circumstances such as hurricanes.

Other regulations relevant to CJR are available via links listed under the Regulations and Notices section on the CJR webpage: <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:** The first performance period for the CJR model began on April 1, 2016. The CJR model consists of 5 performance years, as shown below in Table 1.

**Table 1. CJR Model Performance Years**

<b>Performance year</b>	<b>Calendar year</b>	<b>Episodes included in performance year</b>
1	2016	Episodes that start on or after April 1, 2016, and end on or before December 31, 2016
2	2017	Episodes that end between January 1, 2017, and December 31, 2017, inclusive
3	2018	Episodes that end between January 1, 2018, and December 31, 2018, inclusive
4	2019	Episodes that end between January 1, 2019, and December 31, 2019, inclusive
5	2020	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

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

**A:** As of February 1, 2018, nearly all acute care hospitals in selected mandatory geographic areas, except for those that are low volume or rural, 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. In addition, acute care hospitals in selected voluntary geographic areas were able to opt-in to performance years 3 through 5 during a participation election period in January 2018. Medicare beneficiaries who have an inpatient hospitalization for lower extremity joint replacement (LEJR) and/or other major leg procedure as designated by MS-DRG 469 or 470 at these participant hospitals are included in the model. These MS-DRGs primarily include single joint total hip and total knee replacement procedures.

**Q: Where has the CJR model been implemented?**

**A:** The CJR model has been implemented in 67 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:** Hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) and located in the 67 selected MSAs, with few exceptions, were required to participate in the model for the first 2 performance years. As of February 1, 2018, 34 of the 67 areas will remain mandatory participation areas and all hospitals, except low volume or rural hospitals, in those areas are required to participate. CJR participant hospitals in the 33 voluntary areas, along with those hospitals in all 67 areas identified as low-volume or rural, were given a one-time opportunity during January of 2018 to voluntarily opt-in to the CJR model for the remainder of the model. Those providers eligible for voluntary participation who chose not to opt in will have all of their CJR performance year 3 episodes cancelled.

**Q: How many hospitals are included in the model?**

**A:** As of April 1, 2016, there were approximately 800 acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) that were eligible to be included in the CJR model, noting that about 100 of these providers do not typically perform joint replacement procedures and as a result may not have had any CJR episodes. The total number of participating hospitals as of February 1, 2018 is 465; 390 of these 465 hospitals are located in the 34 mandatory MSAs (10 of these 390 are rural and 1 is low volume; all 11 opted into continue participation in CJR) while 75 of these 465 providers are located in the voluntary MSAs. The list of CJR participant hospitals is available on the CJR webpage: <https://innovation.cms.gov/initiatives/cjr>.

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

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

**Q: How were hospitals that were eligible for voluntary participation able to opt into the model?**

**A:** Hospitals located in a voluntary MSA, or those identified as low-volume or rural, were able to voluntarily elect continued participation in the model by submitting an opt-in letter during the one-time participation election period from January 1, 2018 to January 31, 2018. The opt-in letter acts as a participation agreement for the model and the requirements for opting into the CJR model are codified at 42 CFR 510.115.

**Q: I am a hospital in a voluntary MSA and have chosen not to opt-in to the model. When does my participation end?**

**A:** Hospitals that are located in a voluntary MSA or that are identified as low-volume or rural and did not elect continued participation in the model will have all performance year 3 episodes cancelled as of February 1, 2018. As of February 1, 2018, they will no longer be considered CJR participant hospitals and therefore will not be able to use program rule waivers under the model. After February 1, 2018, hospitals that are no longer CJR participant hospitals will only receive data for performance years 1 and 2. The final reconciliation for performance year 2 activity will be conducted in the spring of 2019.

**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 MS-DRG 469 or 470 at discharge from a CJR participant hospital, when those beneficiaries meet the model's inclusion criteria. CMS has instituted a risk stratification methodology to set different target prices for hip fracture cases, to recognize the significantly higher spending and distinct clinical characteristics of these patients. 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. Beginning in the second year of the model, 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:** Like all models tested by CMS, there will be a formal, independent evaluation using quantitative and qualitative data. Outcomes evaluated will include both quality and costs of care.

**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:** All acute care hospitals paid under the IPPS in a selected MSA were required to participate in CJR performance years 1-2, with the exception of acute care hospitals that were active participants in BPCI Model 1 or Models 2 or 4 for the major joint replacement of the lower extremity clinical episode. For performance years 3-5, all acute care hospitals paid under IPPS in selected mandatory MSAs, except those considered low volume or rural or active BPCI participants, are required to participate. CMS recognizes that some acute care hospitals in the selected MSAs do not perform LEJR procedures. However, such hospitals are technically still participants in the CJR model and must comply with all requirements of the CJR final rule should they furnish 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. Hospitals in the selected voluntary MSAs had the option to elect participation for performance years 3-5 in January 2018.

**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](mailto: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 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.

**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 plans for the evaluation to include 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.

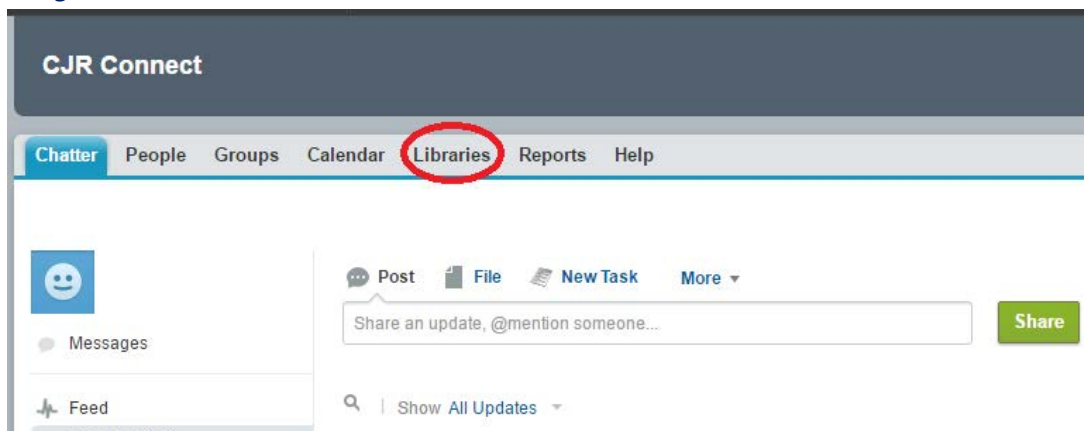
Beneficiaries who feel their care has been compromised should call 1-800-MEDICARE or contact their Quality Improvement Organization (QIO). CJR model participants will also be monitored for compliance with all existing rules and regulations.

## 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 on the “Libraries” tab on CJR Connect, as shown below in Figure 1.

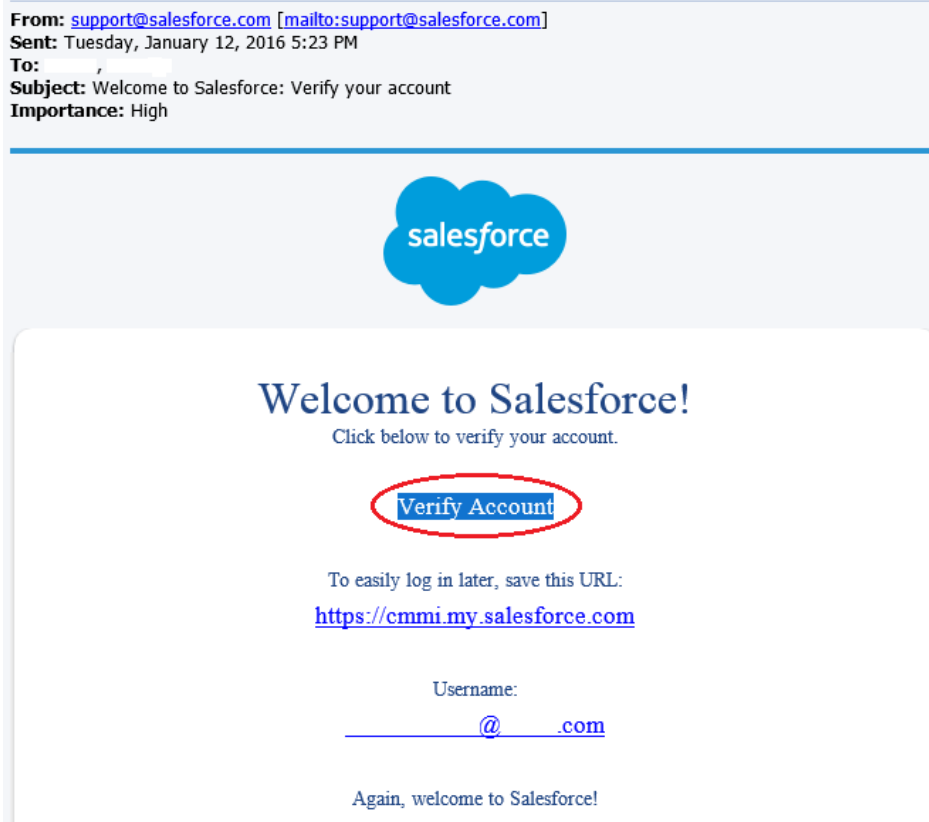
*Figure 1. CJR Connect Libraries Tab*



### Q: How do we access the CJR Connect website?

A: The CJR Connect site is located at <https://app.innovation.cms.gov/CJRConnect>. A password is required to enter the 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](mailto: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 (see Figure 2).

**Figure 2. CJR Connect Welcome Email**



The requester will then have 24 hours during which he or she 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 4, or email [CMMIConnectHelpDesk@cms.hhs.gov](mailto:CMMIConnectHelpDesk@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.

**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](mailto:CJRSupport@cms.hhs.gov).

**Q: If a health system includes participants in CJR as well as BPCI, can participant hospitals or other providers within the system access BPCI 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](mailto: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 payment methodology. 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 quality-adjusted target prices prior to each performance year that represent expected spending based on historical spending data for LEJR episodes (i.e., the episode benchmark price) with a 3% discount applied. The episode benchmark prices initially incorporates a blend of both hospital-specific historical LEJR spending, as well as spending for LEJR episodes at the regional level. 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 have implemented a specific pricing methodology for hip fracture patients due to the significantly higher spending associated with these more complex cases. At the conclusion of a performance year, CMS will compare the quality-adjusted target price at reconciliation 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 quality-adjusted target price 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 quality-adjusted target price and actual episode spending, up to a stop-gain limit. Hospitals with LEJR episode spending that exceeds the quality-adjusted target price will be financially responsible for paying a portion of the difference to Medicare, with the responsibility phased in beginning in year two of the model and fully implemented in year four.

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

**A:** The episode benchmark prices used to calculate quality-adjusted target prices are based on a blend of a hospital's historical spending and regional hospital spending on LEJR episodes. Benchmark prices were based on LEJR episodes beginning in 2012-2014 for performance years 1 and 2, and are based on historical episodes from 2014-2016 for performance years 3 and 4, and 2016-2018 for performance year 5. The episode benchmark prices incorporated two-thirds of the hospital's own spending and one-third regional spending for performance years 1 and 2, which transitioned to one-third hospital-specific and two-thirds regional spending for performance year 3, and regional historical spending only for performance years 4 and 5. Starting in performance year 3, historical spending data includes CJR reconciliation payments and repayment amounts in spending totals, as well as regional BPCI LEJR spending.



**Q: When do we receive the prospective quality-adjusted target prices?**

**A:** CJR participant hospitals can now access their prospective quality-adjusted target prices for 2018 in the CJR Data Portal. CMS updates quality-adjusted target prices at least twice a year, to account for payment system updates, and provide quality-adjusted target price updates to CJR hospitals prior to the performance period to which the prices will apply. For example, CJR hospitals generally will receive two sets of quality-adjusted target prices per year for each episode type, one set which will apply to episodes beginning January-September, and the other set pertaining to episodes beginning October-December of a performance year. If your hospital needs access to the CJR Data Portal, please email [CJR@cms.hhs.gov](mailto:CJR@cms.hhs.gov).

**Q: Are the quality-adjusted target prices risk-adjusted?**

**A:** Quality-adjusted target prices are risk-adjusted based on the presence or absence of 1) major complications and comorbidities, and 2) fractures. Episodes are stratified by MS-DRG 469 vs 470, and fracture vs. non-fracture, resulting in four separate quality-adjusted prices. Quality-adjusted target prices thus reflect the different patterns of utilization and cost, both during the anchor hospitalization and in the 90 days post-discharge, that tend to occur based on these factors.

**Q: How are hip fracture cases identified in CJR?**

**A:** CMS sets separate quality-adjusted target prices based on fracture status. Hip fracture cases will be identified using the principal diagnosis code on the inpatient claim for the inpatient hospitalization that initiates the CJR episode. A list of ICD-CM codes is available on the public CJR website at <https://innovation.cms.gov/initiatives/cjr>. The list includes the ICD-9-CM diagnosis codes that were used to identify fracture cases in the historical period used to calculate initial episode benchmark prices, as well as the ICD-10-CM diagnosis codes that are used to identify hip fracture cases during the model performance years.

**Q: Are the stop loss and stop gain limits applied to the prospective quality-adjusted target price or the final quality-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-adjusted target price at reconciliation, which incorporates an effective (or applicable) discount based on the hospital's composite quality score for the performance year.

**Q: Does the regional component of quality-adjusted target prices include all episodes from all hospitals in a region (US Census Division) or only CJR hospitals? What about BPCI episodes?**

**A:** The regional component includes all LEJR episodes at acute care hospitals located in a given region (US Census Division), including BPCI 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-adjusted target prices 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: I am trying to replicate my quality-adjusted target prices. However, my numbers are not the same as what is provided in my data.**

**A:** Although CMS has included detailed instructions on the data portal, hospitals will not be able to exactly replicate their quality-adjusted target prices. One reason is that certain mental health and substance abuse treatment-related claims are not allowed to be shared due to privacy concerns, so those claims will be included in CMS's target price calculations but not in the individual claims data provided to participants. Additionally, the summary statistics are based on standardized payments, but the ultimate quality-adjusted target prices incorporate wage factors, which can be +/- 20% for some hospitals.

**Q: How is sequestration applied to the claims data used for CJR?**

**A:** As of April 2013, all Medicare claims incorporate the 2% sequestration. For CJR claims from before April 2013, CMS incorporated a 2% sequestration so that they would be comparable across the entire historical period.

**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.

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

**A:** The total knee arthroplasty (TKA) CPT code (27447) was removed from the inpatient-only 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. While this means that Medicare will now pay for TKAs performed in the outpatient setting, it **does not** mean that CMS expects that all TKA procedures for Medicare beneficiaries will be done in outpatient settings.

**Q: How will the outpatient TKAs affect CJR target prices?**

**A:** Since CJR is a regulatory model, changes to the model, including how target prices are calculated, generally must be made through notice and comment rulemaking. Target prices are calculated based on historical claims data without regard to the length of stay for the inpatient claim that forms the anchor stay for the episode. Currently there are no mechanisms to make adjustments to the CJR target prices should the removal of TKA procedures from the inpatient only list lead to a decrease in the number of actual CJR episodes with shorter, less expensive anchor stays. The CJR model team is actively analyzing claims data and may engage in rulemaking on this issue during 2018.

**Q: Does the “Two-Midnight” rule apply to TKAs done at CJR participant hospitals?**

**A:** Yes, the “Two-Midnight” rule applies for TKA 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 list, 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.

For more information on criteria that need to be documented in order to support a claim for inpatient stays not expected to span at least two midnights, please see the 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/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html?DLPage=1&DLEntries=10&DLFilter=midnight&DLSort=0&DLSortDir=descending>.

**RECONCILIATION**

**Q: Please clarify the CJR reconciliation timeline.**

**A:** CMS will perform a reconciliation calculation beginning approximately 2 months after the conclusion of a performance year. CJR hospitals will receive reconciliation reports in the second quarter of the year following a given performance year. For example, the

reconciliation calculation for performance year 2016 began in March 2017, and CJR hospitals received reconciliation reports with their results in the second quarter of 2017. CMS will also perform a subsequent, or “final,” reconciliation calculation during the following performance year’s reconciliation, to account for claims runout and overlap with other models and programs. Final reconciliation calculations for each performance year occur 14 months after the close of the performance year.

**Q: Are CJR participant hospitals allowed to delay reconciliation as in BPCI?**

**A:** No. The CJR regulations do not allow for CJR participant hospitals to delay reconciliation.

**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 plan to conduct quarterly reconciliation for CJR hospitals or provide interim reconciliation reports. An annual reconciliation process is necessary for CJR in order to implement the composite quality score methodology, as well as to account for overlap with other models and programs, including accountable care organizations (ACOs).

**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 total hip arthroplasty/total knee arthroplasty (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.

**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 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 performance year 2 (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 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.

**OVERLAP WITH THE BPCI INITIATIVE**

**Q: CMS has applied “precedence” to BPCI Model 2 and Model 3 physician group practice (PGP) and post-acute care (PAC) provider LEJR episodes. What does this mean?**

A: If at any time during a CJR LEJR episode, that beneficiary would also be in a BPCI Model 2 or Model 3 LEJR episode, the beneficiary's CJR episode would either not be initiated or would be canceled. The episode would not be included in the participant hospital's CJR reconciliation. Several examples are provided on page 73389 of the CJR final rule.

**Q: Do “precedence” rules apply to BPCI or CJR if the BPCI 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, each model would calculate episode spending and perform financial reconciliation as normal.

**Q: If a beneficiary is admitted to a CJR hospital for an LEJR procedure and discharged to a PAC provider participating in BPCI Model 3 for the LEJR episode, what happens?**

A: The CJR episode is canceled and the episode is attributed to the BPCI Model 3 PAC provider.

**Q: Our hospital is in a CJR MSA but there is a physician group practice in the area that participates in BPCI Model 2 for the LEJR episode and initiates episodes at our facility. Will those episodes be BPCI or CJR episodes?**

**A:** Because BPCI LEJR episodes have precedence over CJR episodes, in circumstances in which a physician (that is a member of a PGP participating in BPCI Model 2 for the LEJR episode) is the operating or attending physician on the inpatient claim, such episodes would be attributed to the BPCI participant, not the CJR participant. All otherwise eligible LEJR episodes initiated at the CJR hospital would be included in CJR. Please note that in such circumstances, CMS will determine at the time of reconciliation whether a given episode is attributed to CJR or BPCI.

**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:** BPCI Advanced participants that are also participating in any Innovation Center model implemented via regulation (e.g., CJR) will not be permitted to participate in BPCI Advanced for the episodes included in those models. If a hospital is participating in CJR for performance years 3-5 (and located in either a mandatory or voluntary MSA), that hospital may not drop out of CJR in order to participate in BPCI Advanced for the LEJR episode. In addition, if a physician group practice participating in the BPCI Advanced LEJR episode initiates an episode at a CJR participant hospital, that episode will be attributed to the CJR participant hospital.

## **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:** For episodes beginning prior to July 1, 2017, beneficiaries who are aligned or assigned to an ACO and who undergo a LEJR procedure at a CJR participant hospital will be included in both the CJR model and ACO model or program. Pages 73391 through 73398 of the November 2015 CJR final rule discuss in detail the policies that will affect reconciliation. In general, we have instituted policies to avoid double counting savings or losses for beneficiaries included in multiple CMS initiatives. The CJR annual reconciliation will occur prior to the ACO reconciliations, and any reconciliation or repayment amount from CJR will be made available for other models and programs to take into account when performing reconciliation. In addition, if a portion of the CJR discount is paid out as shared savings to an ACO, in certain situations CMS will incorporate this into the subsequent, or “final,” CJR reconciliation calculation. In cases where the CJR hospital is not an ACO participant in the Shared Savings Program or an ACO model, we would not make such an adjustment.

For episodes beginning on or after July 1, 2017, however, we will no longer initiate CJR episodes for beneficiaries who are prospectively aligned with 1) a Next Generation ACO, 2) an ESRD Seamless Care Organization (ESCO), or 3) a Medicare Shared Savings Program ACO participating in Track 3. CMS will implement an online system to allow CJR participant hospitals to identify beneficiaries who are aligned with such ACOs and would be excluded from the CJR model.

**Q: Can an ACO be a CJR collaborator?**

**A:** Beginning January 1, 2018 an ACO can be a CJR collaborator if it participates in Tracks 1 or 2 of the Shared Savings Program, or the Medicare ACO Track 1+ Model.

**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, as of January 1, 2018 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.

**Q: What is the incentive for a provider or supplier to participate in both CJR and the Medicare Shared Savings Program?**

**A:** Both of these CMS initiatives promote increased quality of care for beneficiaries at lower cost to Medicare, while financially rewarding participants who achieve these aims. While the full financial incentive is not available in its entirety to those entities participating in both (in order to protect Medicare from paying twice for the same service), these entities may still derive financial and quality benefits from both CJR and the ACO program.

## **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 and 470 alone.

The Complications measure includes only elective THA/TKA patients and, therefore, excludes fractures. Please refer to page 73474 of the 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 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 and 470 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.hcahponline.org>) or contact the HCAHPS Project Team at [hcahps@HCQIS.org](mailto: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.hcahponline.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.

**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 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**

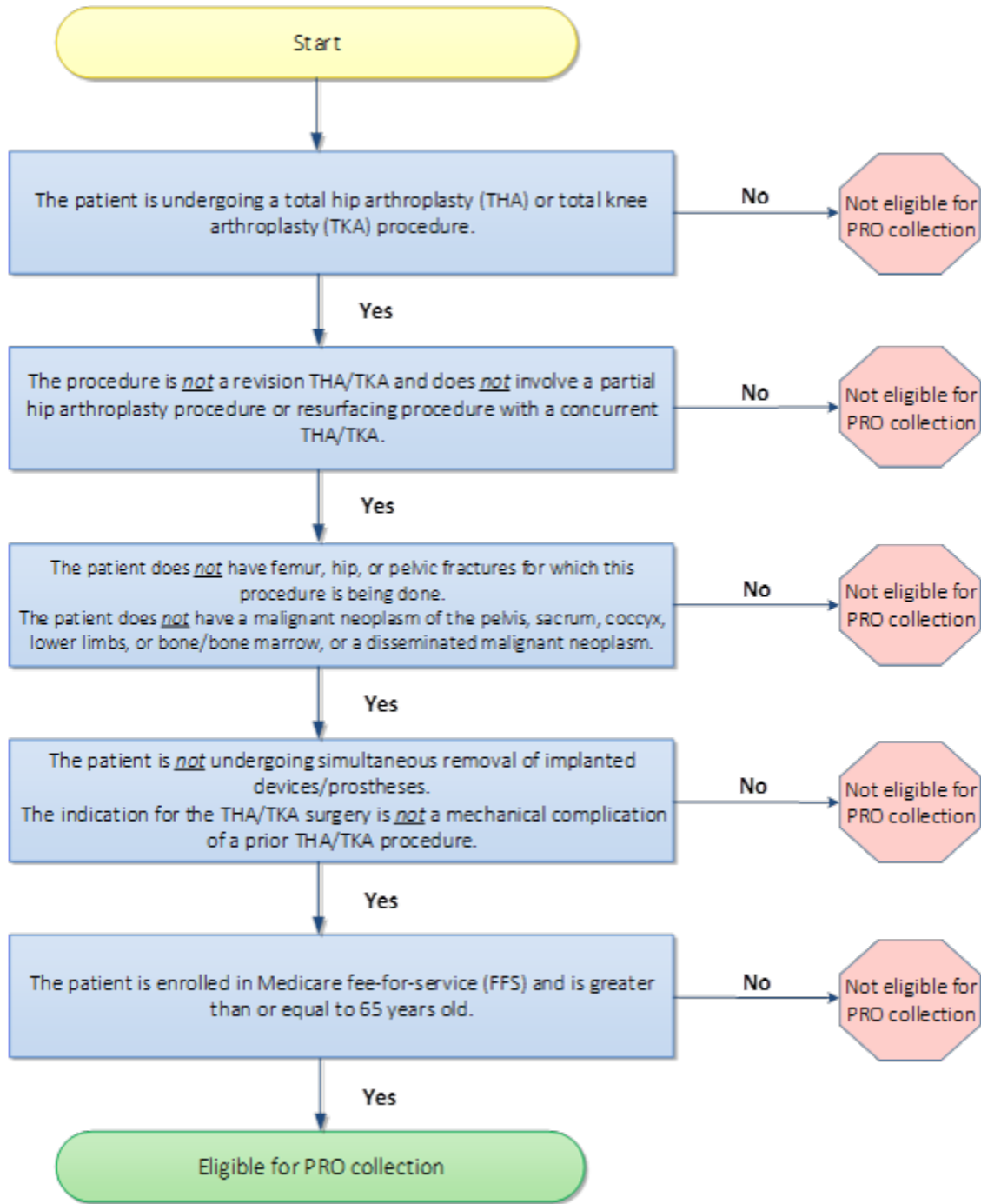
Data Collection Requirements										
Pre-Operative Data Collection					Post-Operative Data Collection					
VR-12		OR	PROMIS-Global			VR-12		OR	PROMIS-Global	
<u>AND</u>					<u>AND</u>					
HOOS/KOOS Jr.		OR	HOOS/KOOS subscales			HOOS/KOOS Jr.		OR	HOOS/KOOS subscales	
HOOS Jr	KOOS Jr.		HOOS subscales	KOOS subscales	HOOS Jr	KOOS Jr.		HOOS subscales	KOOS subscales	
<ul style="list-style-type: none"> <li>• Pain (2Qs)</li> <li>• Function, daily living (4Qs)</li> </ul>	<ul style="list-style-type: none"> <li>• Stiffness (1Q)</li> <li>• Pain (4Qs)</li> <li>• Function, daily living (2Qs)</li> </ul>		<ul style="list-style-type: none"> <li>• Pain (10Qs)</li> <li>• Function, daily living (17Qs)</li> </ul>	<ul style="list-style-type: none"> <li>• Stiffness (2Qs)</li> <li>• Pain (9Qs)</li> <li>• Function, daily living (17Qs)</li> </ul>	<ul style="list-style-type: none"> <li>• Pain (2Qs)</li> <li>• Function, daily living (4Qs)</li> </ul>	<ul style="list-style-type: none"> <li>• Stiffness (1Q)</li> <li>• Pain (4Qs)</li> <li>• Function, daily living (2Qs)</li> </ul>		<ul style="list-style-type: none"> <li>• Pain (10Qs)</li> <li>• Function, daily living (17Qs)</li> </ul>	<ul style="list-style-type: none"> <li>• Stiffness (2Qs)</li> <li>• Pain (9Qs)</li> <li>• Function, daily living (17Qs)</li> </ul>	
<u>AND</u>					<u>AND</u>					
Medicare Provider Number	Mode of Collection		Body mass index (BMI) or height in cm and weight in kg		Medicare Provider Number			Mode of Collection		
Medicare Health Insurance Claim (HIC) number	Person completing survey		Pre-operative Use of Narcotics		Medicare Health Insurance Claim (HIC) number			Person completing survey		
Date of Birth	Patient-reported Pain in Non-operative Lower Extremity Joint(s)		Patient-reported Health Literacy Screening (SILS2) questionnaire		Date of Birth					
Date of Collection	Patient-reported Back Pain (Oswestry Index question)		Race and Ethnicity		Date of Collection					

**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**

<b>Code</b>	<b>Description</b>
OSR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
OSR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
OSR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
OSRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
OSRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
OSRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
OSRC07Z	Replacement of Right Knee Joint with Autologous Tissue Substitute, Open Approach
OSRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
OSRC0KZ	Replacement of Right Knee Joint with Nonautologous Tissue Substitute, Open Approach
OSRD07Z	Replacement of Left Knee Joint with Autologous Tissue Substitute, Open Approach
OSRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach
OSRD0KZ	Replacement of Left Knee Joint with Nonautologous Tissue Substitute, Open Approach
OSRT07Z	Replacement of Right Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
OSRT0JZ	Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
OSRT0KZ	Replacement of Right Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
OSRU07Z	Replacement of Left Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
OSRU0JZ	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
OSRU0KZ	Replacement of Left Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
OSRV07Z	Replacement of Right Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
OSRV0JZ	Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
OSRV0KZ	Replacement of Right Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach
OSRW07Z	Replacement of Left Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
OSRW0JZ	Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
OSRW0KZ	Replacement of Left Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach

(Note: not all patients with the codes in Table 2 will qualify)

**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 year<sup>1</sup> in order to fulfill the successful data collection criterion set forth in the CJR final rule. For example, in Performance Year 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 Performance Year 1.

**Table 4. Successful Criterion by CJR Performance Year**

Performance Year	Minimum Case Requirement for Successful PRO Collection
Performance Year 1	≥ 50% of eligible procedures or ≥ 50 cases
Performance Year 2	≥ 60% of eligible procedures or ≥ 75 cases
Performance Year 3	≥ 70% of eligible procedures or ≥ 100 cases
Performance Year 4	≥ 80% of eligible procedures or ≥ 200 cases
Performance Year 5	≥ 80% of eligible procedures or ≥ 200 cases

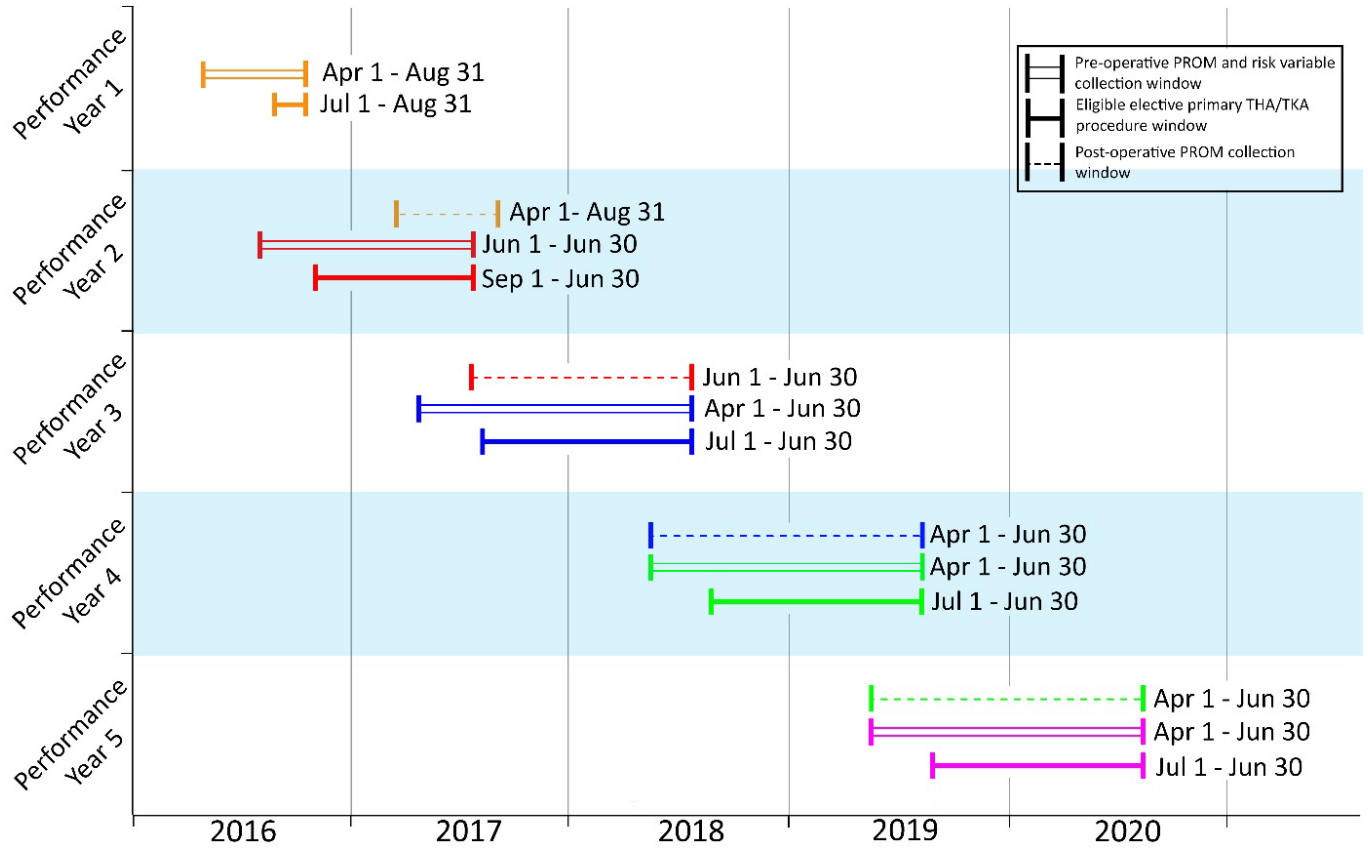
**Q: When should my hospital collect the PRO data?**

**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 365 days (9-12 months) after the patient’s procedure. The time for each performance year is presented in Figure 4 below.

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<sup>1</sup> Post-operative data must match to the patients that on which the hospital submitted data pre-operatively to fulfill the successful data collection criterion. Table 3 shows the minimum requirement for pre-operative data collected in the given performance year.

**Figure 4. Timeline for PRO Data Collection by Performance Year**



This figure provides dates for the pre- and post-operative collection time periods for each Performance Year (double barred and dashed lines, respectively). It also includes the defining dates for the period of eligible elective primary THA/TKA procedures in each Performance Year (solid lines).

**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
Deadline	October 31, 2016	October 31, 2017	August 31, 2018	August 31, 2019	August 31, 2020
Data to be Submitted	Pre-Operative Data on Performance Year 1 Patients	Post-Operative Data on Performance Year 1 Patients <i>AND</i> Pre-Operative Data on Performance Year 2 Patients	Post-Operative Data on Performance Year 2 Patients <i>AND</i> Pre-Operative Data on Performance Year 3 Patients	Post-Operative Data on Performance Year 3 Patients <i>AND</i> Pre-Operative Data on Performance Year 4 Patients	Post-Operative Data on Performance Year 4 Patients <i>AND</i> Pre-Operative Data on Performance Year 5 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 point of contact (POC) send an email to [CJR@cms.hhs.gov](mailto: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**

PY	Below Acceptable CQS <5		Acceptable CQS >=5 and <6.9		Good CQS >=6.9 and <=15		Excellent CQS >15	
	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

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.

Participant hospitals are not responsible for any repayment in performance year 1 of the CJR model.

**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.

**Q: What performance period will CMS use to determine improvement points for performance year 1?**

**A:** Quality improvement points for each measure are added to the composite quality score if the hospital's score on that quality measure increases by at least 2 deciles on the performance percentile scale compared to the corresponding time period in the previous year, for performance year 1. For performance years 2 through 5, we will compare the hospital's performance percentile with the previous performance year.

**Q: Which quality category cut-off values will be used for performance year 1 subsequent reconciliation?**

**A:** As finalized in the final rule published on December 1, 2017, CMS will apply the following quality category cut-off values to performance year 1 subsequent, or "final," reconciliation calculations and all reconciliations going forward: Below Acceptable (<5), Acceptable (≥5.0 and <6.9), Good (≥6.9 and ≤15.0), and Excellent (>15).

### **Q: Why did CMS change the quality category cut-off values that will be used for performance year 1 subsequent reconciliation?**

**A:** The quality category cut-offs finalized in the original CJR model final rule published on November 24, 2015, were as follows: Below Acceptable (<4.0), Acceptable (≥4.0 and <6.0), Good (≥6.0 and ≤13.2), and Excellent (>13.2). These quality category cut-offs were applied to the composite quality scores for initial PY1 reconciliation.

In the EPM final rule published on January 3, 2017, CMS changed the quality category cut-offs to the following: Below Acceptable (<5), Acceptable (≥5.0 and <6.9), Good (≥6.9 and ≤15.0), and Excellent (>15). This change was intended to be effective before the CJR model's performance year 1 initial reconciliation. However, the effective date for these provisions were delayed until May 20, 2017. As a result, the CJR reconciliation reports issued in April 2017 were created in accordance with the provisions that were finalized in the CJR model final rule, i.e., when Excellent was considered >13.2.

In the final rule published on December 1, 2017, CMS finalized applying the quality categories as established in the EPM final rule (i.e., Below Acceptable (<5), Acceptable (≥5.0 and <6.9), Good (≥6.9 and ≤15.0), and Excellent (>15)) to performance year 1 subsequent, or "final," reconciliation calculations. These quality category cut-offs will be applied to all initial and final reconciliations going forward.

## **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](mailto: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:

- Target prices
- 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](mailto: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](mailto: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](mailto: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 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.

## 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 arrangements 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/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html#Comprehensive Care for Joint Replacement \(CJR\) Model](https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html#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:** Yes. A gainsharing payment means a payment from a participant hospital to a CJR collaborator, under a sharing arrangement, composed of only reconciliation payments or internal cost savings or both. The total amount of a gainsharing payment for a calendar year paid to an individual physician or non-physician practitioner who is a CJR collaborator must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule (PFS) for services furnished to the participant hospital's CJR beneficiaries during a CJR episode by that physician or non-physician practitioner. This cap also applies to gainsharing payments made to physician group practices and nonphysician provider group practices.

**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:** Yes. Except for a distribution payment from a PGP to a PGP member that complies with 42 CFR 411.352(g), the total amount of distribution payments for a performance year paid to a collaboration agent must not exceed the following:

In the case of a collaboration agent that is a physician or nonphysician practitioner, 50 percent of the total Medicare-approved amounts under the Physician Fee Schedule (PFS) for items and services furnished by the collaboration agent to the participant hospital's CJR beneficiaries during CJR episodes that occurred during the same performance year for which the

participant hospital accrued the internal cost savings or earned the reconciliation payment that comprises the gainsharing payment being distributed.

In the case of a collaboration agent that is a PGP or NPPGP, 50 percent of the total Medicare-approved amounts under the PFS for items and services billed by that PGP or NPPGP for items and services furnished by PGP members or NPPGP member respectively to the participant hospital's CJR beneficiaries during CJR episodes that occurred during the same performance year for which the participant hospital accrued the internal cost savings or earned the reconciliation payment that comprises the gainsharing payment being distributed.

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

**A:** Yes. Except for a downstream distribution payment from a PGP to a PGP member that complies with 42 CFR 411.352(g), the total amount of downstream distribution payments for a performance year paid to a downstream collaboration agent who is a physician or nonphysician practitioner and is either a member of a PGP or a member of an NPPGP must not exceed 50 percent of the total Medicare-approved amounts under the PFS for items and services furnished by the downstream collaboration agent to the participant hospital's CJR beneficiaries during a CJR episode that occurred during the same performance year for which the participant hospital accrued the internal cost savings or earned the reconciliation payment that comprises the distribution payment being distributed.

**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 could be based solely on internal cost savings. In a calendar year, the aggregate amount of all gainsharing payments distributed by a participant hospital that are derived from a CJR reconciliation payment may not exceed the amount of the reconciliation payment the participant hospital receives from CMS.

**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.

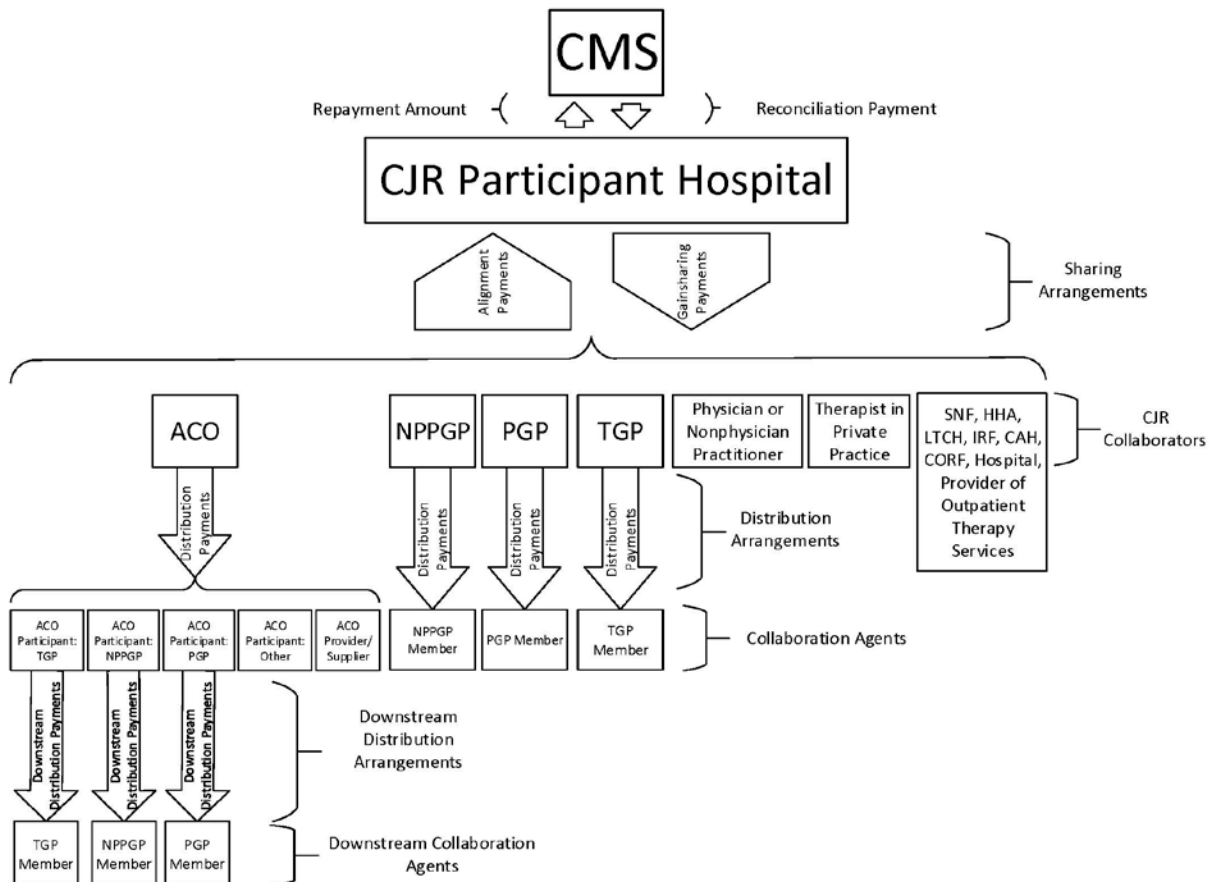
The aggregate amount of all alignment payments from a CJR collaborator that is an ACO to the participant hospital may not be greater than 50 percent of the participant hospital's repayment amount.

**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 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.

### **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 MPFS using the nine HCPCS G-codes listed in Table 27 on page 73450 of the CJR 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 Medicare Physician Fee Schedule (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 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 waiver?**

**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 BPCI Model 3 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 Model 3.

**Q: Can a CJR hospital that dropped out of BPCI continue using the SNF 3-day waiver (as they were using it in BPCI)?**

**A:** The SNF waiver for CJR does not begin until Year 2 of the model. A hospital that is in CJR, regardless of whether or not it used to be in BPCI Model 2, would not be able to begin using the CJR SNF waiver until it is available for CJR episodes initiated on or after January 1, 2017.

**Q: How will the removal of TKA from the inpatient-only list affect use of the CJR model SNF waiver?**

**A:** Use of the CJR model SNF waiver would be allowed for cases in which an inpatient level of care is appropriate, but the inpatient stay does not span at least two midnights. Generally, CMS expects that a patient needing a skilled level of post-acute care that warranted a SNF admission would not be an appropriate candidate for an outpatient TKA. The SNF waiver would continue to work just as it has for any CJR episodes where an inpatient admission is discharged to an approved SNF prior to a 3- day inpatient stay.

## **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. 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:** Hospitals in the CJR model must notify beneficiaries of the requirements surrounding the model upon admission to the CJR participant hospital if the admission that initiates the CJR episode is unscheduled. If the admission is scheduled, then the CJR participant hospital must provide notice when the decision to schedule admission is made. In circumstances where, due to the patient's condition, it is not feasible to provide notification at such times, the notification must be provided to the beneficiary or his or her representative as soon as is reasonably practicable but no later than discharge from the CJR participant hospital accountable for the CJR episode. In the case of all CJR collaborators, the notice must be provided no later than the time at which the beneficiary first receives items or services from all CJR collaborators, collaboration agents, or downstream collaboration agents, and the ACO, PGP, NPPGP, or TGO during a CJR episode, except in circumstances where it is not feasible to provide notification at such time, in which case the notice must be provided as soon as is reasonably practical.

**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 webpage, beneficiary notices for use by the participant hospitals, as well as physicians, physician group practices, and post-acute care providers collaborating with participant hospitals. The CJR regulations, as amended by the ACC final rule, contain revised requirements for when hospitals and their CJR collaborators must furnish written notification to beneficiaries.

**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:** In circumstances where, due to the patient's condition, it is not feasible to provide notification upon admission or scheduling of surgery, the notification must be provided to the beneficiary or his or her representative as soon as is reasonably practicable but 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 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 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: Will the removal of TKA from the inpatient-only list affect use of the CJR model beneficiary notifications?**

**A:** No. It is still the responsibility of the participant hospital to provide beneficiaries with written notice of the model as required in § 510.405. If it is not obvious upon arrival whether the beneficiary will be an outpatient or inpatient TKA, beneficiary notification materials should be provided.

## **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 final rule describe the discharge planning requirements included in the CJR model. 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, no later than the time that the beneficiary discusses a particular PAC option or at the time the beneficiary is discharged, 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, no later than the time that the beneficiary discusses a particular PAC option or at the time the beneficiary is discharged, whichever occurs earlier.

**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: Has CMS provided regional episode spending data associated with the historical data used for performance year 3 target prices? If yes, where is this data available?**

**A:** The Performance Year 3/4 baseline statistics for hospitals and region are available for download on the CJR portal under "Historical Aggregate Claims Data." In October, they replaced the analogous Performance Year 1/2 data files, which are now available under "EPM File 2."

**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 an inpatient hospitalization for lower extremity joint replacement as designated by MS-DRG 469 or 470 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 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/gplookup> .

##### **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.