

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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## FACT SHEET

FOR IMMEDIATE RELEASE  
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### **Notice of Proposed Rulemaking (NPRM) [CMS-5524-P]**

On August 15, 2017, CMS displayed a notice of proposed rulemaking in the federal register (<https://www.federalregister.gov/public-inspection/current>) which announces proposed changes to the Episode Payment Models (EPMs), Cardiac Rehabilitation (CR) Incentive Payment Model, and Comprehensive Care for Joint Replacement Model (CJR). We are proposing to cancel the EPMs and the CR incentive payment model established by the Center for Medicare and Medicaid Innovation (Innovation Center) under the authority of section 1115A of the Social Security Act (the Act) and to rescind the regulations at 42 CFR part 512. Additionally, this proposed rule proposes to prospectively make participation voluntary for all eligible hospitals in approximately half of the geographic areas selected for participation in the Innovation Center's Comprehensive Care for Joint Replacement (CJR) model (that is, in 33 of the 67 Metropolitan Statistical Areas (MSAs) selected; See the original CJR final rule, 80 FR 73299 Table 4, for a full listing of MSAs included in the CJR model) and for low volume and rural hospitals in all of the geographic areas selected for participation in the CJR model. We are also proposing several technical refinements and clarifications for certain CJR model payment, reconciliation, and quality provisions and a change to the criteria for the Affiliated Practitioner List to broaden the CJR Advanced Alternative Payment Model (APM) track to additional eligible clinicians.

#### *Proposed Participation Election (Opt In) for Certain MSAs and Low Volume and Rural Hospitals in the CJR Model*

We propose that the CJR model would continue on a mandatory basis in approximately half of the selected geographic areas (that is, 34 of the 67 selected geographic areas), with an exception for low volume and rural hospitals, and continue on a voluntary basis in the other areas (that is, 33 of the 67 selected geographic areas). We are proposing to exclude low volume hospitals in the proposed 34 mandatory participation MSAs, as identified by CMS as those hospitals having fewer than 20 CJR episodes in total across the 3 historical years of data, from required participation in the CJR model beginning in February 2018 and allow them instead to choose to voluntarily participate by making a one-time participation election that complies with the

proposed regulations at § 510.115. We are also proposing that rural hospitals (as defined in § 510.2) with a CMS Certification Number (CCN) primary address in the 34 mandatory participation MSAs would have a one-time opportunity to opt in to continued participation in the model. We are proposing that any hospitals eligible for voluntary participation that does not elect to participate will have all their performance year 3 episodes (i.e. those episodes ending on or after January 1, 2018, and before January 1, 2019) cancelled. A summary of the proposed changes to the CJR model participation requirements are shown in the Table below.

**PROPOSED PARTICIPATION REQUIREMENTS FOR HOSPITALS IN THE CJR MODEL**

	<b>REQUIRED TO PARTICIPATE AS OF FEBRUARY 1, 2018</b>	<b>MAY ELECT VOLUNTARY PARTICIPATION</b>	<b>PARTICIPATION ELECTION PERIOD</b>	<b>ELECTION EFFECTIVE DATE</b>
<i>Mandatory Participation MSAs</i>				
All IPPS participant hospitals, except rural and low-volume*	Yes	No	n/a	n/a
Rural hospitals *	No	Yes	1/1/2018-1/31/2018	2/1/2018
Low-volume hospitals	No	Yes	1/1/2018-1/31/2018	2/1/2018
<i>Voluntary Participation MSAs</i>				
All IPPS participant hospitals	No	Yes	1/1/2018-1/31/2018	2/1/2018

\*Note: Participation requirements are based on the CCN status of the hospital as of January 1, 2018. A change in rural status after the voluntary election period does not affect the participation requirements.

*Participation Election Timing*

We are proposing that the one-time participation election period for hospitals with a CCN primary address located in the voluntary participation MSAs and for specified low-volume hospitals and rural hospitals in the mandatory participation MSAs would begin January 1, 2018, and would end January 31, 2018. CMS must receive the participation election letter no later than January 31, 2018. We are proposing that the hospital’s participation election letter will serve as the model participant agreement. Voluntary participation would be effective February 1, 2018, and continue through the end of the CJR model.

*Participant Election Template Requirements:*

1. We are proposing that the participation election letter must include all of the following:
  - Hospital Name
  - Hospital Address
  - Hospital CCN
  - Hospital contact name, telephone number, and email address
  - If selecting the Advanced APM track, attestation of CEHRT use as specified in § 510.120(c)
2. We are proposing that the participation election letter must include a certification in a form and manner specific by CMS that:
  - The hospital agrees to comply with all requirements of the CJR model (that is, 42 CFR Part 510) and all other laws and regulations that are applicable to its participation in the CJR model; and

- Any data or information submitted to CMS will be accurate, complete and truthful, including, but not limited to, the participation election letter and any quality data or other information that CMS uses in reconciliation processes and/or payment calculations.
3. We are proposing that the participation election letter be signed by the hospital administrator, Chief Financial Officer or Chief Executive Officer.

#### Codification of CJR Model-related Evaluation Participation

We propose to add provisions in § 510.410(b)(1)(i)(G) to specify that CMS may take remedial action if a participant hospital and its collaborators, collaboration agents, and downstream collaboration agents fail to participate in model-related evaluation activities conducted by CMS and/or its contractors.

#### Clarification of CJR Reconciliation Following Hospital Reorganization Events

Reorganization events that involve a CJR model participant hospital and a hospital that is not participating in the CJR model and result in the new organization operating under the CJR participant hospital's CCN do not affect the reconciliation for the CJR participant hospital for episodes that initiate before the effective date of the reorganization event. Episodes that initiate after such reorganization event would be subject to an updated quality-adjusted episode target price that is based on historical episodes for the CJR participant hospital, which would include historical episode expenditures for all hospitals that are integrated under CCN. These policies have been in effect since the start of the CJR model on April 1, 2016. However, to further clarify this policy for the CJR model, we propose the addition of a provision specifying that separate reconciliation calculations are performed for episodes that occur before and after a reorganization that results in a hospital with a new CCN at § 510.305(d)(1). We believe this clarification will increase transparency and understanding of the payment reconciliation processes for the CJR model.

#### Adjustment to the Pricing Calculation for the CJR Telehealth Healthcare Common Procedure Coding System (HCPCS) Codes to Include the Facility Practice Expense (PE) Values

We are proposing to replace the zero PE value currently used in the CJR Telehealth HCPCS Code pricing calculation and to instead use the facility PE relative value units (RVUs) for the analogous services in pricing the 9 CJR HCPCS G codes. We are also proposing to revise § 510.605(c)(2) to reflect the addition of the relative value units (RVUs) for comparable codes for the facility PE to the work and malpractice RVUs we are currently using for the basis for payment of the CJR telehealth waiver G codes.

#### Clinician Engagement Lists

To increase opportunities for eligible clinicians supporting CJR model participant hospitals by performing CJR model activities and who are affiliated with participant hospitals to be considered Qualifying APM Participants (QPs), we are proposing that participant hospitals that choose to participate in the Advanced APM track would submit a clinical engagement list with information for each physician, non-physician practitioner, or therapist who is not a CJR

collaborator during the period of the CJR model performance year specified by CMS, but who does have a contractual relationship with the participant hospital based at least in part on supporting the participant hospital's quality or cost goals under the CJR model during the period of the performance year specified by CMS. We propose the clinician engagement list would also be considered an Affiliated Practitioner List. The clinician engagement list and the clinician financial arrangement list would be considered together an Affiliated Practitioner List and would be used by CMS to identify eligible clinicians for whom we would make a QP determination based on services furnished through the Advanced APM track of the CJR model.

#### Clarification of Use of Amended Composite Quality Score Methodology During CJR Model Performance Year 1 Subsequent Reconciliation

We conducted the initial reconciliation for performance year 1 of the CJR model in early 2017 and expect to make reconciliation payments to CJR participant hospitals by the end of September 2017 to accommodate the performance year 1 appeals process timelines. We will conduct the subsequent reconciliation calculation for performance year 1 of the CJR model beginning in the first quarter of 2018, which may result in additional amounts to be paid to participant hospitals or a reduction to the amount that was paid for performance year 1. However, the results of the performance year 1 subsequent reconciliation calculations will be combined with the performance year 2 initial reconciliation results before reconciliation payment or repayment amounts are processed for payment or collection. Changes to the CJR model established in the "Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model" final rule, published in the **Federal Register** on January 3, 2017 (82 FR 180), impact this process. Specifically, the methodology used to determine the quality-adjusted target price for the performance year 1 subsequent reconciliation calculation will differ from the methodology used to determine the quality-adjusted target price for the performance year 1 initial reconciliation calculation, which may result in significant differences between the reconciliation payments calculated during the performance year 1 initial reconciliation and the performance year 1 subsequent reconciliation. To remedy this issue, we believe the best approach is to apply the quality specifications as established in the final rule – that is, the amendments to §§ 510.305 and 510.315 that became effective May 20, 2017 – to performance year 1 subsequent reconciliation calculations to ensure that reconciliation calculations for subsequent performance years will be calculated using the same methodology and to improve consistency across performance years for quality improvement measurement. Thus, for the reasons noted previously, we are not proposing to change the amendments to §§ 510.305 and 510.315 that became effective May 20, 2017.

#### Innovation Center

The Center for Medicare and Medicaid Innovation (Innovation Center) was established by Section 1115A of the Social Security Act. Congress created the Innovation Center to test innovative payment and service delivery models to reduce CMS program expenditures and preserve or enhance the quality of care for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. The Innovation Center's mission is to take locally-driven approaches –

approaches from doctors and other healthcare partners providing care to patients every day – and give them platform to scale through a very collaborative and highly transparent process.

The Advancing Care Coordination through Episode Payment Models proposed rule can be viewed at <https://www.federalregister.gov/public-inspection/current> starting August 15, 2017. For more information about the proposed rule, go to <https://innovation.cms.gov/initiatives/>.

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