CJR Model Updates: Performance Years 1-4 PRO Results and QPP Financial Arrangement and Clinician Engagement Lists[i]

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Laura Maynard: Hello everyone and welcome to the CJR Learning System All Participant Webinar, Performance Years 1-4 PRO Results, and QPP Financial Arrangement and Clinician Engagement Lists. This is Laura Maynard and along with Alicia Goroski, we'll be your facilitators for today's event. Audio for this event is being broadcast through your device speakers only. If at any point during the webinar, you experience any issues with audio, please contact the CJR Learning System via the Q&A pod or at LS-CJR@lewin.com.

I'm going to review the agenda and logistics today before turning things over to our first presenters. Today, we'll be covering the CJR background of PRO. We'll be talking about performance year one to performance year four, CJR risk variable and PRO results. There will be a presentation on the future directions of PRO data in measure development. Then we'll have some questions and answers related to that presentation. Following that, we will have a presentation on financial arrangement, clinician financial arrangement and clinician engagement base list. We will have submission upload instructions for the data portal and then some time for Q&A. We'll end up with our announcements and our reminders.

Again, access the audio today through your device speakers. There are no telephone lines for this call and your speakers are all muted. We acknowledge that there are many questions right now surrounding the CJR Model three-year extension and changes to episode definition and pricing proposed rule that was published on February 24th, 2020. At this time, we are unable to provide additional details and we refer you to the May 14th, 2020 webinar, which was on the CJR Model three-year extension and changes to episode definition and pricing. Many participants found this webinar really helpful in answering their questions about the proposed rule. Those webinar materials are available on CJR Connect as well as during today's event in the Event Resources pod. The final rule has not yet been published and therefore, we are unable to comment on the timeline at this time. An announcement will be sent out as soon as more information becomes available. In addition, we will also not be addressing the recent interim final rule with comment period in this webinar, register for our webinar next week on November 18th for more information on that topic.

Today, this is the layout you'll be working with. You'll notice that there is closed captioning below the slides. The Q&A pod is to the right of the slide. If you have any questions or comments throughout the webinar, please post them there. Use the @ symbol if your question or comment is directed to a specific speaker. Just submit your question, click the bubble icon and it will come right on through. In order to enlarge the slides, click on the four outward facing arrows in the upper right hand corner of your slide to take up the full screen. To return to the original view, you click on those arrows again, they'll be facing inward at that point, that will take you back to this view of the slide.

You can download resources from the Event Resources pod that's in the upper right hand corner next to the slides. We have quite a few resources in that pod today for download. You've got the materials for today's session there and a list of other pieces of information that might be helpful for you. In order to download, just select the file, click the Download File button, and it will open a pop up window that will allow you to save that document to your computer.

One of the resources that's in the event pod today is the CJR Model Toolkit 2.1. When we talk about Patient-Reported Outcomes, that is relevant to our driver on Data-Driven Continuous Quality

Improvement. There's more information about this driver in the driver diagram in the toolkit. This is within that Data-Driven Continuous Quality Improvement driver. It's under Data Collection, Analysis and Reporting Infrastructure, and the toolkit and the appendix for that are on CJR Connect. They're also in the Event Resources pod today.

At this time, I'm pleased to introduce our first speakers. We have with us from the Yale New Haven Health Services Corporation, the Center for Outcomes Research & Evaluation, Demetri Goutos and Kristina Burkholder. Demetri?

Demetri Goutos: Thank you. Hi everyone. My name is Demetri Goutos, and I'm a Project Coordinator at the Yale Center for Outcomes Research & Evaluation. I'm going to give a quick background of the CJR Patient-Reported Outcomes and Risk Variable Collection before my colleague Kristina Burkholder reviews results of the past years and discusses future uses of this data.

The PRO and Risk Variable Data Collection is part of the comprehensive care for joint replacement model based out of CMS' Center for Medicare and Medicaid Innovation. In 2014, there were more than 400,000 hip and knee procedures performed on Medicare beneficiaries, costing more than $7 billion in hospitalizations alone. Despite the high volume of these surgeries, quality and cost of care for these procedures varies greatly between facilities.

The CJR Model uses an episode benchmark price based on the hospital's own history and regional standardized spending. This benchmark can be adjusted based on the hospital's quality score, which is calculated using procedure of complication rates and patient satisfaction scores. Patient-Reported Data Collection is voluntary, but successful reporting can contribute two bonus points towards the hospitals' quality score. Data collected voluntarily as part of the CJR Model was used to develop the hospital level performance measure of Patient-Reported Outcomes following elective primary total hip arthroplasty and total knee arthroplasty measure. This innovative initiative supports CMS' goal to move towards outcome measures that assess outcomes that are more patient centered.

The CJR PRO incorporates four tools to record Patient-Reported Outcomes for eligible hip and knee procedures. Two of these tools, the VR-12 and Promise Global Survey, are general surveys assessing patient satisfaction with their care, mental health scores and quality of life. The remaining tools, the HOOS, JR and KOOS, JR are short forms of longer assessments designed specifically to assess outcomes for hip and knee procedures and have a greater focus on mobility and joint pain.

Along with the PRO instrument data, other data are required for submission. For both preoperative and postoperative submissions, one complete general instrument and one complete joint specific instrument is required as well as the patient's Medicare Health Insurance Claims number, or Medicare Billing Identifier as well as the patient's date of birth. It is important to note the same instruments used for preoperative data collection must be used for postoperative data collection.

Patient risk variables are only required for preoperative submission. Risk variables include race and ethnicity, body mass index or the patient's height and weight, patient-reported health literacy, narcotic use, and patient-reported pain and non-operative lower extremity joint or back. The patient's date of admission and date of procedure are only required for postoperative submissions. The Medicare provider number, the CMS Certification Number (CCN), and the CJR Performance Year are requested data variables that are not required.

Not all patients receiving a hip or knee procedure are eligible for PRO and Risk Variable data collection. Procedures eligible for PRO data collection are based on ICD-10 codes, but because the

patients must be selected for preoperative data collection before ICD-10 codes are assigned, we suggest providers use clinical factors to select patients for data collection. Applicable ICD-10 codes and clinical variables can be found in the PY 5 CJR FAQs available on CJR Connect. But note, the CJR total knee arthroplasty and total hip arthroplasty measure uses diagnosis related groups for patient selection, which are not to be used to select patients for PRO data collection because there's not complete overlap with PRO eligible patients.

On slide 15, you will see the CJR Model timeline for the last five years. For most performance years, the eligible procedure window was between July 1st and June 30th. Preoperative data are collected 90 days before the procedure and postoperative data are collected between 270 and 365 days after the procedure. These collection windows were developed with input from clinical experts. I'll now turn the presentation over to Kristina who will present results from the past performance years.

Kristina Burkholder: Thanks, Demetri. Hi, everyone, and thank you for joining us today. I'm Kristina Burkholder, the Project Lead of the CJR PRO Data Collection with the Yale CORE Team. I'll be sharing some of the results from the voluntary PRO data that's been collected for the last performance years.

This first graph on slide 17 shows the number of PRO records submitted each performance year or PY. Each year, the number of submissions have increased. In PY 1, there was almost 6,000 pre-op records submitted. Please note, that this was only for two months of eligible procedures. In PY 2, there is a little under 35,000 PRO submitted with about 30,000 pre-ops and 3,500 post-op records. The post-op records submitted in performance year two were for the same patients for which preoperative data was submitted in PY 1, hence the smaller number. In PY 3, there were over 45,000 PRO cases submitted about 30,000 pre-ops and 16,000 post-ops. Lastly, in PY 4, there were over 40,000 PROs submitted. It looks like there was a slight decrease in the number of submissions from PY 3 to PY 4. This is partially due to slight reduction in the number of hospitals that participated, and a large amount of duplicative submissions.

This graph depicts the average number of PRO submissions per hospital for CCN. The green line represents the total average number of PROs submitted. The red line is the average number of pre-ops records submitted, and the blue line is the average number of post-op PROs submitted. As you can see, each year, the average number of PROs submitted per hospital has increased. In Performance year one, the average number of PROs submitted was 22 and they were all preoperative cases. In PY 2, the average number of PROs was 112, with 100 pre-op cases and 12 post-op cases. In PY 3, that number increased to 189 with 124 pre-ops and 66 post-op. The average number of PRO records increased again in PY 4 to 209. On average, there were 129 pre-op and about 82 post-op cases submitted for each hospital in PY 4.

As Demetri mentioned earlier, hospitals submit data on a variety of things: risk variable data such as race or literacy as well as PROM data, the HOOS/ KOOS scores about pain and functioning, and mental and physical health from the PROMISE Global or VR-12. Over the next few slides, I'll be discussing what some of those results look like. On slide 19, we have some aggregate results from PY 1 to 4 for a couple of the risk variable data elements.

On the top left is the breakdown of how hospitals collected the PRO data. Most hospitals collect the data via paper 55%. About a third are collecting it electronically, and only about 15% use telephone. For the electronic data collection, some hospitals are using EHRs, some use a vendor or other web-based tool. When asked about their health literacy levels, almost half the patients stated they were

extremely comfortable filling out medical forms. However, 17% stated they were not comfortable at all. Lastly, the majority of patients identified as white.

On the next few slides I'll be showing you the pre versus post-op score for the PROM data. The performance years on the x-axis are the performance year the patient had surgery and the year the pre-op data was submitted. The post-op data represented by the blue bars next to the pre-op data is a corresponding post-op records for those patients. On the first graph, are the average pre and post-op HOOS scores for the hip replacement patients across the performance years. As you can see, on average, patients had about 50 on their pre-op HOOS and about 85 on their post-op. This is about a 35-point change in scores for patients before and after surgery. We can also see the average pre and post-op HOOS scores were consistent across all the performance years. Note, there are no PY 4 post-op scores because that data was just submitted by hospitals a few months ago, and is currently being processed.

Now we can see the average pre and post-op KOOS scores for knee replacement patients across the performance years. As you can see on average, patients had about a 50 on their pre-op KOOS and about an 80 on post-op, the purple bars. This is about 30-point change in scores for patients before and after surgery. You can also see that the average pre-op scores year-to-year are roughly the same. This is also true for post-op data.

On slide 22, we have the average pre and post-op mental health scores for all patients across the performance years. This data comes from the PROMISE Global and VR-12 survey instruments. On average, patients had about a 50 on pre-op and about a 53 on their post-op or the green bars. This is about a three-point change in scores for patients before and after surgery. Again, patient scores on the pre-op and post-op across the performance years remain consistent.

On this slide, we have the average pre and post-op physical health scores for all patients across the performance years. This data also comes from the PROMISE Global and VR-12 survey instruments. On average, patients had about a 40 on the pre-op and a little under 50 on their post-op. This is about nine-point change in scores for patients before and after surgery. As you can see, there is a little more of a difference in physical scores than mental health scores before and after surgery.

We also looked at the number of records with missing data. In PY 3, there were about 3,000 records with missing data. In PY 4, there is less than a 1000.

There are some common reasons that data may be missing, or why might pre-op data not match to claims or post-op data. Hospitals might not have collected the required variables that Demetri mentioned earlier in his presentation. They provided data out of the valid range, or the data was formatted improperly. For example, for the patient identifiers, the hip number or the MBI. Another reason is that the PRO data was collected on a patient who did not have an eligible procedure or the patient was not eligible. For example, the patient was under 65, or was a Medicare fee for service beneficiary at the time of the procedure. One reason that they might not match is that the procedure date provided on the post-op PRO record did not match to claim. Lastly, the preoperative PRO Data was collected after the procedure date.

In the final section of the presentation, I'll walk through the newly developed Patient-Reported Outcome measure. As was mentioned earlier, PRO data collected voluntarily as part of the CJR Model was used to develop this measure. This initiative supports CMS' larger goal to move towards outcome measures that assess Patient-Reported Outcomes.

What was the rationale for developing this measure? Currently, there are over 600,000 total hip and knee replacement surgeries performed each year on Medicare fee-for-service patients. These procedures are intended to improve the patient's pain and physical functioning. One of the ways to assess this is using Patient-Reported Outcomes. This allows patients to have a voice in measure development and the assessment of their quality of care. As we saw with the HOOS and KOOS scores earlier in this presentation, on average, patient scores increased after surgery. However, this isn't the case for all patients. Some patients have a smaller increase after surgery, and some even have a worse score.

Lastly, there's been research which shows variation in clinical practice. Some places have better outcomes for their patients and some have worse. This information would be valuable for providers so that they can take steps to improve care and for patients so they can make better decisions about where they receive care.

CMS developed a hospital level total hip and knee Patient-Reported Outcome Performance Measure or PRO-PM. This measure was created in collaboration with both providers and patients. This measure aims to provide a signal of quality of care for patients who are getting these elective procedures, better informed consumers about quality, increase the transparency in health care quality, and incentivize efforts to practice patient-centered care through public reporting on the hospital level scores.

What is the measure? On slide 29, we have a high level conceptual overview of the hip knee PRO-PM. In order to calculate this, we first look at the patient level outcome as depicted on the left side of the screen. Patients who meet or exceeded a threshold. You look at the patient score before surgery so the pre-op HOOS or KOOS, JR score, and then look at the patient's score after surgery. If the change in the patient's score met or exceeded the threshold, then they had a clinically substantial improvement. This would be considered a good outcome. For example, the threshold for knee patients is a 20-point increase in KOOS score.

Let's say a patient Joe had a pre-op KOOS score of 50. After surgery, he had a data score 65. This would only be an increase of 15 points, and thus, Joe didn't meet the threshold and he would be represented by that orange face. Now let's say Sally also had a preoperative score of 50. But she has post-op score of 80, this would be a 30-point increase, it would be higher than the threshold of 20 and thus she exceeded the threshold and would be represented by the blue smiley face.

Now we take all those individual patient scores, and look at how all the patients did within the hospital as shown on the right side of the screen. The hospital level outcome looks at the proportion of patients who met or exceeded the threshold at that hospital. All the blue smiley faces combined. For this hospital, the risk standardized improvement rate is 60%, or otherwise stated 60% of patients at this hospital had a substantial improvement after their procedure.

Here is some other information about the measure of patients who are used in the measure are the same that are in the CJR PRO data collection. This includes Medicare fee-for-service, age 65 and older and are having the elective primary total hip and knee replacement procedure. As I described on the previous slide, the outcome for the measure looks at the binary improvements in PROs following hip or knee replacement surgery, or the substantial clinical benefit. This means that patients either had the improvement, or they did not. Hip replacement patients need a 22-point improvement on the HOOS, JR and knee replacement patients need a 20-point improvement on the

KOOS, JR. Lastly, the measure is risk adjusted, this means it counts the differences in case mix between hospitals, so it counts for some hospitals having sicker patients than others.

As I mentioned earlier, this measure is developed with input from both patients and providers. It has also gone through the National Quality Forum or NQF, which is an organization which conducts a rigorous review of quality measures like this one, and has gone through public comments. There is general support for this measure by both patients and providers. Particularly, patients have indicated a strong support for a measure which uses patient reported outcomes. Patients' input also helped determine the use of the improvement threshold methodology and thresholds themselves, for what is considered a substantial clinical benefit. And now, I'll turn it back to the learning system.

Laura Maynard: Thank you so much, Kristina. Thank you, Demetri. We appreciate that presentation. We are going to now open things up for a Q&A. I want to encourage participants, if you have questions related to the presentation you just heard, feel free to type those into the Q&A pod and we will triage and answer some of them. I'll turn it back over to Kristina to field some of these questions.

Kristina Burkholder: Great, thank you. Are you able to hear me all right?

Laura Maynard: Yes.

Kristina Burkholder: Great. We did get a couple of questions. The first one here: "Current PRO specifications state that only inpatient episodes are eligible for reporting. Is there a possibility in PY 5.2 the outpatient episodes may be required for PRO reporting?" I'm assuming that this participant is referring to the PY 5 second reconciliation period. We can confirm that outpatient episodes will not be included in PRO data collection for PY 5.

We do have another question here about the list of ICD-10 codes for eligible patients on CJR Connect, again just talking about the PRO eligible patients. On CJR Connect, there's a complete list of ICD-10 codes that are available, and you can find this in the PY 5 FAQ document. We do want to note that sometimes when you're collecting preoperative data on patients, ICD-10 codes might not be available. There's also a flowchart in the FAQ document as well to help providers use clinical factors to identify eligible patients. You can see this on the patient selection flowchart for determining eligible elective primary hip/knee procedures, which is also in the FAQ document on CJR Connect. Now I'm going to send it back to you, Lewin, to start the next webinar. For any questions we did not get to, we will be responding to them after the webinar.

Laura Maynard: Absolutely. We will perhaps have a brief amount of time at the end of this webinar. But most likely, any questions that have come through and not yet been answered, we'll be able to answer on CJR Connect for you. If you have other questions in regard to PRO, go ahead and send them in. Please indicate in your question that is related to PRO. We're going to move now to our second presentation. I'm happy to introduce Sarah Mioduski and Heather Holsey from CMS and they will be presenting on the CJR Model as an Advanced Alternative Payment Model.

Sarah Mioduski: Thank you, hello everyone. Again, my name is Sarah Mioduski, and today Heather and I will be presenting today's webinar. We'll be going over how a CJR hospital can participate in the CJR Model as an advanced APM, and what effect that has on clinicians and affiliated down to collaborators in financial arrangements with CJR hospital. I will also review the requirement for the financial arrangement list and the clinician engagement list. As we just said we will use the excel document to review some examples of how information must be entered into the excel document.

The excel document is also available in your resource tab, and was provided to you in the email regarding the requirements for submission. Heather will then review access to the CJR data portal and the upload instructions for the CJR data portal. Next slide.

When requested by CMS, participant hospitals must provide a list of previous and current collaborators, collaboration agents, and downstream collaboration agents. This list must include specific information on hospitals, affiliated collaborators, collaboration agents, and downstream collaboration agents. If no documentation is submitted, CMS will consider the CJR participant hospital has no financial arrangement established for the model and interact to the non-advanced APM track. Next slide.

Here, this chart shows the various financial arrangements that can be formed. These financial arrangements became effective on January 1st, 2018. We had added tab numbers to this chart to correspond to the excel document. As you can see, it says tab three, tab four and tab five. Tab three corresponds to collaborator information, tab four corresponds to collaboration agent information, and then tab five includes all downstream collaboration agent information. I will review these tabs in the excel document in a few moments. Next slide.

The Quality Payment Program allows clinicians to choose two pathways, either the advanced Alternative Payment Model (APM), or the Merit-Based Incentive Payment System referred to as MIPS. The Alternative Payment Model approach gives an added incentive payment to provide high quality and cost efficient care to be used within the CJR model.

APMs can apply to assist specific clinician condition or a care episode or a population. In the Advanced APM track of the Quality Payment Program eligible clinicians who achieve threshold levels of participation in advanced APM can qualify on APM participant statuses of a qualified practitioner. For that year, the clinician would earn a 5% APM incentive by going further and improving patient care and taking on risk through an advanced APM. As of 2017, the CJR model was eligible for QPP as advanced APM.

Hospitals must choose whether they would like to participate in the model as an advanced APM and if so, they had to attest to CEHRT. On the excel spreadsheet, a hospital will choose whether or not it wants to participate in which track: track one being the Advanced APM track or track two which is the non-advanced APM track. Hospitals who have abide to participate in track one, again, must attest to the use of CEHRT, or Certified Electronic Health Record Technology. CEHRT is 42 CFR Part 414 Section 1305. Hospitals participating in CJR as advanced APMs must use CEHRT to document and communicate clinical care to their patients, or other healthcare professionals. If the hospital does not want to be in the CJR model as an advanced APM, the hospital can either choose track two, or in the event of no response to CMS, so it's not providing as the excel document, the hospital will be considered a track two hospital, so a non-advanced APM. Next slide.

Each participant hospital that chooses CEHRT must contain documentation of their adaptation to CEHRT use, clinician financial arrangement list and clinician engagement list. The clinician engagement list and financial arrangement list will be considered together as an affiliate practitioner list, which is used by CMS to identify eligible clinicians for the qualified practitioner determination under the Quality Payment Program. With the financial arrangement list hospitals that choose track one must submit to CMS a financial arrangement list or attest that there are no individuals to report. We derive the information for financial arrangement list from the excel document that is submitted. It is not a separate list for the hospitals to provide.

The eligible clinician for determination are physicians, non-physician practitioners or therapists. They will be able to be considered for a qualified practitioner determination under QPP. Also, we will put this information for partial qualified practitioners.

At the end of the determination by the Quality Payment Program, a clinician will be considered a QP or a partial QP. For those who are considered a partial QP, CMS will then reach out to the hospital in early 2001, and then the clinician can choose if they would like to be a partial QP or if they want to participate in the advanced program. Next slide.

Again, this is the financial arrangement list. I just went over and just pointing out again, that a hospital must choose track one if they want to attest to CEHRT. Then all the information that is submitted on the excel document will be used for the financial arrangement list and submit for QP determination. Next slide.

The clinician engagement list is a newer part of the CJR model that began in 2018. We added this policy to increase opportunities for eligible clinicians that are supporting the CJR participant hospitals by performing CJR model activities and are affiliated with participant hospitals. They are then maybe consider qualified practitioners or partial QPs. Each clinician, non-clinician practitioner or therapist who is not a CJR collaborator during the 2020 performance year, but who does have a contractual relationship with the participant hospitals based at least in part on supporting the participant hospitals quality or cost goals under the model during 2020, must be added to the clinician engagement list. Hospitals that choose track one must submit to CMS, a clinician engagement list or attest there are no individuals to report.

You will notice that I said previously if a hospital selects track one they must attest to whether or not they have a clinician engagement list or a financial arrangement list to submit. This is a requirement under the regulation. With a clinician engagement list, the list must include information on individuals for the 2020 performance year. The term contractual relationship encompasses a wide range of relationships, whereby a participant hospital engages clinician to perform work that at least in part supports the cost and quality goals of the model. You can look to the term of CJR activities that is defined regulation as those activities support the cost and quality goals of the model.

I will now be sharing my screen to go over some examples of different arrangements that would be submitted to CMS. Just give me one moment as I share my screen. Okay, now you will see the excel document that was provided to you in the submission requirements, in the e-mail and also is in the resources tab of this webinar. As you go over some examples, the first example is going to be a hospital that is in track one that have no financial arrangement, but is submitting a clinician engagement list. This hospital would fill out all the information in question one, as you see here. As I said, they are in track one, so they would select that information from the down arrow, so you see track one or track two. But as I said, they have no financial arrangements list.

The attested to the CEHRT in number three, you can see that they will be proceeding to question four. Note that there's no financial arrangements, there was no sharing arrangements, which is their first level. You indicate no here. Then as the instructions note, you would proceed to question nine. Question nine, is about the clinician engagement list. As I said, for this example, this hospital has the clinician engagement list. What they would do is select yes, for number nine, and then they actually could skip all the way down to tab six. Tab six indicates that if the physician, non-physician practitioner or therapist who is not a CJR collaborator during the 2020 CJR Model performance year,

if they have a relationship with the participant hospital based at least in part on supporting the participant hospitals quality or cost goals under this CJR model, we want them to be included here.

Again, I apologize for the typo. But as you can see, this is where you can provide CMS with clinicians that may not have the financial arrangement, but they are supporting the CJR model. That's what we want you, the participant hospital to do so then they could possibly get that incentive bonus from the QPP program and be considered a qualified practitioner, or if they so choose a partial QP, if that is where their achievement levels get them.

Okay, so we'll go back to the first. Again, as another example, if a hospital has a financial arrangement, so a sharing arrangement with a physician group practice, and that physician group practice also have collaborators (so they have physicians under them that are working for their PGP) and they are in track one, this is how the hospital would fill out the excel document. Again, you're going to want to answer all the questions in question one, including providing the list of the location of your collaborators. That as I just said, that's your PGP, and providing that list and that information, and then also providing the URL where that list is included on the hospital's website.

Then you would proceed down to the next questions. As before, we said that this hospital is in track one, so you would fill that out. Being in track one, you do have to attest to CEHRT, so you would then answer the question for number three. You would then enter yes to track one, so that's your attestation. Then as you scroll down, you'll see that this question says "Has the participant hospital established sharing arrangement under the CJR model?" For that, that's yes, because as we just said, the hostel had established the arrangement with a PGP.

Here, it says type all that apply in the below cell using only options provided below. Here these are the eligible provider entities that can be a collaborator. But as I said in this example, this hospital only has a sharing arrangement with a physician group practice, or with a PGP, so they would be considered their collaborator, so there's their PGP so you're eligible to have that. Then what you're going to do is you just type entities as the instructions indicate in row 31 here.

After indicating a PGP, you could then scroll down to question six. If the sharing arrangement is with an ACO or PGP, so right there it's with the PGP, you would then indicate yes right here, and proceed to question seven. Question seven asked that you type all that apply in the below cell, using the options below, so which entities and/or individuals have established a distribution arrangement with its members or ACO participants? For this, as we indicated, the PGP established that arrangement, and indicating that it is with the member physician. Then as we indicate question nine, as we see that it was on the ACO, so we would proceed directly to question nine. Again, the question nine asks about the clinician engagement list.

For this example, as we noted this hospital does not do clinician engagement lists, but they do need to state that they know because they selected track one. As I noted before, if you are a hospital that is looking track one, and is attesting to CEHRT, you need to indicate whether or not you have clinicians to submit on the clinician engagement list. For this example, that was no. Now that these questions are filled out, you would then proceed to tab three. Tab three is where you're going to provide the physician group practices' name, TIN, NPI, and the rest of their information. Then, once that is finished, you would then proceed to tab four, which is the collaboration agent tab.

This is where a hospital provides the physicians within the practice that they have a distribution arrangement with for the CJR model. Again, you would then apply that information here starting with tab D. The reason that we have it set up this way is because if you have multiple sharing

arrangements with a physician and then if you may also have distribution arrangements, from the PGP to the physician. This way we know which PGP goes with which physician and everything is submitted to us correctly, and then we can provide that information to the Quality Payment Program.

Okay, give me one moment here. Our last example is a hospital that is in track two, but they have physicians to submit -- that they want to submit to the Quality Payment Program, so this is actually not allowed. What track two does is track two is a non-advanced APM track. Though we definitely want this information from the hospitals when you are providing your financial arrangement list as you are required to, these clinicians would not, again, they would not be submitted to the Quality Payment Program for determinations because the hospital is selecting track two. Right here, track two is a non-advanced APM track, and you are not attesting to CEHRT, which is a requirement for the Quality Payment Program.

This hospital would still be required to submit the information to us. We would definitely want the hospital fill out the information in question one as applicable, indicate that they are in track two for the model, and then proceed to filling out the information for the model in the different tabs that they are applicable for, so whether or not they have a PGP for the collaborator. Then if that PGP has arrangements, we would still want all the information as indicated in an excel form, but again that information will not be submitted to the Quality Payment Program.

We are done with the example for right now. Let me just go back to the presenter role here. Okay, so now that we've gone over the examples, I will now be passing the presentation over to my colleague Heather Holsey, who will be going through the rest of the presentation.

Heather Holsey: Thank you Sarah. As a reminder, submissions are due on November 27th, 2020 at 11:59 p.m. Hospitals selecting track two with no financial arrangements do not need to submit. Hospitals that must submit include the following: hospitals selecting track two with financial arrangements established, hospitals selecting track one with no financial arrangements established, and hospitals selecting track one with financial arrangements established. If your hospital submitted this documentation during the August 2020 collection selection and has no changes, your hospital does not need to resubmit. If your hospital did not commit in August 2020 and does not submit during this collection you will be considered a track two hospital with no financial arrangement. The excel documents must be saved and uploaded as a .xls or .xlsx document to the CJR data portal. Next slide please.

Participant hospitals must submit their financial arrangement and clinician engagement list via the CJR data portal. To do this, you must log into the data portal. The URL is shown on the slide. In the event that your hospital does not currently have access to the CJR data portal, you must submit a completed CJR model data request and attestation form as well as two data primary points of contact. Upon receipt of the completed data request and attestation form we will send the primary data points of contact instructions for signing up for the data portal.

Additional guidance may be provided by submitting questions to CJRSupport@cms.hhs.gov or under the Connect site under the data section. Please note that a power point presentation titled CJR Data Portal Upload File Instructions was attached to the email blast that was sent to all participant hospitals on October 28, 2020. The power point presentation reiterates the instructions that I am about to provide. Next slide please.

After you have logged into the CJR Data Portal, you will see Tabs across the top. Select the upload files tab. The upload history table will display the records that have previously been uploaded from your PCM. Next slide please.

Next, you will select your CCN and file type using the drop down menu. You must select the file type collaborator list collection two for this selection. Please note that the file name cannot include any spaces. Next, you will click the select file button to begin the upload process of the excel document. The excel document again must be saved as .xls or .xlsx document. Next slide, please.

You will have the option to comment in the file upload information textbox. If a comment is entered it will be viewable in the update history table at the bottom of the page. Next, select upload as a supporting document to the upload history table. Next slide, please.

After the file is successfully uploaded, a confirmation message will display. Select the close icon or X to close the confirmation message. Once the upload file screen is refreshed, the uploaded supporting document will display in upload history table. Now we will pause for a few minutes to review questions.

Laura Maynard: Thank you so much. We will be taking questions. We have a limited amount of time remaining for some Q&A on this, so I would encourage Heather and Sarah pick the questions that have come in so far that you think you might be able to answer pretty quickly. Those of you that have submitted questions, I encourage you to also submit those questions to CJRSupport@cms.hhs.gov and we'll also be gathering questions from this webinar. If you have additional questions, go ahead and type them in, and I'll turn it back to Heather and Sarah to answer a few.

Sarah Mioduski: Great, and this is Sarah. Are you able to hear me clearly?

Laura Maynard: Yes.

Sarah Mioduski: Great, perfect. Okay, we do have some questions that came in and as Laura said, I'll be trying to do this quickly. But some questions are in regards to how far back you can provide information for these lists. For the financial arrangement list, it is your historical and current list. Any financial arrangements that you had in the CJR model should be provided in the excel document. And then for the clinician engagement list, you would just provide the current date that you have for those specific clinicians. If the contract spans past say 2018 to the end of 2020, that's fine. We just want the current date of those for the clinician engagement list.

Some people asked about why are we doing this so close to the August collection. As you all know, with the PHE going on we just want to share our support for all these guys and the work that you've been doing since March. But given that PHE we definitely didn't want to deter your focus anywhere but on the patient. That's where we kind of pushed back the collection for this year. As you guys know, normally we do it around like May/June, but we decided to do it in August and November of this year. As Heather said, if you have no changes from the August submission, then you do not need to submit another excel document.

Someone asked about if you had multiple changes. I think if you have three or more changes, it's fine. You could update the excel document as many times as you need. We would just take the one excel document version that is uploaded to the data portal as of the due date for the list

Then obviously this is a pretty similar presentation to last year. Someone asked to clarify any changes. The main change is that this information is for the 2020 Quality Payment Program. This information will be submitted to them for this year.

Someone asked is there any way to just add or delete clinicians from your previous submissions. Unfortunately, no, you would have to re-upload the excel document. Then lastly, someone asked about information if you are new to the program, like what track your hospital might be in. I will just reach out to your hospital in terms of the submission of the excel document. If you're not sure and you are kind of at a loss, just reach out to us at CJR Support to allow us to look up that information for you. If you are the point of contact then we can provide you some additional information, if not we can provide you who the point of contact is for your hospital and let you know who you need to contact to make sure that all the information is provided and submitted on the excel document.

I'm going to close this up right now for the presentation. If you have any questions, feel free to submit them to CJR Support. Again, we just want to thank you all for all your hard work and everything that you've been doing for the program since it's begun, and especially the hard work that all the hospitals been doing since the PHE. Thank you again, and I will turn back over to Lewin.

Alicia Goroski: Thank you so much, Sarah, really appreciate it. I want to make a few very quick announcements. I mentioned that we have a webinar coming up next week on the 18th on the additional policy and regulatory revisions in response to the COVID-19 Public Health Emergency. Our registration link is there, and if you have questions to submit with your registration, you can do that at that time, or you can submit questions to CJRSupport@cms.hhs.gov.

On November 2nd, a CJR Connect Security Update was implemented. The slide is going to tell you about that, most of you are already well aware of that. If you require additional information about CJR Connect, please reach out to LS-CJR@lewin.com. CJR News is now coming out every other month, so look for it on the second Tuesday of every other month. It's your one stop shop for all kinds of great information. If you think you should be getting it and you're not, check your spam filter, and please add this address to make sure that you'll receive the CJR News.

Follow up or unanswered questions. If your question wasn't answered, you want to make sure it is. If it's related to today's webinar, send it to LS-CJR@lewin.com. Any technical or programmatic questions, send those to CJRSupport@cms.hhs.gov. If you have any changes to your point of contact, it goes to that same e-mail address, CJR Support. To request a Connect Account, there's the link on this slide to new user registration. You'll notice that the post event survey will pop up for you now, please take a few moments to complete that. We really appreciate that feedback. Many, many thanks to our presenters Kristina Burkholder, Demetri Goutos, the Yale CORE team, to Sarah Mioduski, and Heather Holsey from CMS. Thanks for sharing that great information. And thanks to all of you for participating. Thank you very much.

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[i] *Please note that this transcript is designed to help organizations implement the CJR model. The Center for Medicare & Medicaid Services (CMS), its employees, agents, and staff assume no responsibility for any errors or omissions in the content of this transcript. CMS makes no guarantees of completeness, accuracy, or reliability for any data contained or not contained herein. CMS shall not be held liable for any use of the information described and/or contained herein and assumes no responsibility for anyone's use of the information. This transcript does not serve as advice provided by CMS. CMS and the Department of Health and Human Services Office of the Inspector General have not verified this transcript as compliant with Title 42 CFR Part 510. Although every reasonable effort has been made to assure the accuracy of the information, the ultimate*

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