Proposed Changes to the Comprehensive Care for Joint Replacement (CJR) Model Webinar

Final Transcript
Prepared by: Hendall, Inc.
Date: Wednesday, September 7, 2016

Speakers: Sarah Mioduski, Maria Agresta Workman, Claire Schreiber, and Audrey Mitchell
INTRODUCTION

**Moderator:** Good afternoon. Thank you for joining us today for the CMS Innovation Center’s webinar, “Proposed Changes to the Comprehensive Care for Joint Replacement (CJR) Model,” hosted by the CJR program team. If you have questions during today’s webinar, please submit them to the Q&A feature, and we will address them following the presentation. To submit a question, click on the “Q&A” button located at the top of your screen, enter your question in the text box, and click “Send.” Participant phone lines will remain muted during the webinar. Please note that the default audio connection is through your computer. If you are unable to connect through your computer, please use the toll number provided in the confirmation email you received upon registering. After the conclusion of the presentation, you will be asked to participate in a short survey regarding today’s webinar. We would appreciate you taking a moment to complete the survey. Thank you again for joining us. I will now turn it over to Sarah Mioduski from the Innovation Center.

PRESENTATION

**Sarah Mioduski:** Thank you, Kathleen. Good afternoon everyone, my name is Sarah Mioduski. I am a member of the Comprehensive Care for Joint Replacement model team. Welcome to today’s webinar, which will provide an overview of the proposed changes to the CJR model that were put forth on August 2, 2016, in the CMS proposed rule entitled, “Advancing Care Coordination through Episode Payment Models (EPMs), Cardiac Rehabilitation Incentive Payment Model, and Changes to the Comprehensive Care for Joint Replacement Model.”

First, I would like to start with a few brief announcements. The slides from today’s presentation will be available on the CMS website in the next few days. In addition, we will take questions at the end of the presentation, so as we go through the slides, please feel free to use the Q&A function to submit a question as Kathleen said. We really appreciate your feedback and use it to improve and enhance our webinar presentations, so we ask that you please take a few minutes to respond to the survey at the end of this webinar.

We are providing links and proposed rule in this presentation and encourage listeners to reference the proposed rule for a more in-depth discussion of the policy we will be reviewing today. We also note that the CJR model website contains a breadth of information about the model, including an updated frequently asked questions (FAQs) document. A link to the CJR model website can be found on the last page of the slide deck.

Given that our presentation today will be discussing proposed Medicare policy changes, we urge the public and our CJR model participants to read the proposed rule and to comment on the proposed changes discussed here in accordance with the current process spelled out in the rule and summarized at the end of this presentation. As referenced on this slide, the information provided today is only intended to be a general summary, not to take place of the written law or regulation.

Our agenda begins today with a summary of the more significant proposed changes to the CJR model. Then I will provide greater detail about specific proposals around financial arrangements, beneficiary incentives, and pricing/reconciliation. My colleague, Lieutenant Maria Agresta
Workman, will discuss the proposed changes surrounding accountable care organizations, beneficiary exclusions, composite quality score methodology, beneficiary notification, the 3-day skilled nursing facility (SNF) waiver, and Advanced Alternative Payment Model (APM) status.

At the end of this presentation—with time permitting—the CJR model team will answer questions submitted through the Q&A function. The goal today is to discuss specific changes to the CJR model policies outlined in the proposed rule, and as I said, it was recently published in the Federal Register. The proposed rule is available on the Federal Register website, which can be accessed through the link in this presentation. The rule proposes three new episode payment models and a cardiac rehabilitation model, in addition to the changes to the CJR model we will be reviewing today. We would also like to note that there is a 60-day public comment period for this proposed rule and that this comment period closes on October 3, 2016. Unless otherwise indicated, any proposed policies finalized would be effective 60 days after the final rule is published.

Eligibility for participation in the CJR model has not changed. The acute care hospitals that are paid via the Inpatient Prospective Payment System (IPPS) and are located in the 67 metropolitan statistical areas selected for the CJR model will continue to be participants in this model. While the majority of the CJR model policies and/or requirements remain the same, CMS is proposing to clarify, modify, and update certain provisions of the CJR model around target pricing, composite quality, and beneficiary incentives and exclusions, which we will discuss in greater detail in the following slides.

In regards to financial arrangements under the current CJR policy, a participant hospital may elect to enter into a sharing arrangement, meaning a financial arrangement between a CJR collaborator and a participant hospital for the sole purpose of making gainsharing payments or alignment payments under the model. Currently, the definition of a CJR collaborator includes the following types of Medicare enrolled persons or entities entering into a sharing arrangement: skilled nursing facilities, home health agencies, long-term care hospitals, inpatient rehabilitation facilities, physicians, non-physician practitioners, providers or suppliers of outpa
tient therapy services, and physician group practices.

Current CJR policy requires that a collaborator agreement must contain a description of the sharing arrangement between the participant hospital and the CJR collaborator. This description must specify the parties in the sharing arrangement, the date of the sharing arrangement, the purpose and scope of the sharing arrangement, and the plans regarding care redesign, as well as other requirements outlined in the regulation.

Now, as for the proposed changes to the financial arrangement section, they are either largely organizational in nature or are not changes to current policy or requirements. However, in several cases, they are proposing new financial arrangement policies and/or requirements for the CJR model. Specifically, in addition to the collaborators discussed on the previous slide, we are proposing to allow accountable care organizations, hospitals, and critical access hospitals (CAHs) to be CJR collaborators. We have developed a proposed financial arrangement chart, which is referenced as Figure 3 in the proposed rule, and we recommend that listeners view this figure in the proposed rule. This figure illustrates proposed CJR collaborators and how they can be integrated into the CJR model.
The rule also proposes to revise some of the terminology used to describe several financial arrangements and payment terms. Specifically, in order to reduce duplicate language in the current CJR model financial arrangement section and to streamline the regulation for financial arrangements between CJR participant hospitals and CJR collaborators, we are proposing to delete the term “collaborator arrangement” and to transition the requirements of the collaborator agreements to requirements of sharing arrangements. Overall, this proposal would allow CMS to align the financial agreements with those of the proposed EPMs and would authorize consistent regulations for potential parties that may participate in both the CJR model and EPMs. We recognize that current participant hospitals and CJR collaborators already have existing collaborator agreements and although we are proposing these new changes, we note that proposed sharing arrangement policies are largely similar to the current policies regarding collaborator agreements.

Additionally, we are proposing to use the term “CJR activities” to identify certain obligations of parties in a sharing arrangement that are currently described as “changes in care coordination or delivery” in current CJR regulations. In addition to the quality of care provided during episodes, we believe the activities that would fall under the proposed definition of “CJR activities” would encompass the total activities upon which it would be appropriate for certain financial arrangements under the CJR model to be based in order to value the contributions of providers, suppliers, and other entities toward meeting the CJR model’s goals of improving the quality and efficiency of episodes.

Lastly, regarding the changes to financial arrangements, we are proposing to consolidate the requirements under the CJR model for access to records and record retention and to apply them more broadly in the model. We believe this proposed change would better clarify the access to records and record retention requirements under the CJR model.

In regards to beneficiary incentives, most proposed changes to this section are organizational in nature. However, similar to the proposed financial arrangement section, we note that we are proposing to consolidate the requirements for access to records and record retention in the beneficiary incentive section and to apply these requirements more broadly in the model.

Given the length between quality and the price used to determine reconciliation results, we are proposing to replace the term “target price” with “quality-adjusted target price.” Consistent with our current CJR policy, hospitals with higher quality composite scores may have a lower discount factor at reconciliation, whereas hospitals with lower quality composite scores would have a 3% discount factor. The quality-adjusted target price used at reconciliation would reflect the discount factor adjusted for a hospital’s composite quality score.

The quality-adjusted target price would also be used at reconciliation to determine if a CJR participant hospital is eligible for reconciliation payment or payment amount and the amount of the reconciliation payment or payment amount. As proposed, CMS would continue to provide participant hospitals with a price that reflects a 3% discount factor prior to each performance year. In addition, in each year of the model, a CJR participant hospital would receive eight prospective quality-adjusted target prices reflecting the MS-DRG and fracture status. The proposed target prices would also reflect the payment system updates that occur at two different intervals throughout a performance year. One set of four prices would apply to episodes.
beginning January through September, and another set of four prices would apply for episodes beginning October through December.

We are proposing two changes that could affect the CJR reconciliation process. First, we are proposing to modify our policy to hold hospitals responsible for post-episode payments. We are proposing to continue the current policy that hospitals would be responsible for post-episode payments that exceed three standard deviations from the regional mean. However, we are proposing to calculate whether a hospital has exceeded this threshold and is responsible for post-episode payments using the same timeframes we used for the subsequent reconciliation calculation for performance year. That is, we would calculate the post-episode threshold and assess whether a hospital is responsible for post-episode payments beginning 14 months after the conclusion of each performance year. For example, for Performance Year 1, we would conduct the initial reconciliation in early 2017 and calculate whether hospitals are responsible for post-episode payments when we conduct the subsequent reconciliation calculation in early 2018.

Second, we are proposing that the post-episode spending and ACO overlap calculation would not be subject to stop-loss and stop-gain limits. Therefore, only actual episode spending would be subject to stop-loss and stop-gain. I am now going to turn the presentation over to my colleague, Lieutenant Maria Agresta Workman, who will take you through the remaining slides.

Maria Agresta Workman: Thanks, Sarah. Let’s turn our attention to ACO beneficiary exclusions. In terms of beneficiary exclusions, we are proposing to exclude some beneficiaries aligned to CMS ACO models beginning in July 1, 2017. Specifically, we are proposing to exclude from CJR beneficiaries who are aligned to a Next Generation ACO or an end-stage renal disease (ESRD) Seamless Care Organization. In other words, a beneficiary that is aligned to one of these ACOs would not initiate an episode if they received a lower extremity joint replacement at a CJR participant hospital. The ACO would retain all financial accountability for care of this beneficiary. Now let’s move on to quality.

This slide summarizes the current use of quality measures and the composite quality score as finalized in the CJR final rule. Currently, CMS calculates quality performance points based on a participant hospital’s performance percentile relative to the national distribution of results for that measure. We currently define “quality improvement” as an increase of at least three deciles on the performance percentile scale. We currently calculate improvement by comparing a hospital’s performance percentile to the previous performance year.

CMS currently determines the four quality categories using the composite quality score cutoff values indicated in the table on this slide. This slide summarizes the changes we are proposing to quality measures and the composite quality score. CMS proposes to calculate quality performance points based on a participant hospital’s performance percentile relative to the performance distribution of all “subsection (d)” hospitals that are eligible for payment under IPPS and meet the minimum patient case or survey count for that measure. We have proposed to define “quality of improvement” as an increase of at least two deciles on the performance percentile scale compared to the previous performance year. For Performance Year 1 only, we are proposing to compare the performance percentile with the corresponding time period of the previous year. For Performance Years 2–5, we propose to continue to compare the performance percentile to the previous performance year. Finally, we are proposing to modify the composite
quality score cutoff values for the four quality categories as indicated in the third column of the
table on this slide. Now let’s move on to the beneficiary notification.

Currently, we require CJR participant hospitals, collaborators, physicians, and post-acute care
providers to notify beneficiaries about the CJR model. We are proposing the addition of several
collaborator types, ACOs, and hospitals to ensure that they also notify beneficiaries of the model
and their CJR financial relationship. We are proposing to add physician group practice
collaborators, collaborating hospitals, and ACOs to the list of collaborators that must notify
beneficiaries of inclusion in the CJR model. Specifically, we are proposing that all CJR
collaborators provide beneficiaries with notification documents about the CJR model.

In addition, we are also proposing that all providers and suppliers providing notification
materials to the CJR beneficiaries must be able to provide evidence of compliance with the
beneficiary notification requirements to CMS upon request. Relative to the policy on the required
timing of beneficiary notification, we are proposing that participant hospitals must notify
beneficiaries of the CJR model upon admission to the participant hospital or immediately
following the decision to schedule the LEJR procedure, whichever occurs later. In addition, in
circumstances where patients may have a unique condition or circumstances such as an emergent
hip fracture that results in immediate surgery, we are proposing that the notification may be
given to the beneficiary or their representative as soon as reasonably possible. The notification
template designed by CMS is available on the CJR model website and has not changed. Now
let’s move on to the SNF waiver.

In addition to other proposals in CJR, we also wanted to highlight our proposed changes around
the SNF 3-day stay waiver. Under the current policy, the 3-day stay waiver, which will begin on
January 1, 2017, waives the skilled nursing facility 3-day rule. This rule normally requires that a
beneficiary must have an inpatient admission that is not less than 3 days in order to qualify for
Medicare-covered skilled nursing facility services.

A 3-day stay waiver will waive that rule if the beneficiary is:

- In the CJR episode at a participant hospital at the time the waiver is utilized;
- Discharged to a skilled nursing facility after an inpatient stay of less than 3 days as
  medically necessary; and
- Transferred to a skilled nursing facility rated three stars or higher for at least 7 of the
  previous 12 months on the Nursing Home Compare website.

A list of the SNFs that meet the quality requirements will be listed on the CMS website prior to
each calendar quarter. Please note that none of these requirements have been changed or
proposed to be changed by the recent proposed rule. Let’s move on to the proposal surrounding
the SNF 3-day stay waiver.

In response to concerns from stakeholders that CJR hospitals may inadvertently misuse the SNF
waiver if a beneficiary is not eligible for the CJR model at the time the waiver is used, we
propose the following: Beginning in January 2017 when the SNF 3-day stay waiver is available
for CJR participant hospitals, we 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. 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, we require—consistent with our current CJR regulations—that the hospital must provide a discharge planning notice to the beneficiary detailing any potential financial liability for the SNF stay.

However, we are proposing that, in cases where the beneficiary does not have a qualifying 3-day hospital stay is discharged to a SNF that does not meet the above quality requirements, that the hospital does not provide the required discharge planning notice. The hospital would be financially liable for the SNF stay. This proposal is intended to protect beneficiaries from financial liability. Finally, we would like to remind everyone again that the CJR SNF waiver will be available for episodes that begin on or after January 1, 2017. The waiver is not available prior to January 1, 2017. A list of eligible SNFs will be updated quarterly and posted on the CJR public website beginning this fall. Let’s move on to Advanced APM.

Similar to the proposals we are making for other EPMs discussed in the proposed rule, we are proposing features that can permit CJR participant hospitals to be in an Advanced APM that would allow eligible clinicians to be considered for a qualifying APM participant (QP) determination. Based on the criteria proposed in the Quality Payment Program proposed rule, what this means is that we are proposing some changes to the CJR model that would allow for eligible clinicians to potentially be considered QPs, assuming that they meet all other quality payment program requirements.

Currently, CJR meets the proposed criteria in the Quality Proposed Payment rule for quality measures, as well as the nominal risk criteria for Performance Year 2 for most CJR participants. However, in order to ensure CJR would meet the certified electronic health record technology (CEHRT) requirement to be considered an Advanced APM, we are also proposing the following to implement two different tracks within CJR. CJR participant hospitals that meet proposed requirements for use of CEHRT and financial risk would be in Track 1, an Advanced APM track; CJR hospitals that do not meet these requirements would be in Track 2, a Non-Advanced APM track. Participant hospitals that wish to be in Track 1 would need to meet and attest to the CEHRT use requirement in the proposed Quality Payment Program rule. The different tracks would not change how the CJR participant hospital operates within CJR itself—the only requirements are associated with selecting to meet CEHRT use requirements. The only distinction between the two tracks is that only Track 1 CJR could be considered an Advanced APM for purposes of the Quality Payment Program based on the proposed criteria in the Quality Payment Program proposed rule.

This slide contains more information and the link for commenting on the EPM CJR proposed rule. We encourage you to read and comment on the proposed rule and note that the comments on the proposed rule must be submitted in accordance with the process set forth in the proposed rule. This slide also contains some general information and where to go to get more information on the CJR model. Again, we thank you for joining us to hear the proposed changes for the CJR rule. At this time, we encourage you to submit some questions over the Q&A function, and now we will take a short break and we will address those questions.
Q&A SECTION

Claire Schreiber: Hello, this is Claire Schreiber with the CMS CJR model team. We are going to take some questions from the audience now, so please continue to submit your questions via the Q&A function. I am first going to turn it over to my colleague, Audrey Mitchell, who is going to address some of the questions that we have gotten on the quality measures and the PRO data for the model.

Audrey Mitchell: Hi everyone. First question: “What are the changes that have been proposed to the quality improvement?” For Performance Year 1, CMS would compare the hospital’s performance percentile with the corresponding time period in the previous year, not the previous performance year. We have also proposed to define “quality improvement” as an increase of at least of two decile on the performance percentile scale compared to the previous performance year and that is changed from three decile. Just a reminder for Performance Years 2–5, we are proposing to continue to compare a hospital’s performance to the previous performance year. The proposed change is just for Performance Year 1.

Another question that came in about the changes to the quality category. I believe in the slides there was a table at the bottom that had three columns, and the new cutoff values that are being proposed are in the third column of that table. CMS is proposing to modify those point values that determine each of the four quality categories according to that. Any composite quality score of less than five would be below acceptable. Anything above a composite quality score of 15 would be considered excellent quality. The best thing to do would be to refer to that slide for the full table.

“What are the proposed changes to the distribution of hospitals that are included in the quality performance distribution?” As you know, we use a distribution of hospitals to determine the relative performance for each CJR participant hospital, and that is how performance points are awarded for the composite quality score. CMS is proposing to calculate those performance points based on performance relative to the distribution of all subsection (d) hospitals eligible for IPPS meeting the minimum case or survey count. Again, in the CJR final rule it was the national distribution of results for that measure. We are proposing to specify that to be the performance distribution of all subsection (d) hospitals eligible for IPPS that meet the minimum case count.

Also, a couple of questions about the submission of PRO data being required for the model. Submission of the patient-reported outcomes (PRO) and risk variables data for the CJR model is not required for reconciliation payment eligibility. However, CJR participant hospitals that successfully submit PRO data per the requirements in the rule can increase their financial opportunity under the model. That is because if you successfully submit PRO data, you can receive up to two points towards your composite quality score. Again, it is not required for a reconciliation payment but there is some potential for financial incentive.

There is a question about subsection (d). That is referring to subsection (d) of the Social Security Act and it refers to hospitals that are eligible for IPPS.

A question about patient-reported outcomes data timing. The PRO data is due for submission on October 31, 2016. That is coming up soon, and that is preoperative data that was collected on
Performance Year 1 patients. For more information about the PRO data collection, we have many resources on CJR Connect, including the data collection template, user guides, data dictionaries, timelines, patient selection, flow charts, and many other in-depth materials to help hospitals with the data submission for this year and other years of the model. With that, I will turn it back over to Claire.

**Claire Schreiber:** Thank you, Audrey. We have received a number of questions on the slide we presented about our proposals related to Advanced APMs. We are actually going to return to that slide as some of the participants requested and Maria is going to discuss the content again on this slide. I just want to give a few reminders because we have received many questions about this and some of the questions relate to the MIPS program, the EHR requirements, how to apply to be an Advanced APM. I just want to clarify that CMS has released a proposed rule for the Quality Payment Program so we would point folks to that as well as the final rule that would be coming out for the Quality Payment Program. In addition, because this is currently just a proposal for the CJR model, we would provide more detail in those rules that I have mentioned already as well as any final rule about these policies. With that, Maria Agresta Workman will address some of those questions and will go over the information again that we are proposing about eventually making CJR an Advanced APM.

**Maria Agresta Workman:** Thanks, Claire. I am just going to go back over the information that I provided previously. Similar to the proposals we are making for the other APMs discussed in the proposed rule, we are proposing features that would permit CJR participant hospitals to be in an Advanced APM that would allow eligible clinicians to be considered for a qualifying APM participant (QP) determination based on the criteria proposed in the Quality Payment Program proposed rule. What this means is that we are proposing some changes to the CJR model that would allow for eligible clinicians to potentially be considered QP assuming they meet all other Quality Payment Program requirements. Currently, CJR meets the proposed criteria in the Quality Payment Program proposed rule for quality measures as well as the nominal risk criteria in Performance Year 2 for most CJR participants.

However, in order to ensure CJR would meet the certified electronic health record technology (CEHRT) requirements to be considered an Advanced APM, we are also proposing the following to implement two different tracks in CJR. CJR participant hospitals that meet proposed requirements for use of CEHRT and financial risk would be in Track 1, an Advanced APM track; CJR participant hospitals that do not meet these requirements would be in Track 2, a non-Advanced APM track.

Participant hospitals that wish to be in Track 1 would need to meet and attest to the CEHRT use requirements in the proposed Quality Payment Program rule. A different track will not change how CJR participant hospitals operate within CJR itself. Beyond the requirements associated with selecting to meet certain use requirements, the only distinction between the two tracks is that only Track 1 CJR could be considered an Advanced APM for purposes of the Quality Payment Program, based on the proposed criteria in the Quality Payment Program proposed rule. Now I am going to turn it back over to Claire.

**Claire Schreiber:** Thanks, Maria. We are continuing to get some questions. We have several questions about the proposed exclusion of beneficiaries who are aligned to an ACO, so I am
going to turn this over to Sarah Mioduski. The question is, “If a patient is currently an attributed beneficiary in an ACO and then is admitted to a CJR hospital for joint replacement, would that beneficiary be excluded from the CJR model?” Sarah is going to address that.

Sarah Mioduski: Thanks, Claire. We are proposing to exclude from CJR beneficiaries who are aligned to a Next Generation ACO or ERSD Seamless Care Organization. A beneficiary who is aligned to one of these ACOs would not initiate an episode if they receive a lower extremity joint replacement at a CJR participant hospital. The ACO would retain all financial accountability for care of this beneficiary.

Also, we received some questions in regards to collaborators and beneficiary notification regarding if a hospital is accountable for their collaborators to provide the beneficiary notification. Currently, participant hospitals must require physicians and post-acute care providers and suppliers that they have a collaborator agreement with to provide the beneficiary notification to beneficiaries in a CJR episode. I believe, as Maria went through, there are going to be some additions to that with us proposing to add new collaborators, so those proposals would then take effect there. Currently, the physician and post-acute care supplier that has a collaborative agreement with a participating hospital is required to provide the beneficiary notification, and those current notifications can be accessed on the CJR model website.

Claire Schreiber: Thank you, Sarah. One other thing to add here. We had a follow-up question to the ACO question and we do want to reiterate for everyone that, as Sarah mentioned, the exclusions that we are proposing would only apply to certain ACOs, so Next Generation ACOs and ERSD Seamless Care Organizations in a downside risk-track. We are not currently making any proposals around Pioneer ACOs or ACOs that are in the Medicare Shared Savings Program. We just want to make that very clear that we are talking about a subset of ACOs here.

We have gotten a couple of questions about the proposals in the proposed rule around the SNF 3-day stay waiver and in particular, we have a few requests to return to that slide where we talked about the new proposals. I am going to turn it back over to Maria Agresta Workman, and she is going to talk again about what we are proposing with regards to the SNF 3-day waiver and beneficiary protection.

Maria Agresta Workman: Thanks, Claire. For some of the stakeholders’ concerns that CJR hospitals may have inadvertently misused the SNF waiver if a beneficiary is not eligible for the CJR model at the time the waiver is used, we are proposing the following change. Beginning in January of 2017, when the SNF 3-day stay waiver is available for CJR participant hospitals, we 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. If the CJR participant hospital discharges the beneficiary without the qualifying 3-day stay to a SNF that does not meet the quality requirements for waiver use, we require—consistent with our current CJR regulations—that the hospital provide a discharge planning notice to the beneficiary detailing any potential financial liability for the SNF stay.

However, we are proposing that in cases where the beneficiary does not have a qualifying 3-day hospital stay, the discharge does not meet the above quality requirements, and the hospital does
not provide the required claim notice, the hospital would be financially liable for the SNF stay. This proposal was intended to protect beneficiaries from financial liability.

Finally, we have gotten questions on when participant hospitals can begin using the SNF 3-day waiver and if this will change in the proposed rule. The SNF waiver will be available for applicants beginning on or after January 1, 2017. The waiver is not available prior to January 1, 2017, and it did not change in the proposed rule as well.

We have also gotten a question on where the list for the SNFs that meet the quality requirements is. The list will be updated and posted quarterly on the CMS public website. If you go to the last page, we actually pointed people to the CMS website on the CJR model, and that is where you can find the SNF list.

Claire Schreiber: Thank you, Maria. Maria is going to answer one more question that we have received from a few participants about where hospitals can get the beneficiary notification and whether it is for current requirements or the new beneficiary notification requirements that we are proposing. Maria will address where those are available.

Maria Agresta Workman: The beneficiary notification template are available on the CJR public website as well as the CJR Connect website. They will not change. They are the different tracks with collaborators as well the participant hospitals.

Claire Schreiber: Thank you, Maria. We have a few more questions on the quality data, which Audrey is going to address. Before we turn it over to her, I just want to quickly address a few questions that we got as a follow-up on the ACO beneficiary exclusion questions. We have a couple of questions about how a hospital or an ACO would know if the beneficiary is in both initiatives.

“How would a CJR know if a given beneficiary is aligned to an ACO that may be excluded from the model?” I just want to clarify that we will be providing more information in a final rule should we finalize that proposal. Given that it is currently a proposal, we are working together with the other partners at CMS in these initiatives to make sure that information will be available should we finalize the proposal. With that, I will turn it over to Audrey to address a few more questions that came in on the PRO data.

Audrey Mitchell: Thanks, Claire. First, I wanted to address the performance percentile. A couple of questions came in about how to get that information. At reconciliation, CJR participant hospitals will receive their composite quality scores, and that will be around the second quarter of the year following the conclusion of a performance year. The composite quality score will be on that report, as well as the performance percentile for the complications and the HCAHPS survey measures, and then whether or not the hospital successfully submitted PRO data. There is information on how to estimate your performance percentile for both the complications measure and the HCAHPS measure in our FAQs.

Our FAQs are posted on the CJR webpage under “Additional Information.” If you go to the main CJR webpage and scroll down to the bottom—I think it is the third or fourth link—you will see “Frequently Asked Questions.” It is a very comprehensive document. The quality section of that document will describe that to estimate the performance percentile, hospitals would need to first
obtain their measured value from Hospital Compare or their hospital-specific report that is on Quality Net. Then, to recreate the distribution, obtain the measure values for the hospitals that again would recreate the performance distribution and then calculate the decile cutoff values for that distribution and from there determine what their point values for the composite quality score is. I just want to note that again, in addition to the FAQs, we have more information on how to determine your performance percentile. Please note that while hospitals can estimate their performance percentile for the measures, an exact recreation is not possible due to variations such as data suppression, which are not included in the publically available data.

Another question that came in about subsection (d). There is a very in-depth discussion and definition in section 1886 of the Social Security Act. In general, they are hospitals that are not psychiatric hospitals, rehab hospitals, pediatric, long-term care, PPS-exempt hospitals, or outside the 50 states and DC. Those are the subsection (d) exclusions. In terms of eligibility for IPPS, this would not include critical access hospitals, Veterans Affairs (VA) hospitals, foreign hospitals, or hospitals in Maryland. Then, the measure value refers to the minimum amount of responses or completed surveys to get either a risk standardized complications rate for the complications measure or a HCAHPS linear mean roll up score for the HCAHPS measure. I believe it is 25 cases for complications measure, that is the minimum and that is 100 completed surveys for the HCAHPS.

Claire Schreiber: Thank you, Audrey. We have a couple of questions on the beneficiary notification that Sarah Mioduski is going to address. The first question is, “Who has to provide the beneficiary notification?” Then another couple of questions on what that means when we say that we are proposing that hospitals and collaborators show evidence of having given the notification. A couple of questions on who has to do it and what does that mean when we say that they must keep records of it. I will turn that over to Sarah.

Sarah Mioduski: Thanks, Claire. Under current user policies, participating hospitals in the CJR model are required to provide beneficiary notification to a CJR beneficiary. Additionally if those participant hospitals have a collaborator agreement with a post-acute care provider or supplier or a physician or non-physician provider, those collaborators are required to provide the CJR beneficiary with a beneficiary notification.

I did see a question about whether or not the participating hospital will have to make these notifications. No, as Maria said, these notifications are provided in English and Spanish on the CJR model webpage.

In regards to what we are proposing, because we are proposing to add additional collaborators to the model, we are also proposing some more beneficiary notifications and some organizational changes in nature for the beneficiary notifications. Specifically, we propose to add a physician group practice, collaborator notification, collaborating hospital notification and an ACO notification in the proposed changes in the CJR model. As Claire said, we are proposing that all providers that are required to provide the notification materials to a CJR beneficiary must be able to provide evidence of compliance with the beneficiary notification requirements to CMS upon request. Currently in the CJR model, participant hospitals are required to provide access to records and record retention of these beneficiary notifications. What we are adding to this is a clearer and more concise explanation of these record retention and access to records.
requirements and explaining that the collaborators must also keep detailed records showing which beneficiary received these notifications. In the proposed regulation, we are leaving the record keeping up to the person, hospital, and collaborators, but currently some hospitals have added some things to the beneficiary notification, such as a signature line or bar code that they are then able to scan into their electronic health record. That is up to the hospital, but I will add that under the current CJR regulations for the beneficiary notifications that are on the CJR webpage, they are not modifiable unless otherwise noted.

**CONCLUSION**

Claire Schreiber: Thank you, Sarah. We have come to the end of the questions and I just want to give a couple of reminders. First, the slides from this presentation will be posted on the CJR Connect website, which is a website for the hospitals in the model. If you do not currently have access to CJR Connect and would like it, please send an email to CJRsupport@cms.hhs.gov. In addition, we have many other materials posted on that site. For example, many materials about the patient reported outcomes data. I know we are receiving many questions on that. There are many materials that can help hospitals understand the PRO data submission on the CJR Connect website. We want to encourage folks to review that and please feel free to reach out to us if you are not able or do not currently have access to the site.

Secondly, we have posted a new Frequently Asked Questions document on the CJR model webpage. That is on the CMS or CMMI public website. The new FAQs document has many questions that we have been receiving from hospitals and our responses to those. So please review that document as well—it has a lot of information. With that, I would like to say thank you to everyone on our team for the presentation today. Thank you to everybody for participating in the webinar and please feel free to reach out to us if you have any further questions. We also encourage folks to submit comments on the proposed rule. The instructions for that is on the slides that we will also be providing to all the participants of the webinar. Thank you.