CJR Model Update:
December 2017 Final Rule and Interim Final Rule with Comment
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Alicia Goroski: Good afternoon and welcome to this CJR learning system all participant webinar, CJR Model Update December 2017 Final Rule and Interim Final Rule with Comment. Audio for today's event is available through your computer speakers or by dialing in to the number that you see on the first slide. This is Alicia Goroski with the CJR Lewin Learning System Team and today's agenda will begin with a brief review of the logistics for today's webinar. Then I'll be turning things over to our presenters for today's session, they will begin by reviewing the background then a summary of the December 1st 2017 Final Rule. They will then be reviewing the extreme and uncontrollable circumstances policy and changes to the CJR model which will be effective on January 1st 2018. Finally there will be a question and answer period.

Now for a brief introduction to today's platform. As I mentioned audio's available through your speakers, however if at any point you experience any issues you may dial in to the telephone number and you should see that telephone number in your upper right hand corner of your screen. The largest portion of your screen should be the slides, you may enlarge the slides at any point during today's webinar by clicking on the four arrows pointing outwards just at the top right hand corner of that slide. And if you want to minimize and pull those slides back into fit into the screen just hit those four arrows that will then be pointing inward. Just below the slides you should be seeing live close captioning during today's event, and to the right of that you will see the Q&A pod, this is where you can submit questions at any point throughout today's presentation. Just a reminder that you will only see those questions that you submit.

And finally there is a pod or a box right above that Q&A on the right hand side of your screen that contains event resources. You may download the PDF of today's slides and text alternative. To download you click on the file you wish to download and then the download file button will highlight, activate and you can download each file individually. As a reminder I've already reviewed you can submit questions at any point, questions will be answered following the presentation. So at this time I would like to introduce our two presenters for today's session. I'm pleased to introduce Lisa Opdycke and Sarah Mioduski with the CJR/CMS model team. Lisa I'll turn it over to you.

Lisa Opdycke: Thank you Alicia. We'd like to start the webinar by providing some background information on the final rule. On August 17th, the proposed rule was published in the federal register, the comment period for this rule closed on October 16th 2017 and we received 85 comments. On December 1st, 2017 we published the final version of that August 17th proposed rule and a final rule, an interim final rule with comment. I will speak about later the interim final rule with comment finalized and seeks comment on an extreme and uncontrollable circumstance policies that applies to recent hurricanes and wild fires. The December 1st, 2017 final rule and interim final rule with comments, finalized cancelation of the episode payment models or EPMs in a cardiac rehabilitation incentive payment model, as well as rescinded the regulations governing these models. It also revised certain aspects of the CJR model. The rule established voluntary participations for two sets of participants, those in 33 voluntary MSAs and those who classify as

low volume or rural. A list of all hospitals and their statuses under the final rule is available on the CJR website.

Hospitals with voluntary participation under the rule will have a one-time option to choose whether to continue their participation in the model. In addition the final rule includes technical refinements and clarifications for certain payment, reconciliation, and quality provisions. CMS has also finalized the changed, increase the pool of eligible clinicians that qualified as affiliated practitioners under the advanced EPM track. Under the final rule CJR will continue on the mandatory basis in 34 of the 67 current MSAs, this leave 33 MSAs as voluntary, along with low volume and rural hospitals in the mandatory MSAs. These hospitals will be able to continue participation in CJR through one time participation election period that will be held January 1st through January 31st 2018. In order to continue participation in CJR, these qualifying hospitals must opt into the model. If a qualifying hospital chooses not to let participation a hospitals episodes for performance year three will be canceled and their participation will end. Again, a list of all hospitals and their statuses under the final rule can be found on the CJR website at the link provided.

We'd also like to note in response to questions that the message for calculating regional target prices will remain the same include all hospitals in the region not fully those participating in CJR. This slide reiterates which hospitals have voluntary participation under the final rule that is rural and low volume hospitals and the 34 mandatory MSAs along with hospitals in 33 voluntary MSAs. Participation requirements are based on the CCM status of hospitals as of January 1st 2018. A change in role status after the voluntary election period does not affect the participation requirements.

As noted before there's a onetime participation election period that will begin on January 1st 2018 and ends at 11:59 PM eastern standard time on January 31st 2018 for hospitals and voluntary MSAs or those identified as low volume overall. To elect participation CJR performance year is three through five, hospitals must send completed opt in template or letter to cjrsupport@CMS.HHS.gov, the opt in template is also available in the CJR website. The participation election letter serves as the participation agreement for the hospital and certifies that the hospital will comply with all requirements of the CJR model under 42 CFR part 1510. Voluntary participation will be effective on February 1st 2018 and will continue through the end of the CJR model, which ends of December 31st 2021. It is not possible to opt out of the model once the hospital elects to participate.

In the final rule we also implemented several technical refinements and clarifications. First we finalize that CMS may take remedial action if hospitals and their collaborators fail to participate in the CJR model evaluation. Additionally for each individual hospital that is part of a merger or reorganization during the performance period we will continue to calculate reconciliation separately for the period immediately before the merger reorganization. Consequently if a hospital that is not participating in the model reorganizes and results in a new organization operating under the participant hospital CCN, there is no effect on reconciliation for the participant hospital for episodes initiated prior to the reorganization.

Episodes that initiate after reorganization would be subject to an updated quality adjusted episode target price, based on historical episodes which would include historical episode expenditures for all hospitals that are reorganized under the CCN. Furthermore we finalize the price adjustment to the CJR, Telehealth Healthcare Common Procedure Coding System or HCPCS codes, include the facility practice expense values which will increase the payment amount. Previously the practice expense values were set to zero, the nine CJR HCPCs decodes where Telehealth visits can be found in table five of the final rule. To ensure that model participants are aware of periodic ICD pin code updates to the hip-knee complications measure participants must use the applicable ICD-10 code set that is updated and release to the public each calendar year in April by CCS-2 and posted on the hospital quality initiative measure methodology website. I will now turn over to my colleague Sarah Mioduski who's going to finish reviewing the technical refinements and clarifications along with the interim final rule comment.

Sarah Mioduski: Thank you Lisa. We additionally happen to have technical requirements and clarifications regarding quality measures and the composite quality score methodology. Changes to the CJR model quality measures and composite quality score methodology were finalized in the MPA final rule which should apply during the performance year one subsequent reconciliation. To note that they result in significant differences between the reconciliation payments calculated during performance year one initial reconciliation and performance year one subsequent reconciliation. Also the methodology differs from that use the terminal quality there is a target price for PY1 initial reconciliation calculation as follows. The quality at this target price will be recalculated to apply the many reductions to be effective discount factors including applying more generous criteria for earning quality improvement points.

Also this rule finalized that the addition of the clinician engagement list to broaden this scope of eligible clinicians that may be considered affiliate practitioners under the CJR model. As many of you are aware this relates to the quality payment program. Previously only clinicians that had a collaboration agreement with the participant hospital that shows the advance EPM track or a clinician that had distribution arrangement with a physician group practice and that physicians group practice have a collaborative agreement with an advanced EPM participant hospital were allowed to be submitted for qualified participant determinations under the quality care program. In order to expand opportunities for clinicians now physicians, non-physician 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 advance EPM 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 determination.

These clinicians will be included on clinician engagement list spent by the hospital. To note the term contractual relationship encompasses the wide range of relationships whereby participant hospital engages a clinician to perform work that at least in part support the cost and quality goals of the CJR model. The clinician engagement list and the clinician financial or arrangement list will be considered together and affiliate practitioner list which is used by CMS to identify eligible clinicians for the qualified practitioner determination under the qualitative program.

We will collect this information for the clinician financial arrangement list and a clinician engagement list together in order to reduce further burden on hospitals. Several commenters requested that CMS recognize the unique challenges faced by CJR participant hospitals during the recent hurricanes and wild fires that have occurred in or near several of the CJR MSAs. This internal fire commentary most notably addressed as Hurricane Harvey, Hurricane Irma, Hurricane Nate and the California wild fires that took place in 2017. But also could include other similar events that occur within a performance year, including performance year two, if those events meet the requirements we are setting forth in this policy.

Out of the performance year two initial reconciliation this policy will apply to CJR participant hospitals that have a CCN primary address that is located in emergency area during an emergency period, and those terms are defined in section 1135 of section G of the act for which the secretary had issued a waiver under section 1135 and is located in a county, parish or tribal government designated in a Major Disaster Declaration under the Stafford Act. Using these criteria CMS was able to identify at least a 101 CJR participant hospitals located in the areas affected by Hurricane Harvey and Hurricane Irma approximately 12 CJR participant hospitals in the areas affected by Hurricane Nate and at least 22 CJR participant hospitals in areas impacted by the California wild fires. CMS will notify providers for extreme and uncontrollable circumstances policy will apply to performance year two and subsequent performance years if and when the policy is in vote via the initial reconciliation reports CMS delivers to providers upon completion of the reconciliation calculations.

Specifically, the interim final rule comment implements the following changes for episodes in the impacted areas. For a non-fracture episodes with dates of admission to the anchor hospitalization on or within 30 days before the date at the emergency period begins actual episode payments are kept at the target price determined for that episode under section 510300. For a fracture episodes with dates of admission to the anchor hospitalization on or within 30 days before or after the date of the emergency period it begins actual episode payments are capped at a target price determines for that episode under 510300. This policy will apply to performance year two, we are accepting comment on this policy for performance years three, four and five, whereas, interim final rules comment there is a 60 day comment on this extreme and uncontrollable circumstance policy which will close on January 30th, 2018. For more information on extreme and uncontrollable circumstances policy please view this policy in section three of the ISC at page 57092 in the federal register.

As we've mentioned on previous webinars certain provisions of the December 2016 EPM rule that were delay until May 20th will now taking effect on January 1st, 2018. I will go into great detail about this information in the remaining of the presentation. But for now the following changes will take effect on January 1st, 2018 relate to the access to records and retention and also to the financial rated sections of the model. Beginning January 1st, 2018 the CJR model records access and retention requirements are consolidated and applied more broadly throughout the model. The access to records or retention section is codified at 510.110. In addition, the remainder of changes to that financial arrangements will take effect on January 1st, 2018. First we deleted the term collaborator agreement and transitioned the requirement under collaborator agreement to the requirements of the January arrangements. We did consider that current participant hospitals and collaborators have already have existing collaborator agreements.

However, although we change these terms the sharing policy that will now be in effect are largely similar to the current policies or the growing collaborator agreement.

Second, we also expand the scope of the financial arrangements under the CJR models like seeing the list of eligible collaborators. Lastly, we add the term CJR activities. CJR activities means activities related to promoting accountability with a quality cost and overall care for beneficiaries, including managing and coordinating care, encouraging investment infrastructure, enabling technologies and redesigning care processes for high quality and vision service liberty. The provision of items and services during episodes in a manner that reduces cost improves quality or carrying out any other obligation or duty under the CJR model.

Here you will see a diagram of financial arrangements that will be effective on January 1st, 2018. As you can see in the diagram, we have expanded we have expanded eligible collaborators and continued the expansion with a downstream methodology. Staring January 1st a collaborator will include an ACO or one of the following Medicare individual entities that enter into a sharing agreement which include non-physician practitioner, a non-physician provider group practice, a physician group practice, a therapy group practice, a physician, a therapist, a skilled nursing facility, a Home Health Agency, a long term care hospital, an inpatient rehab facility, a critical access hospital, a certified outreach rehab facility, a hospital, a provider of outpatient house and a provider of outpatient therapy services. As the diagram demonstrates this list has increase significantly.

The downstream methodology continues as you can see collaborators that may enter into distribution arrangement and a collaboration agent that may enter into a downstream distribution arrangement. As we sent out a blast week about this we want to just bring up in the webinar that the HHS Office of the inspector general and CMS has jointly issued new waivers effective January 1st, 2018 for specified ranges permitted under the comprehensive care for joint replacement model. These new areas are the result of certain programmatic changes being made by CMS to the CJR model and on their effective date supersede the original waiver notice which was jointly issued by OIG and CMS on November 16th, 2015. To note that this is comprised of two parts, part one sets forth this specific conditions that must be met to qualify for waiver and part two consist of commentary explaining the reason that certain changes were made when establishing their requirements for waivers in this 2017 notice, clarifying certain waiver requirements that were retained in the 2017 notice and described in general locations to the waivers.

For CJR model enquiries, please direct your questions to the CJR model team at CJR@cms.hhs.gov for participant hospitals that have questions as I'm sure you know the email the email is CJRsupport@HHS.gov. And also you could find documents on the CJR model website as well as a list of low volume hospitals, rural hospitals and the voluntary MSAs as applying to the opt in that Lisa had talked about -- Lisa had discussed prior. Also just to remind everyone the deadline to sending your voluntary participation selection letter is January 31st, 2018 and that should be emailed to CJRSupport@cms.hhs.gov. The template is on the website as well as the instructions. We will now pause to compile the questions that have submitted by the webinar participants and we will get back to you all shortly.

Alicia Goroski: Thank you Sarah and thank you Lisa. This is Alicia again and I just wanted to give a quick reminder that you can continue to submit any questions that you may have by typing those into that Q&A box and then hitting -- pressing the send, the little bubble. And I did just want to say thank you several that you pointed out. We had a little technical glitch with the slide there. As a reminder things are back on track, you can download the PDF of today's slides in the event resources pod to the right hand side of your screen, just click on slides and then click download file. And then one other reminder that just as we do with all of our events, both the recording and the transcript will be posted to CJR Connect within a couple of weeks following this webinar. So following those reminders I will now turn it back over to the CMS team as they are working behind the scenes to triage and they'll be providing answers to some of the questions that have been submitted.

Lisa Opdycke: Thank you Alicia. Good afternoon, so our first question that we received prior to the webinar was as a low volume hospital we are automatically excluded from the program unless we opt in, is that correct? Thank you for your question. Yes that is correct. If you qualify as a low volume hospital and do not submit and opt in or participation election letter by the January 31st, 2018 deadline you will no longer be a CJR participant and your performance year three episodes will be canceled. This means that you will not be able to participate in performance years three through five.

Second question is can you please discuss how or if BPCI will roll into CJR? So, consistent with the current policy, hospitals participating in LEJR episodes under BPCI are not included in CJR. So if the hospital terminates participation in LEJR episodes under BPCI and is located in the mandatory MSA and is of course not low volume or rural then that hospital would become a participant in CJR upon termination in BPCI. So rural and low volume and former BPCI hospitals located in voluntary MSAs would not be eligible for a special election period, in other words they would not have an opportunity to opt in for performance year three through five.

Next question is our hospital is rated rural, participation is mandatory, please resolve our ability to opt out as a rural hospital had that option. So to answer this I'd say that on the list of hospital status under the final rule that is available on the CJR website, if your hospital is listed as mandatory and also rural you can opt out of the remainder of the CJR model by not submitting an opt in letter during the participation election period.

Nora Fleming: Sorry, one item for that, rural hospitals we have done our very best to consolidate a list of hospitals that have rural status under CJR on the excel file that is available on the CJR webpage that list every hospital status in CJR. We are not a 100% sure that we have a complete full and accurate list of rural hospital status. So if you are a rural provider you have a 401 reclass so you reclassified yourself as a rural provider under section 42CFR 4.12.103 and you are not on that list and you are not tagged as rural assuming you're not also in a voluntary MSA please email CJRSupport@cms.hhs.gov and list your CCN and if you can provide your 401 reclass letter from the regional office we can add you to our list of rural providers. We do strive to have the most accurate as possible however rural reclassifications do go through our regional office that are in number of communication point and between your application and

us getting a copy of it. So if you are rural and you do not believe you're categorized correctly please email CJR Support and let us know we need your CCNs to be able to research this properly thank you.

Audrey Mitchell: Thank you Nora. Okay, next question was will there be reimbursement changes with the new rule, how do providers bill for MSDRG 469 and 470 which are included in the model? No there will not be reimbursement changes with the new rule, providers and suppliers should continue to build fee for service as normal as usual. And that include submitting claims for inpatient stays that may be include in the model unassigned to MSDRG 469 or 470. Okay, our hospitals are in the voluntary CJR regions effective January 1st, 2018 based on the final rule, we are discussing if we should opt in or not and need to understand how the regional target pricing will be determined. Will all hospitals in the region be included in determining target pricing or only those hospitals that opt in? So all hospitals in the region will continue to be included in determining regional component of the target prices, thanks for your question. And with that I'll turn it over to my colleague, Rhya Ghose.

Rhya Ghose: Thanks Audrey. We received a couple questions asking us to discuss the impact on CJR hospitals that have participated in PRO but are on the voluntary list and not opting in. Some of you would like to know what constitutes successful submission for the end of this year. Possible that opt out of CJR are held to the PRO and risk variable data submission criteria set forth in the 2015 CJR final rule regulation for the duration of their participation in this model. Because the opt in period applies to performance year three any hospital choosing not to opt into the model and wishing to earn two quality performance points for PRO toward their composite qualities for performance year two must have met the successful submission criteria for performance year two. And just as a reminder the successful submission criteria for performance year two were as follows. First, hospitals must have submitted complete post-operative data on total hip and or total knee arthroplasty procedures for at least 50% of their eligible procedure or greater than 50 eligible procedures. In order to be successful these procedures must match the procedures on which hospitals have submitted pre-operative data in performance year one. Second, hospitals must have submitted complete pre-operative data on total hip and or total knee arthroplasty procedures for at least 60% of their eligible procedures or at least 75 procedures performed between September 1st, 2016 and June 30th, 2017. Please note that the window for PRO submission for performance year two closed on November 30th, 2017. At this point I'll turn questions over to my colleague, Claire Schreiber.

Claire Schreiber: Thanks Rhya. So I'm going to drop the couple of the questions that have come in during the webinar. So one question we got from few folks was whether the model the CJR model includes hip fracture patients. So just want to clarify that, the model does include episodes for both elective surgeries that are assigned to MSDRG 469 and 470 and also emergent procedures that occur as a result of a hip fracture. And as a result of that we do provide separate target prices for fracture cases versus non-fracture cases. So just to reiterate that any case that is assigned MSDRG 469 or 470 whether that's a fracture or not, is included in the model. So we do include some fracture patients. We had a couple of question about the opt-in process, so one question does our election need to be electronically signed or can it be hand signed and scanned in? And the answer is either option is fine, and just want to refer you

back to the slide that has the email address to send in that opt in form but the answer to the question either way you can hand sign it and then scan it in or sign it electronically.

Another question, are any forms required prior to January 31st, 2018 for the hospitals that are located in the mandatory MSAs? The answer to that is no, so if you are located in a mandatory MSA and you're not low volume or rural you will continue to participate in CJR and there is nothing that you need to do to continue participation. There's no form that you need to fill out for that. Only those hospitals that are located in one of the voluntary MSAs or hospitals that have a rural status or are listed as low volume on our website, on the CJR model website, need to fill out and send to us the opt in form if they elect to continue participation. I'm now going to turn it over to Nora Fleming who's going to address a number of questions that we received about recent removal of total knee arthroplasty from the inpatient only list.

Nora Fleming: Hi this is Nora. So we got a couple of questions that I'm just going to sort of talk generally about this issue and then if people send in more questions and we can't get to them today we'll certainly respond to them by email. So in the calendar year 2018 final rule that was published for the outpatient payment system during November of 2017 they removed the total knee arthroplasty code from the inpatient only list, and we've gotten several questions about how this will impact CJR. So first to stress the removal of the TKA from the inpatient only list does not mean that Medicare is now expecting every total knee arthroplasty procedure to be done at an outpatient setting. Medicare in the outpatient final rule they went out of their way stress that providers will surely need to gain experience determining which patients are most medically appropriate to have this procedure done in outpatient setting. So while the two-midnight rule does apply to procedures that are not on the impatient only list, case by case exceptions for inpatient admission that don't meet the two-midnight benchmark are allowed. So essentially and there's a provision on the RAC (Recovery Audit Contractor) review of these cases for two years going forward.

So generally and quickly the two-midnight rule which has plenty of documentation on, on the outpatient website but in general what that is, is that if the doctor admits the patient and the expectation is that that patient will be discharged in under two-midnights from the hospital that the care is generally speaking, something that could be done in outpatient basis. However, because this removal of the total knees is new because the Medicare population is often full of folks who have comorbidities and other health concerns that would make an inpatient level of care necessary and appropriate even though the expectation is not over two-midnight. We are allowing the cases to continue on an inpatient basis. So some folks have asked if they will lose all of their one and two day CJR cases that is not the case as long as the medical record support that the patients needed inpatient level of care even though the expectation is that they don't need to be in the hospital longer than two-midnights those are still allowed to be inpatient. So I just want to clarify that for folks, we've also had questions about how this SNF waiver would work in cases where the discharge is early or the cases billed outpatient.

So Medicare's expectation is that if someone needed a level of post-acute care that warranted a SNF admission that is not an outpatient surgery, that is a patient who would need an inpatient level of care possibly for under two-midnights but definitely an inpatient level of care. So in those cases the SNF waiver

would continue to work just as it has, we would get an inpatient bill for that stay, this patient will be discharged when medically appropriate to the SNF and the waiver would hold. Any CJR episodes where the inpatient admission is under 24 hours, so like one day discharge, Medicare's assumption is generally that that would be an outpatient claim however again medical necessity if it's supported in the notes would allow that to be bill inpatient. So that's our general statement and Sarah can now take up other questions.

Sarah Mioduski: Thanks Nora. We had some questions asking to clarify the provisions in the access records, and records retention. So the addition of that section 5.10.110 did not add any new requirements to the model, it's simply just organized all of the language related to access records, record retention that was in each section and combined it put it in section 5.10.110 and then applied that section throughout the model where it was applicable. So again it did not change any requirements it was simply an organization on clarification for the hospitals. And then secondly, we had a question was to meet advance EPM requirements to financial arrangements either require physicians to accept risk, that is no, the CJR model participant is the entity that under the model that is accepting risk. If the hospital has an agreement with the physician where risk is a part of that through the gain sharing through sharing the payments or having internal cost savings then that is the discussion of the hospital. But again the answer to that of the physician having to accept risks would be no. And I will now turn over to Audrey Mitchell to address some other questions that we've received.

Audrey Mitchell: Thank you Sarah. We've seen a couple questions asking for more detail about the quality measure changes that were finalized in the rule published in December 1st of this final rule that we're just discussing today. So in the final rule CMS will apply this following quality category cut off values to the performance year one subsequent reconciliation calculations and all reconciliations going forward, the below acceptable less than five on the composite quality score acceptable is greater than equal to five less than 6.9, good is greater than equal to 6.9 and less than or equal to 15 and excellent is over 15. So again those cutoffs -- so the excellent being over 15, those cutoffs will be applied to the performance year one subsequent reconciliation calculation, and all reconciliation's going forward. And I'm going to explain that a little bit more since you ask for more detail but just bear with me because I'm going to refer to the cutoff by just what the excellent category value is just for simplicity. So sounds like some of you want to know why those were changed and like have kind of the background on this. So the quality category cutoff finalized in the original CJR model final rule, so that was published November 24th, 2015 were excellent being greater than 13.2 and again I'm not going to go through all of them but just that was the set that was finalizing the original CJR model rule in November 2015.

Those quality category cutoff were applied to the composite quality scores for the initial performance year one reconciliation, so the initial one that was just this past year. So in the EPM final rule that was published on January 3rd, 2017 CMS changed the quality category cutoff to excellent being greater than 15. This change was intended to be effective before the CJR model's performance year one initial reconciliation. However, the effective date for these provisions was delayed until May 20th, 2017 so because of that delay the CJR reconciliation reports that were issued in April of this year were created in accordance with the provisions that were finalized in the CJR model final rule i.e. when excellent was

greater than 13.2. So the reconciliation reports from April this year excellent was greater than 13.2 now going forward excellent is going to be greater than 15 and that's what was finalized in this rule. I am going to hand it over to my colleague, Claire Schreiber.

Claire Schreiber: Sure. So we received several questions about whether CMS is going to offer an additional or a new bundled payment initiative anytime in the near future and whether CJR hospitals would be able to decide whether to participate in CJR or a different initiative. So we do have plans for a new initiative, we are hoping to continue to offer opportunities for participation in bundled payment models and as soon as we have more specific information about that we will make that available to folks but just wanted to acknowledge that we are getting questions and we hear them. We don't have anything else to offer at this point and so we will share any information as soon as we have it. I am going to turn it over to Sarah for a couple of more questions.

Sarah Mioduski: And just a follow up to the inpatient – outpatient issue we previously discussed. We have some questions asking where hospitals can find criteria that need to be documented to support an inpatient stage if it's less than two-midnights and we are going to refer the hospitals to an MLN Matters document it is MM10080 again its MLN Matters document that's MM10080. We will also post a link to this on connect and obviously if anyone has any follow up questions please submit them to the email box and we will link that document there. Again we will also post that document and link that document on connect.

CMS Female: So we received a couple of questions about the extreme and uncontrollable circumstances policy and particularly whether if a beneficiary or a patient is located in one of those areas and they travel to an unaffected areas then does that episode or that beneficiary's episode received the protection? And the answer is no. So the policy applies to the hospitals based on where the hospital is located and so that hospital's episode would then have the policy as described in the slide.

CMS Female: And I saw a question about when was pain management removed from the HCAHPS Linear Mean Roll-up score. So yes that change was made in the EPM rule that was published on January 3, 2017 and so now the HLMR or the HCAHPS Linear Mean Roll-up score that used to determine CJR model quality performance in the HCAHPS survey includes 10 of the 11 HCAHPS measures so it does not include pain management.

CMS Female: We also received a couple of questions and comments regarding our list of hospitals that have rural status. And I just want to reiterate something that Nora mentioned earlier which is if you do see your hospital on that list on our website or you don't see the hospital on the list on our website and you believe you should be on the list, please email us at CJRSupport@cms.hhs.gov as she said we do strive to have the most updated information and we get that information from various sources. But if you believe that your hospital should or should not be on that list, please reach out to us because we will definitely reconcile that information.

Nora Fleming: This is Nora again, so there is also a couple of more questions that are coming through about the total knee. So I just wanted to stress that in the outpatient final rule which is available on the

federal register's website if you Google Outpatient Final Rule 2018 you should find the link. We stressed in setting this policy and removing with TK procedure from the inpatient only list that Medicare does not feel that it should be establishing the evidence-based patient selection protocols. We are leaving that to the physician community, they are in the best positions to establish the protocols that would differentiate patients who should be in an inpatient level of care versus patients in an outpatient level of care. We are prohibiting rack review for two years which basically gives time for physician to figure out who should be treated inpatient versus who should be treated outpatient. So in terms of what needs to be in the medical record the MLN article that Sarah referenced earlier that we will make available on CJR Connect speaks to the criteria that the QIOs would look at when reviewing the medical records for necessity. Again, it's sort of up to the clinician's judgment in terms of the complexity of the case that would be treated in an inpatient setting. So essentially Medicare right now is assuming that the super healthy patients who have no additional complications, they don't have diabetes, they don't have hypertension, they don't have other kinds of potential complicating conditions like no histories of bleeding etc., would probably be the ones that would be appropriate for outpatient care whereas the remainder of the population if you have comorbidities, if you have chronic products conditions that are also being managed would be those patients who we would be expecting to be treated in an inpatient inclusion basis.

So in terms of the target pricing I know we've had questions about will CMS be revising their target amount to adjust for this removal of TKA from the inpatient only list. Again CJR is a regulatory model so any adjustments to populations of target prices or adjustments to targets that all would have to be put forth and those the comment rule making, we are certainly mindful that this is an issue of concern to have those participating in the model and we are looking at the data trying to figure out what we would be able to do with target prices. So we are very likely to engage in rulemaking in the near future to address this issue however because of the time constraints we will not be able to do rule making prior to the January 31 cut off for the opt in period.

CMS Female: And just to add to that we have seen the additional questions just asking for clarifications to whether the model currently includes those outpatient procedures, the answer is no currently and it's just inpatient procedures that are assigned 469 or 470 ERGs at discharge. And Lisa Opdycke is going to take a couple more questions.

Lisa Opdycke: Hi, we just like to clarify couple of questions, if your hospital chooses to opt out of the CJR program you will no longer be able to use any of the waivers including the three day SNF waiver for any performance what would be performance year three episodes. So you could use that waiver if you decide to opt out for all episodes that end on or before December 31st, 2018. So that again is for performance year two episodes with end on before December 31st, 2018, so if you were to initiate an episode now that would not end until sometime in January or February, the 90 days. So therefore that would be technically performance three episode and you could not be using the SNF waiver. However, if you decide to then opt out of CJR all the performance year three or would be performance year three episodes will be cancelled.

CMS Female: And we are going to take a quick minute to compile the last of the questions and answer any more that we think need to be addressed.

Alicia Goroski: All right. So hi, this is Alicia, and I can go ahead and move us on to a couple of those the last reminders and then I will check back in with a CMS team after I do this. So I just wanted to take a moment we're on slide 22 now to let everyone know about a few upcoming events. So first and foremost, the one I think most of you might be interested in is the one in the middle of this table. There will be a follow up office hours on the CJR model updates held after the new year on January 9th and that is set for 2:00 p.m. eastern time and we have registration posted on the connect site and it comes out in our biweekly newsletter. Then there are couple of other affinity groups coming up that we would like to remind folks of. Tomorrow the care navigation affinity group is meeting for its 4th session and then the 5th session for that group will be on January 18th. And then as a final reminder you can, as you heard earlier, send any questions that we're not answered during today's webinar or additional questions that you have to CJRSupport@cms.hhs.gov. And we do ask everyone to just take a couple of minutes to complete today's post events survey and I believe I am seeing that we are going to go ahead and wrap up today, and yes so we sorry, CMS -- okay well I'll -- yes keep talking let me know yes. So we are -- yes if you can just take a couple of minutes to respond to that post event survey, you know, we know there are still lot of -- that you guys probably have a lot of questions and I saw some suggestions for, you know, there may be some topics particularly the inpatient versus outpatient that will be able to dig into in some future events.

Sarah Mioduski: Hi this Sarah, we just want to follow up with some remaining questions we did see some questions about how beneficiary would be attributed to the CJR model under the *Quality Payment* program. We do want to note that on the CJR model website there is an attribution eligible beneficiary document relating to that issue basically trial definition of acquisition eligible beneficiary for the CJR model under the qualitative program. Additionally, a physician is looking to see whether or not they qualified as a qualified practitioner under the qualitative program you can go to the qualitative program's website and view that. I do believe those determinations will be coming out in late December, and so you can also reference our website or if you have additional questions relating that you can email the CJR model team. But I would say your best bet is to go to that website first to determine whether or not you qualified as a QP. Additionally I just want to remind hospitals at the voluntary election participation letter is on the CJR model website for hospitals that want to opt into continued participation in the model if they are rural, low volume, or in the voluntary MSA. If you are in a mandatory MSA, you are a hospital in mandatory MSA and you are not rural or low volume you'll continue to be in the model and you have no reason to then submit an opt in letter. I believe those are the rest of the questions. So if Laura if you want to continue with any remaining questions you all have that will be great.

Alicia Goroski: All right thank you very much Sarah and thank you to the entire CMS team we will go ahead and wrap up today's webinar hope everyone has a great afternoon. And again we will encourage you all to register for that follow up office hours on January 9th thank you everyone.