

Contents

GENERAL MODEL QUESTIONS	8
Q: Where can I find a copy of the CJR final rule?	8
Q: When did the CJR model start and for how long does it last?	8
Q: Who is affected by the CJR model?	8
Q: Where has the CJR model been implemented?	9
Q: How many hospitals are included in the model?	9
Q: Where can I find the list of hospitals included in CJR?	9
Q: Does CJR include only elective procedures?	9
Q: How are providers and suppliers paid under the CJR model?	9
Q: How will this model be evaluated?	10
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?	10
Q: Our hospital recently merged with another entity. How should we communicate this to the CJR model team at CMS?	10
Q: What does an episode mean? How does payment for an episode differ from current Medicare payment?	10
Q: How will you know if care is improving during the model?	10
LEARNING SYSTEM/CJR CONNECT	11
Q: What is the CJR Connect website?	11
Q: How do we access the CJR Connect website?	11
Q: Where can I find the webinars from the CJR 101 series?	12
Q: Are only hospital employees allowed to use CJR Connect? Can external parties not directly employed by CJR hospitals also obtain access?	12
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?	13
PAYMENT AND PRICING	13
Q: Are hospitals and doctors paid differently in the CJR model?	13
Q: When do we receive the prospective target prices?	13
Q: Are the target prices risk-adjusted?	14
Q: How are hip fracture cases identified in CJR?	14
Q: Are the stop loss and stop gain limits applied to the target price or the price at reconciliation that incorporates the effective discount percentage due to quality?	14

Q: Does the regional component of target prices include all episodes from all hospitals in a region (US Census Division) or only CJR hospitals? What about BPCI episodes?	14
Q: Are the data in the CJR Data Portal standardized or unstandardized? What does standardized data mean?	14
Q: What is included in the EPI_OTHER variable on my claims files?	15
Q: I am trying to replicate my target prices. However, my numbers are not the same as what is provided in my data.....	15
Q: How is sequestration applied to the claims data used for CJR?	15
RECONCILIATION.....	15
Q: Please clarify the CJR reconciliation timeline.....	15
Q: Are CJR hospitals allowed to delay reconciliation as in BPCI?	15
Q: Does CJR conduct reconciliation on a quarterly basis or provide quarterly interim reconciliation reports to hospitals?	15
Q: Do reconciliation reports include quality as well as financial results?	16
OVERLAP WITH THE BPCI INITIATIVE	16
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?	16
Q: Do “precedence” rules apply to BPCI or CJR if the BPCI episode is not for LEJRs?.....	16
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?	16
OVERLAP WITH ACOS.....	17
Q: Will beneficiaries who are aligned or assigned to a Medicare Shared Savings Program or other ACO and undergo LEJR be included in CJR?.....	17
Q: Are Shared Savings Program ACOs or other current or future ACOs participating in performance-based risk ACO models able to opt out of the CJR model for beneficiaries aligned to those ACOs?	17
Q: Can an ACO be a CJR collaborator?.....	17
Q: Can a PGP in an ACO be a CJR collaborator?.....	17
Q: What is the incentive for a provider or supplier to participate in both CJR and the Medicare Shared Savings Program or other ACO model?.....	17
QUALITY MEASURES	18
Q: What is the patient population for the CJR quality measures? Do the measures include only CJR patients?	18
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?.....	18

Q: What is the low volume threshold for the THA/TKA Complications measure? What if we do not meet it?.....	18
Q: How do I access my risk-standardized complication rate (RSCR) for the THA/TKA Complications measure?.....	18
Q: Does the HCAHPS Survey measure only include elective total knee and hip patients? .	19
Q: Is it possible to obtain an exemption for HCAHPS to gather the data via secure email, text, or an online portal?	19
Q: How do I submit my HCAHPS score to CJR?	19
Q: What if I don't have more than 100 completed HCAHPS surveys?	19
Q. What is the HCAHPS Linear Mean Roll-up Score?.....	19
Q: How do I calculate the HCAHPS Linear Mean Roll-up Score?	20
PATIENT-REPORTED OUTCOMES (PRO) AND LIMITED RISK VARIABLE DATA	20
Q: Is submission of patient-reported outcomes (PRO) and risk variable data required for the CJR model?.....	20
Q: What data must my hospital submit to meet the CJR requirements for voluntary PRO data collection?.....	20
Q: On which patients should my hospital collect PRO data?.....	22
Q: How many patients do I need to capture to fulfill the PRO successful data collection criterion?.....	25
Q: When should my hospital collect the PRO data?	25
Q: What are the deadlines for PRO data submission?.....	26
Q: Is the PRO Data Collection Template available for download?	27
COMPOSITE QUALITY SCORE	27
Q: How do the composite quality score and pay-for performance methodologies work?.	27
Q: Does the effective discount at reconciliation differ by performance year?	28
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?	28
Q: When do CJR hospitals receive their composite quality scores?	28
Q: How can I calculate my performance percentiles for the HCAHPS Survey measure?	29
Q: How can I calculate my performance percentiles for the THA/TKA Complications measure?.....	29
DATA SHARING.....	30
Q: How do CJR model participants access their data?	30
Q: Can I open my CJR data using Microsoft Access?	31

Q: What types of data can be requested in the CJR model?	31
Q: Is a CJR participant hospital allowed to share the CJR data with our data analysts or consultants?	31
Q: How can Business Associates of CJR participant hospitals request data from CMS?	31
Q: Are CJR participant hospitals or Business Associates allowed to use the CJR data for other research or studies?	32
Q: Can CJR data be shared with academic colleagues or other research organizations associated with our hospital?	32
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)?	32
Q: If there are any issues with data security or unauthorized access to the CJR data do we need to report them to CMS?	32
Q: Can CJR participant hospitals publish research findings using CJR data?	32
Q: Can multiple members of our organization share an EIDM ID to access the data in the CJR Data Portal?	32
Q: How can we obtain other CMS data for research purposes?	33
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?	33
Q: Can we incorporate or comingle CJR data into our existing Electronic Health Record (EHR) or Electronic Medical Record (EMR) system?	33
Q: What needs to happen with the CJR data we received when the model is complete? ..	33
FINANCIAL ARRANGEMENTS	33
Q: Is the cap that applies to reconciliation payments for gainsharing also applicable to payments made to physicians, nonphysician practitioners, and physician group practices based upon internal cost savings?	33
Q: For subsequent years, do collaborating physicians need to sign collaborator agreements by a particular date for each year?	34
Q: Do sharing arrangements need to be executed by the start of the model, April 1, 2016?	34
Q: Can a participant hospital make gainsharing payments to their CJR collaborators if the participant hospital owes money to Medicare at reconciliation?	35
Q: Can gainsharing with collaborators only take place annually after CMS reconciliation? ..	35
PROGRAM RULE WAIVERS	35
Q: Does the telehealth waiver allow for a telehealth visit to originate in a patient's home?	35
Q: How are services furnished under the telehealth waiver billed?	35

Q: Can the telehealth waiver be used in conjunction with home health services? 35

Q: Is telehealth person-to-person communication or can it be vital signs only (transmitted via in-home devices)? 35

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? 36

Q: Can post-discharge home visits be furnished to a beneficiary that is also receiving home health services through the Medicare home health benefit?..... 36

Q: How are the home visits under the waiver billed if the patients are not eligible for home health services under Medicare? 36

Q: Can any of the nine post-discharge home visits be provided by physical therapists and reimbursed by the hospital? 36

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? 36

Q: What specifically does CMS mean by clinical staff or “auxiliary personnel”? 37

Q: When can we begin utilizing the Skilled Nursing Facility (SNF) 3-day stay waiver? 37

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)? 37

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?..... 37

Q: When we give the beneficiaries a list of SNFs eligible for waiver use can we include their star ratings? 37

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?..... 38

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? 38

Q: Do beneficiaries not meeting the criteria for SNF-level care have the right to appeal the decision? 38

Q: How do Critical Access Hospitals’ (CAH) Swing Beds fit under the SNF waiver rule? Currently CAHs do not have a star rating. 38

Q: Do you have any requirement for selecting Home Health Agencies like the SNF requirement of three stars or greater? 38

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? 39

Q: Can a CJR hospital that dropped out of BPCI continue using the SNF 3-day waiver (as they were using it in BPCI)?	39
BENEFICIARY NOTIFICATION	39
Q: Does the beneficiary notification have to be given in writing or can it be given verbally?	39
Q: Where can the CJR beneficiary notification documents be found?.....	39
Q: Can the beneficiary notice be given to the beneficiary prior to admission for an elective LEJR procedure?	39
Q: Will beneficiaries receive multiple notification letters during a CJR episode?	40
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?	40
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?.....	40
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?.....	40
Q: What does CMS mean when they state that the beneficiary notification letters are non-modifiable?	40
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?.....	41
Q: Do CJR hospitals need to provide CJR beneficiary notification materials to beneficiaries for whom Medicare is a secondary payer?.....	41
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?	41
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?	41
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?	41
DISCHARGE PLANNING NOTICE	42
Q: Where can we find information concerning the discharge planning notice in the final rule?	42

Q: How is the discharge planning notice under CJR different from what is currently required?.....	42
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?.....	42
Q: When and how will the hospitals be provided the discharge planning notice?	42
Q: Can you clarify that the discharge planning notice is only required if the beneficiary is discharged to an SNF without a qualifying 3-day stay?	42
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?	43
MONITORING AND BENEFICIARY PROTECTIONS	43
Q: Does the CJR model restrict beneficiaries from receiving certain types of services?	43
Q: Does CJR limit beneficiaries' ability to choose their preferred hospital or other provider or supplier?.....	43
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?	43
Q: Will this new payment system for hospitals affect the way doctors provide care to beneficiaries?	43
Q: What safeguards have you put in place to make sure that patient care is not adversely affected?	44
Q: How will patient data be protected?	44
Q: How will beneficiaries be notified about their rights within the CJR model?	44
Q: If CMS discovers that a hospital participant is non-compliant with the requirements of the CJR model, what actions will CMS take?	44
BENEFICIARY INCENTIVES	44
Q: Can you please provide examples of beneficiary incentives?	44
Q: Is there a limit to the amount of money a hospital can spend on beneficiary incentives?	45
Q: Do hospitals' costs for beneficiary incentive services or items count toward the calculation of episode spending?.....	45
Q: Can the beneficiary incentives be provided prior to official episode start date?	45
Q: Does the hospital have to choose from a list of accepted technologies or services?	45
Q: Will Medicare pay a CJR hospital separately for beneficiary incentives furnished to the beneficiaries?	45
Q: Can hospitals give a beneficiary a technology item to keep after the CJR episode?.....	45
Q: When is a participant hospital required to document beneficiary incentives provide to CJR beneficiaries?.....	45

Comprehensive Care for Joint Replacement (CJR) Model

*These Frequently Asked Questions (FAQs) pertain to Performance Year 1 of the CJR model (2016). CMS has proposed to make several policy changes to the CJR model through notice and comment rulemaking at <https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf>, which may affect some of the policies discussed below in future years of the model.

GENERAL MODEL QUESTIONS

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

A: The full text of the CJR model final rule is available here: <http://federalregister.gov/a/2015-29438>. The final rule contains detailed descriptions of the CJR model parameters as well as a comprehensive discussion of CJR model policies.

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 approximately 5 performance years, per the table below.

Performance year	Calendar year	Episodes included in performance year
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: Who is affected by the CJR model?

A: Nearly all acute care hospitals in selected geographic areas are required to participate in the model and have the opportunity to partner with surgeons, other physicians, and post-acute care providers to coordinate patient care more effectively. Medicare beneficiaries who have an inpatient hospitalization for 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.

Hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) and located in selected MSAs are required to participate in the model, with few exceptions. Note that acute care hospitals currently participating in Model 1, 2, or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for the lower extremity joint replacement clinical episode are not required to participate in the CJR model.

Q: How many hospitals are included in the model?

A: Approximately 800 acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) are included in the CJR model.

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

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

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 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 are required to participate in CJR, with the exception of acute care hospitals that are active participants in BPCI Model 1 or Models 2 or 4 for the major joint replacement of the lower extremity clinical episode. 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.

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 CJR@cms.hhs.gov.

Q: What does an episode mean? How does payment for an episode differ from current Medicare payment?

A: An episode is a period of time during which care is furnished, typically related to a procedure and recovery period.

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

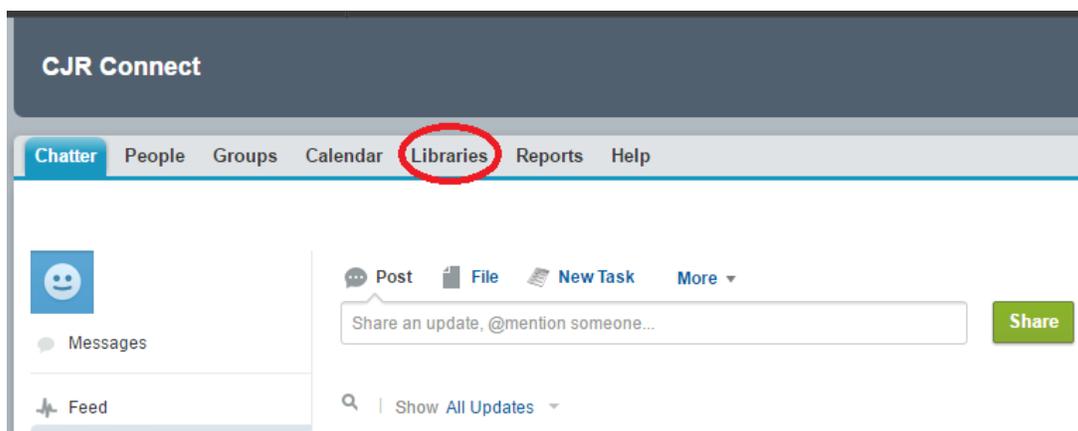
A: As with all Center for Medicare and Medicaid Innovation (Innovation Center) models, during the CJR model we monitor and evaluate the impact of the model to assess the effects on beneficiaries and quality of care. The evaluation includes both quantitative and qualitative data and uses a variety of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



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. Access to the site takes approximately 5 – 10 business days. An email will be sent to the requester when access has been granted:

From: support@salesforce.com [mailto:support@salesforce.com]
Sent: Tuesday, January 12, 2016 5:23 PM
To: ,
Subject: Welcome to Salesforce: Verify your account
Importance: High



Welcome to Salesforce!

Click below to verify your account.

[Verify Account](#)

To easily log in later, save this URL:

<https://cmmi.my.salesforce.com>

Username:

_____@_____ .com

Again, welcome to Salesforce!

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.

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 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 CJR@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 CJR@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 target prices prior to each performance year that represent expected spending based on historical experience for LEJR episodes with a discount applied. The target prices initially incorporate a blend of both hospital-specific historical LEJR spending, as well as spending for LEJR episodes at the regional level. The discount will serve as Medicare's portion of the savings. 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 target price to actual episode spending to determine whether a hospital is eligible for a reconciliation payment or is responsible for making a payment to Medicare.

Hospitals with both LEJR episode spending below the target price and a minimum composite quality score for the required quality measures will be eligible to earn a reconciliation payment from Medicare for the difference between the target price and actual episode spending. Hospitals with LEJR episode spending that exceeds the 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 three.

Q: When do we receive the prospective target prices?

A: CJR participant hospitals can now access their target prices for April-September 2016 in the CJR Data Portal. CMS will update target prices at least twice a year, to account for payment system updates, and provide 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 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.

Q: Are the target prices risk-adjusted?

A: 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 target prices. 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: As described in the CJR final rule, CMS will set separate 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 target 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 target price or the price at reconciliation that incorporates the effective discount percentage due to quality?

A: As discussed on page 73398 of the CJR final rule, the stop loss and stop gain limits are based on the target prices, which are set prospectively for the CJR model. For example, if a CJR hospital's target price for January-September of 2017 is \$25,000, the stop loss and stop gain limit would be \$1,250, because the stop loss and stop gain limit for performance year 2 is 5%. In this example, a CJR hospital would be able to earn up to \$1,250 or only be responsible for repayment up to \$1,250.

Q: Does the regional component of 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. 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 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 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 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.

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 begins in March 2017, and CJR hospitals receive reconciliation reports with their results in the second quarter of 2017. CMS will also perform a subsequent reconciliation calculation during the following performance year's reconciliation, to account for claims runout and overlap with other models and programs.

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

A: No. The CJR final rule did not include a policy allowing for CJR hospitals to delay reconciliation.

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

A: The CJR final rule finalized an 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.

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.

OVERLAP WITH 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: Yes. 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 73399 of the CJR final rule discuss in detail the policies that will impact 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 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.

Q: Are Shared Savings Program ACOs or other current or future ACOs participating in performance-based risk ACO models able to opt out of the CJR model for beneficiaries aligned to those ACOs?

A: No. CJR is intended to test the effect of episode payment across a variety of hospitals, including those affiliated with the Shared Savings Program and other ACOs.

Q: Can an ACO be a CJR collaborator?

A: No. At this time, ACOs may not be CJR collaborators. With the exception of physician group practices that are CJR collaborators, all other CJR collaborators (skilled nursing facilities, home health agencies, long-term care hospitals, inpatient rehabilitation facilities, physicians, non-physician practitioners, and providers or suppliers of outpatient therapy services) must actually furnish a billable service to CJR beneficiaries during CJR episodes in the calendar year in which the savings or loss was created in order to be eligible to receive a gainsharing payment or make an alignment payment.

Q: Can a PGP in an ACO be a CJR collaborator?

A: Yes, PGPs affiliated with ACOs can enter into sharing arrangements with CJR participant hospitals, provided they meet all requirements outlined in the CJR final rule and waiver notice.

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

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 or model.

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 Complications measure based on the national distribution of risk-standardized complication rates. The rates are calculated from claims data submitted by IPPS hospitals in the Hospital Inpatient Quality Reporting Program (HIQR) that have at least 25 patient cases in the three-year performance 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.hcahpsonline.org/home.aspx>) or contact the HCAHPS Project Team at hcahps@HCQIS.org.

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

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

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

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

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

Q. What is the HCAHPS Linear Mean Roll-up Score?

A: The linear mean roll-up 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).

Q: How do I calculate the HCAHPS Linear Mean Roll-up Score?

A: Hospitals can calculate their Linear Mean Roll-up 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.

Once hospitals have their 11 Linear Mean Scores, hospitals can use the formula in the CJR final rule for creating the CJR HCAHPS Linear Mean Roll-up Score. Alternatively, hospitals can apply the formula for creating the HCAHPS Summary Star Rating, available on pages 3-4 of the HCAHPS Star Rating Technical Notes (<http://www.hcahpsonline.org/StarRatings.aspx>), to their Linear Mean scores.

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 1 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.

Table 1. 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"> • Pain (2Qs) • Function, daily living (4Qs) 	<ul style="list-style-type: none"> • Stiffness (1Q) • Pain (4Qs) • Function, daily living (2Qs) 		<ul style="list-style-type: none"> • Pain (10Qs) • Function, daily living (17Qs) 	<ul style="list-style-type: none"> • Stiffness (2Qs) • Pain (9Qs) • Function, daily living (17Qs) 	<ul style="list-style-type: none"> • Pain (2Qs) • Function, daily living (4Qs) 	<ul style="list-style-type: none"> • Stiffness (1Q) • Pain (4Qs) • Function, daily living (2Qs) 		<ul style="list-style-type: none"> • Pain (10Qs) • Function, daily living (17Qs) 	<ul style="list-style-type: none"> • Stiffness (2Qs) • Pain (9Qs) • Function, daily living (17Qs) 	
<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 1).

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 2 for the THA/TKA ICD-10 codes relevant to the PRO collections).

Figure 1. Patient Selection Flowchart

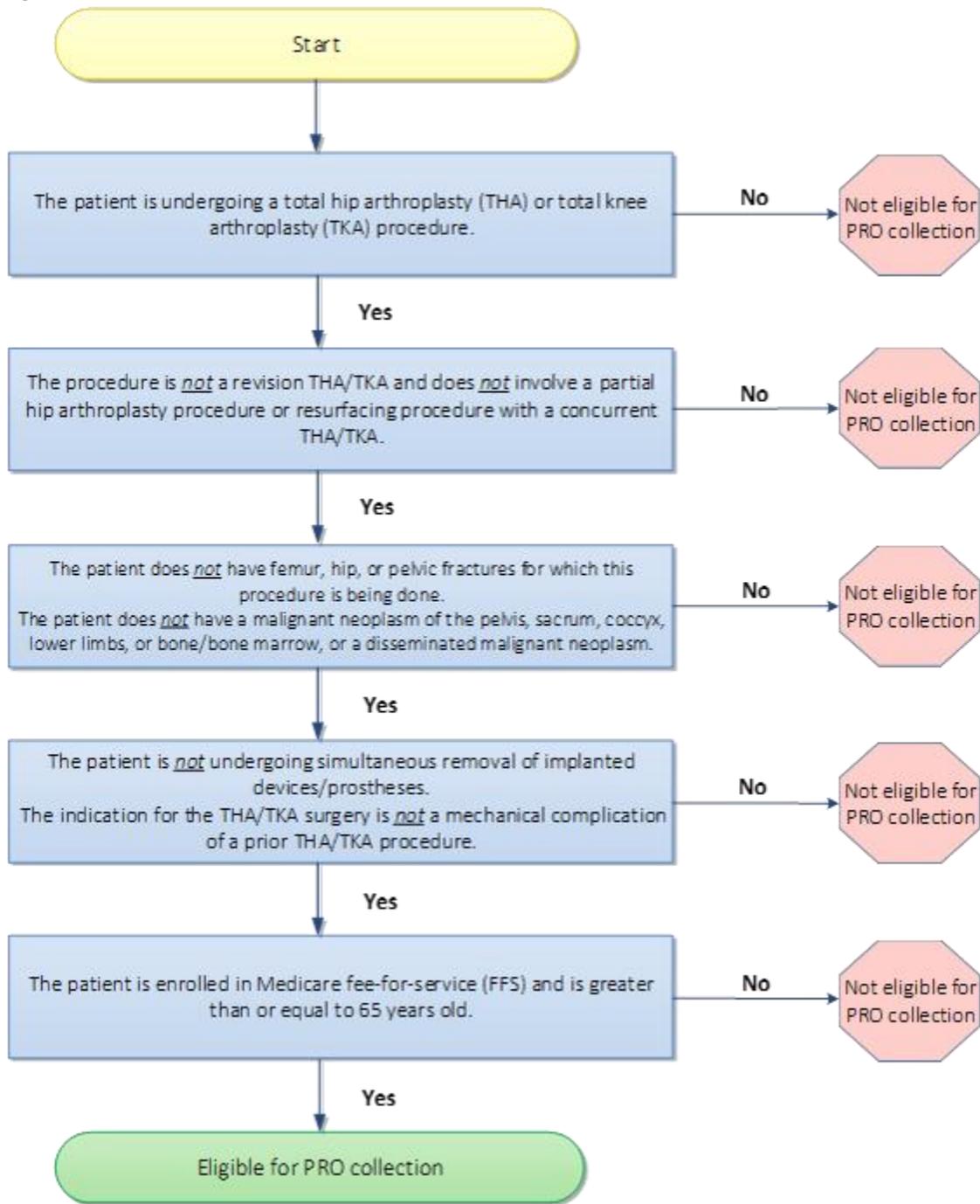


Table 2. THA/TKA ICD-10 Codes Relevant to PRO Collections

Code	Description
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 3 for each performance year¹ 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 3. 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

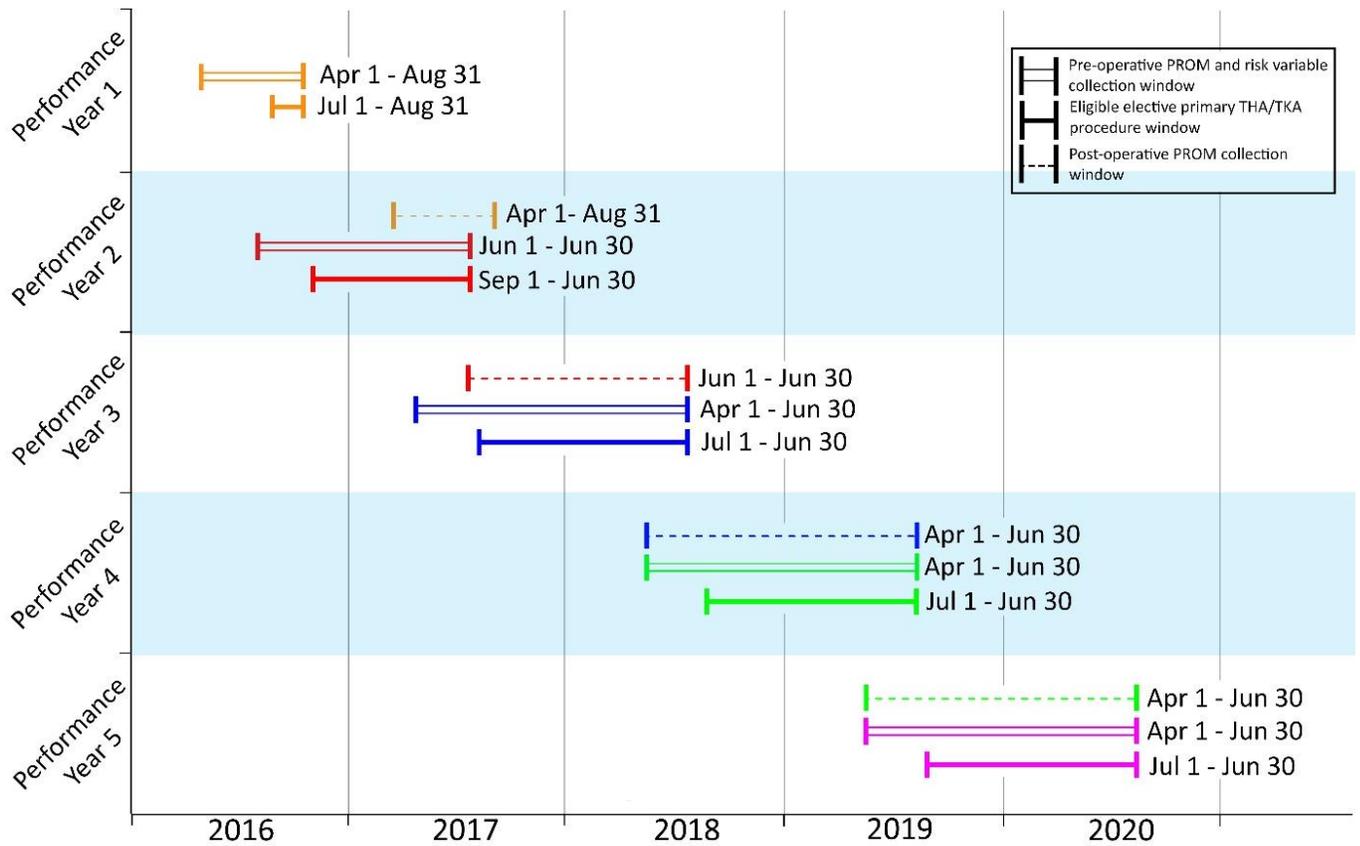
Q: When should my hospital collect the PRO data?

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 2.

¹ 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 2. 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 4.

Table 4. 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 voluntary 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.

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 voluntary reporting of the PRO and limited risk variable data.

The composite quality score is incorporated into the pay-for-performance methodology that assigns a participant hospital to a quality category at the time of reconciliation for a performance year. The effective discount varies by performance year and the participant hospital’s quality category, and depends on whether a hospital is eligible for a reconciliation amount or responsible for a repayment to Medicare. For more information, please refer to Tables 19-21 on page 73378 of the CJR final rule. 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 discount percentage experienced at reconciliation will provide a potential benefit to hospitals.

Q: Does the effective discount at reconciliation differ by performance year?

A: Yes. If a hospital is responsible for a repayment to Medicare, the effective discount varies by performance year and the participant hospital's quality category. For example, if a participant hospital is responsible for a repayment to Medicare and earns a composite quality score in the "Good" quality category for Performance Year 2, the effective discount applied at reconciliation would be 1%. If the participant hospital is responsible for a repayment to Medicare and earns a composite quality score in the "Good" quality category for Performance Year 4, the effective discount applied at reconciliation would be 2%. If a hospital is eligible for a reconciliation amount, then the effective discount percentage still varies by quality category, but it does not vary by performance year. For more information, please refer to Tables 19-21 on page 73378 of the CJR final rule.

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 the hospital's target price is \$19,400 and the hospital's actual spending was \$19,600, but the hospital achieved a composite quality score in the "Excellent" category, then the hospital would not owe Medicare a repayment of \$200. Instead, this hospital would experience an effective discount factor of 1.5% instead of 3% at reconciliation and have actual episode spending compared to \$19,700 at reconciliation. Therefore, the hospital is eligible to receive a reconciliation payment of \$100, even though the actual spending was greater than the target price with the 3% discount factor applied. Please note that although reconciliation will be performed in the aggregate across all episodes in a given hospital, in this example we assumed the participant hospital had only one episode for simplicity.

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 voluntary patient-reported outcomes and limited risk variable data.

Q: How can I calculate my performance percentiles for the HCAHPS Survey measure?

A: To estimate the HCAHPS Survey measure performance percentile, hospitals would need to 1) calculate their own HCAHPS Linear Mean Roll-up Score (HLMR) for the requisite time period; 2) calculate the HLMRs for all IPPS hospitals with more than 100 completed surveys in a four-quarter consecutive period; 3) use the HLMRs calculated in steps 1 and 2 to create a distribution of HLMRs; 4) calculate the decile cut-off values for this distribution; and 5) compare their own HLMR to this distribution to determine their performance percentile, i.e., decile.

Hospitals can calculate their HLMR (i.e., step 1) 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. Once hospitals have their 11 Linear Mean Scores, hospitals can use the formula in the CJR final rule for creating the CJR HLMR. Alternatively, hospitals can apply the formula for creating the HCAHPS Summary Star Rating, available on pages 3-4 of the HCAHPS Star Rating Technical Notes (<http://www.hcahpsonline.org/StarRatings.aspx>), to their Linear Mean Scores.

Hospitals can calculate the HLMRs for other hospitals (i.e., step 2) by applying the methods above to the linear mean scores from the downloadable database on Hospital Compare: <https://data.medicare.gov/data/hospital-compare>. Once on this site, hospitals should select the “Patient Survey Results” category, then the “Patient survey (HCAHPS) - Hospital” dataset. Next, hospitals should filter this dataset by the “HCAHPS Measure ID” column to only show the linear mean scores for each provider. IPPS hospitals have CCNs with “0” in the third position. To determine which IPPS hospitals have more than 100 completed surveys in a four-quarter consecutive period, refer to the “Number of Completed Surveys” column.

Please note that while hospitals can estimate their performance percentile for the HCAHPS Survey measure, an exact recreation of the national distribution is not possible due to variations, such as data suppressions, which are not included in the publicly available data.

Q: How can I calculate my performance percentiles for the THA/TKA Complications measure?

A: To estimate the THA/TKA Complications measure performance percentile, hospitals would need to 1) obtain their THA/TKA RSCR from Hospital Compare or the hospital’s Hospital-Specific Report (HSR) available on QualityNet; 2) obtain the RSCRs for all IPPS hospitals in the HIQR Program that have at least 25 patient cases in the requisite three-year performance period; 3) use the RSCRs from steps 1 and 2 to create a distribution of RSCRs; 4) calculate the decile cut-off values for this distribution; and 5) compare their own RSCR to this distribution to determine their performance percentile, i.e., decile.

Hospitals can obtain data for steps 1 and 2 above by downloading the data from the Hospital Compare site at: <https://data.medicare.gov/data/hospital-compare>. Once on this site,

hospitals should 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). IPPS hospitals have CCNs with “0” in the third position. Hospitals with fewer than 25 patient cases in the requisite three-year performance period will not have a RSCR reported on Hospital Compare.

Please note that while hospitals can estimate their performance percentile for the THA/TKA Complications measure, an exact recreation of the national distribution is not possible due to variations, such as data suppressions, which are not included in the publicly available data.

DATA SHARING

Q: How do CJR model participants access their data?

A: Upon receipt of a completed CJR Model Data Request and Attestation Form from a CJR hospital, we will send the two listed Data Primary Points of Contact instructions for signing up for the data portal. This is a multi-step process and videos detailing these steps can be found below, 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).
 - Video Instructions – <https://youtu.be/YyR2Dc88cKY>
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.
 - Video Instructions – https://youtu.be/vjHVq5EXU_Y
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).
 - Video Instructions – <https://youtu.be/SYENHs7nwTI>

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: 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 our 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.

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.

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 Rule.

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.

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.

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

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

You can get more information on ResDAC or make an online request at:

<http://www.resdac.org/cms-data/request/cms-data-request-center>

You can find more general information on ResDAC from CMS at:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/ResearchDataAssistanceCenter.html>

Email - resdac@umn.edu

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

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

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

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

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

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

A: Per the CJR Data Model Data Request and Attestation 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: Is the cap that applies to reconciliation payments for gainsharing also applicable to payments made to physicians, nonphysician practitioners, and physician group practices based upon internal cost savings?

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. The total amount of gainsharing payments for a calendar year paid to a PGP that is a CJR collaborator must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule for services that are billed by the PGP and furnished during a calendar year by members of the PGP to the participant hospital's CJR beneficiaries during CJR episodes. Finally, the total amount of distribution payments for a calendar year paid to a practice collaboration agent must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule for services billed by the PGP and furnished by the practice collaboration agent to the participant hospital's CJR beneficiaries during a CJR episode.

Q: For subsequent years, do collaborating physicians need to sign collaborator agreements by a particular date for each year?

A: There is no requirement in the final rule that CJR collaborating physicians sign a collaborator agreement by a particular date. However, we note that parties must enter into a sharing arrangement, memorialized in a collaborator agreement, 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 collaborator agreement with the CJR collaborator was in effect. The collaborator agreement must dictate the date of the sharing arrangement, as well as the purpose and scope of the sharing arrangement.

Q: Do sharing arrangements need to be executed by the start of the model, April 1, 2016?

A: No. If a participant hospital wishes to engage in gainsharing, the participant hospital is required to have sharing arrangements with its CJR collaborators, which set forth the provisions between the parties regarding gainsharing payments and/or alignment payments. We expect that participant hospitals will likely enter into these agreements throughout the duration of the model, not only prior to April 1, 2016. While a participant hospital may enter into collaborator agreements throughout the duration of the model, the CJR final rule specifies that “parties must enter into a sharing arrangement before care is furnished to CJR beneficiaries under the terms of 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 collaborator agreement with the CJR collaborator was in effect.

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 would 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: Can gainsharing with collaborators only take place annually after CMS reconciliation?

A: Yes, gainsharing with 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.

PROGRAM RULE WAIVERS

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: 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: In certain circumstances, CJR participant hospitals are required to provide a discharge planning notice to beneficiaries. 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 of discharge or the time that post-acute care is discussed, 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.

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 in the CJR final rule, each participant hospital must provide written notice to any Medicare beneficiary that meets the criteria in § 510.205 for inclusion in the CJR model.

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: The CJR final rule states that hospitals in the CJR model must notify beneficiaries of the requirements surrounding the model upon admission to the participant hospital or immediately following the decision to schedule an LEJR surgery, whichever occurs later. In the case of collaborators who are physicians, this notification must occur at the point of the decision to proceed to surgery. In the case of PAC collaborators, the notice must be given prior to furnishing the first service provided by the collaborator during the CJR episode.

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

A: Participant hospitals are required in all circumstances to provide notice to beneficiaries concerning the CJR model. If a participant hospital does not have any collaborator agreements, neither the physician nor the PAC provider would need to provide written notice to beneficiaries of the CJR model using the templates provided by CMS. The CJR final rule contains the requirements for when hospitals and their CJR collaborators must furnish written notification to beneficiaries. The participant hospital and certain CJR collaborators must provide the CJR beneficiary with written notification.

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

A: The beneficiary notice must be provided to the beneficiary either upon admission to the participant hospital or immediately following the decision to schedule an LEJR surgery, whichever is later. State rules and HIPAA would apply with respect to whether the notice may be provided to someone other than the beneficiary, and under what circumstances.

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: As we stated in the CJR final rule, we believe hospitals are best positioned to determine the ways in which they can use their existing medical records and discharge planning processes to document compliance the CJR beneficiary notification requirements.

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.

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 an 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 is not defined in the CJR final rule. The intent of this requirement is to ensure that beneficiaries are aware of all PAC providers available to them, in order to preserve beneficiary choice and aid beneficiaries in making informed decisions about PAC.

MONITORING AND BENEFICIARY PROTECTIONS

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 are subject to all existing HIPAA restrictions.

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.

BENEFICIARY INCENTIVES

Q: Can you please 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.

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 the beneficiary incentives be provided prior to official episode start date?

A: No, they will be allowed only during the CJR 90-day post-discharge period.

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

A: No. Subject to the CJR final rule, 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.

Q: When is a participant hospital required to document beneficiary incentives provide 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.