Medicare Program; Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model
[CMS-5524-P]

SUMMARY

On August 17, 2017, the Centers for Medicare & Medicaid Services published in the Federal Register a proposed rule, CMS-5524-P (82 FR 39310-39333). The rule proposes to cancel the Episode Payment Models and the Cardiac Rehabilitation Incentive payment model, as finalized January 3, 2017, and having effective dates of January 1, 2018. The rule also proposes to revise aspects of the ongoing Comprehensive Care for Joint Replacement model involving mandatory hospital participation, Track 1 clinician eligibility, reconciliation calculation, and telehealth service payment. Page references given in this summary are to the published proposed rule document available at https://www.gpo.gov/fdsys/pkg/FR-2017-08-17/pdf/2017-17446.pdf .

Comments on the proposed rule are due by October 16, 2017.

I. Executive Summary (82 FR 39311)

A. Terms

The Centers for Medicare and Medicaid Services (CMS) defines terms for use in references to relevant prior rules. These terms are applied similarly in this summary.

CJR final rule: refers to a final rule titled "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services" published in the November 24, 2015, Federal Register (80 FR 73274-73554).

EPM final rule: refers to a final rule titled "Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model" published in the January 3, 2017, Federal Register (82 FR 180-651).

March 21, 2017 IFC: refers to an interim final rule with comment period (IFC) titled "Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date" published in the March 21, 2017, Federal Register (82 FR 14464-14466).

B. Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) Incentive Payment Model

The Centers for Medicare and Medicaid Services (CMS) proposes to cancel the EPMs and the CR Incentive Payment Model finalized January 3, 2017, in the EPM final rule and whose effective dates are currently set for January 1, 2018. The EPMs and the CR model were developed by the Center for Medicare and Medicaid Innovation (the Innovation Center) under the authority of section 1115A of the Social Security Act (the Act) and implemented via notice and comment rulemaking. The EPMs were designed to test the cost and quality effects of bundled payments for Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), and Surgical Hip/Femur Fracture Treatment (SHFFT). The CR model was designed to test the cost and quality effects of providing explicit financial incentives to appropriately increase CR service utilization by beneficiaries recently treated for AMI or undergoing CABG surgery. Participation in the EPMs and CR model is mandatory for hospitals in selected geographic areas. To implement cancellation, CMS proposes concomitantly in the rule to rescind all regulations governing the EPMs and the CR model, currently found at 42 CFR 512.

C. Comprehensive Care for Joint Replacement (CJR) Model

Like the EPMs and CR models, the CJR model was developed by the Innovation Center under section 1115A authority and implemented via notice and comment rulemaking. The CJR model was designed to test the cost and quality effects of bundled payments for lower extremity joint replacement (LEJR) episodes. CJR model participation is mandatory for hospitals in selected geographic areas. Current regulations governing the CJR model are found at 42 CFR 510.

CMS proposes multiple revisions to the CJR model.

- The number of metropolitan statistical areas (MSAs) and the mandated CJR model participant hospitals therein would be reduced by nearly one-half; CJR model participant hospitals in newly exempted MSAs could choose to continue as voluntary CJR model participants.

- The subsequent reconciliation calculation for performance year (PY)1 (April 1, 2016-December 31, 2017) [1] would be revised to reflect changes in the CJR model quality composite score that became effective January 3, 2017 (included in the EPM final rule).
- Payment for postoperative visits via telehealth to beneficiaries in their residences would be increased to account for heretofore unreimbursed practice expense.[2]
- A clinician engagement list would be created for participant hospital submission to CMS, expanding the number of clinicians working in CJR Track 1 hospitals that potentially could reach Qualifying Participant (QP) status under Medicare's Quality Payment Program (QPP).

D. Economic Effects

CMS anticipates that EPM and CR model cancellation will impose no costs on providers. CMS estimates that previously projected Medicare savings from the CJR model test[3] will decrease from $294 million to $204 million due to the proposed CJR model changes (Section V. of the rule).[4] CMS believes that a broader focus on care coordination and quality improvement for beneficiaries triggered by CJR model testing will continue regardless of the proposed changes.

II. Background: Relevant Rule History (82 FR 39311-39312)

CMS notes that rule review and revision are within agency discretion, often being exercised after a change in administration occurs. CMS then reprises relevant prior rulemaking history for the CJR, EPM, and CR models.

- The CJR model was finalized November 24, 2015, with an effective date of January 1, 2016, and an applicability date of April 1, 2016 (80 FR 73274).
- The EPMs and CR models were finalized January 3, 2017 (82 FR 180), with an effective date of February 18, 2017, and an applicability date of July 1, 2017.
    - In the January 3, 2017, final rule, regulatory changes to the CJR model were finalized. Generally, the effective dates for changes to the CJR model were the same as the effective date for the EPM and CR models. However, some CJR model changes that were intended to synchronize the CJR model with the EPMs and CR models[5] (the CJR model synchronization amendments) were finalized with an effective date of July 1, 2017, to synchronize with the applicability date of the finalized EPMs and CR models.
- The EPMs and CR models and the CJR model changes were first delayed through a final rule published on February 17, 2017 (82 FR 10961). The effective date for the EPMs and

[1] The CJR model test began April 1, 2016 and is scheduled to conclude December 31, 2020. Performance year (PY)1 ran from April 1, 2016 through December 31, 2016. The remaining four PYs coincide with the subsequent calendar years respectively (e.g., PY2 = calendar year 2017).
[2] Visits are reported using Healthcare Common Procedural Coding System (HCPCS) codes G9481-G9489.
[3] Discussed in the EPM final rule (82 FR 603)
[4] Section headers and their numbering in this summary may differ from those in the proposed rule. All references in this summary to specific proposed rule sections utilize their numbering in the proposed rule.
[5] The amendments in the January 3, 2017 final rule are as follows: Number 3 amending 42 CFR 510.2; number 4 adding 42 CFR 510.110; number 6 amending 42 CFR 510.120; number 14 amending 42 CFR 510.405; number 15 amending 42 CFR 510.410; number 16 revising 42 CFR 510.500; number 17 revising 42 CFR 510.505; number 18 adding 42 CFR 510.506; and number 19 amending 42 CFR 510.515.

CR models was delayed until March 21, 2017 but the applicability date remained July 1, 2017. The effective date for most CJR model changes was also delayed until March 21, 2017, but the effective date for the CJR model synchronization amendments remained July 1, 2017.

- The EPMs and CR models and the CJR changes were further delayed by the March 21, 2017 IFC (82 FR 14464). The effective date for the EPMs and CR models was changed to May 20, 2017, and the applicability date was delayed until October 1, 2017. The effective date for most CJR model changes was also changed to May 20, 2017, but the effective date for the CJR model synchronization amendments was changed to October 1, 2017.
- The EPMs and CR model and the CJR model changes were subjected to a third delay published as a final rule on May 19, 2017 (82 FR 22895). The effective date for the EPMs and CR models was finalized as May 20, 2017. May 20, 2017, is also the effective date for most CJR model changes (other than the CJR model synchronization amendments). The applicability date for the EPMs and CR models was changed to January 1, 2018; the effective date for the CJR model synchronization amendments also was changed to January 1, 2018.
- The current proposed rule was published August 17, 2017; it proposes to cancel the EPMs and CR models and to make substantial new revisions to the CJR model. The effective date for most CJR model changes remains May 20, 2017, with the exception of the CJR model synchronization amendments which are still effective January 1, 2018.

III. Provisions of the Proposed Regulations (82 FR 39312-39327)

A. Proposed Cancellation of EPMs and CR Incentive Model

CMS reports receiving 47 responses to the March 21, 2017 IFC. Many responses included out-of-scope comments, addressing topics beyond the delayed effective dates (for the EPMs, CR model, and amendatory CJR model provisions) that were open for comment. Commenters' concerns included the following:

- mandatory models that would force rapid care redesign with unintended consequences;
- episode pricing methodology incorporating unrelated services into the bundled payment;
- rapid progression from hospital-specific to entirely regional-based target pricing;
- absence of quality measures uniquely relevant to the SHFFT model;
- continued direct supervision requirement for CR model services; and
- precedence rules for dealing with overlap of the EPMs with Bundled Payments for Care Improvement (BPCI) episodes.

In the May 19, 2017, final rule further delaying EPM and CR model testing, CMS described their option to consider the March 21, 2017 IFC comments in future rulemaking. Combined with stakeholder feedback, these comments have led CMS to conclude that the EPM and CR model designs were insufficiently developed for January 1, 2018, implementation. CMS, therefore, proposes cancellation of the EPMs and CR model, rescinding all of 42 CFR Part 512. **CMS seeks comment on the proposal to cancel the EPMs and CR incentive payment model.** CMS considered altering these models to a voluntary design but decided the time remaining until the January 1, 2018, effective date of the models did not allow sufficient time for provider

preparation for participating in significantly revised models. **CMS solicits comment on the alternative to revise and retain the EPMs and CR models.** CMS notes that the Innovation Center expects to develop new, voluntary bundled payment models similar to the EPMs and to BPCI episodes during calendar year (CY) 2018[6] and may consider pursuing a new, voluntary CR incentive payment model in the future. CMS also notes that notice and comment rulemaking often is not required for voluntary bundled payment programs.

B. Proposed Changes to the CJR Model Participation Requirements

Stakeholder feedback and responses to the March 21, 2017 IFC also led CMS to reassess the CJR model, particularly the mandatory participation structure.

1. Current CJR Model Participation Design

The model was created to test bundled payment episodes for LEJR procedures, expensive and commonly performed on Medicare beneficiaries, across a diverse mix of hospitals and locations. CJR model testing was expected to producing a robust data set, allowing identification of inefficient utilization patterns and of successful methods for incentivizing quality improvement. Model design elements included the following:

- sample stratification by MSA population size and by MSA average, wage-adjusted, historic LEJR episode payments;
- random MSA selection within the strata, incorporating intentional oversampling of high-cost MSAs;
- exclusions for low LEJR episode volume and for overlap with BPCI orthopedic episodes;
- detecting a 2 percent reduction in wage-adjusted LEJR episode spending at one year; and
- assuming a 20 percent chance of false positive results and a 30 percent chance of false negative results.

Applying these and other design elements,[7] led to identification of 196 eligible MSAs from which 67 were selected for CJR model testing at all acute care hospitals within those MSAs. PY1, which included upside risk only (shared savings potential) for participant hospitals, began April 1, 2016, and ended December 31, 2016. PY2 includes all of 2017; beginning with PY2, hospitals bear two-sided risk (shared savings and Medicare repayment potential) for the remainder of the model.

2. Proposed CJR Model Participation Design

Having considered stakeholder feedback and public comments, CMS revisited the assumptions and design elements of the CJR model. Model review incorporated results from BPCI LEJR episodes suggesting that a 3 percent reduction in Medicare fee-for-service spending is possible.[8] CMS states that by substituting detection of a 3 percent spending reduction for the 2 percent decrease assumed in the original model design, the number of MSAs subject to mandatory

[6] For the remainder of this summary, all references to years correspond to calendar years unless otherwise specified.
[7] Full details of CJR model design are discussed in the CJR final rule (80 FR 73274 through 73554).
[8] The Year 2 BPCI report is available for download at https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf .

participation can be reduced from 67 to 34 MSAs. CMS believes that robust data with statistical power similar to the original CJR model design still will be generated by a smaller cohort of mandatory MSAs into which high cost MSAs are preferentially selected. CMS observes, however, that the proposed model's evaluation plan will differ somewhat from that for the original model. The new, continued mandatory MSA cohort was generated by rank ordering the originally selected 67 MSAs by average wage-adjusted historic LEJR payments, then choosing the 34 MSAs with the highest wage-adjusted LEJR payments (see section III.B.1. of the rule).

CMS assessed the heterogeneity of the continued mandatory MSA cohort using the MSA population size median derived from the 196 CJR model eligible MSAs nationwide; approximately one-half of the 34 mandatory MSAs fell above and below the reference size as did approximately one-half of the 33 formerly mandatory MSAs. CMS also examined the average wage-adjusted historic LEJR payment distributions within each of the 34 continued mandatory MSAs. CMS found that each continued mandatory MSA contained hospitals with average cost LEJR episodes along with higher cost hospitals, potentially allowing evaluation of the modified model test results for generalizability.

After reviewing the current CJR model design, CMS proposes to revise the model to include 34 (continued) mandatory participation MSAs and 33 voluntary (formerly mandatory) participation MSAs (Tables 1 and 2, respectively, in the proposed rule).

3. Low-Volume, Rural, and New Hospital Exclusions from Mandatory Participation

CMS proposes to implement exceptions from mandatory participation for low-volume and rural hospitals in the continued mandatory MSAs. Definitions are proposed as follows:

- Low-volume hospital: a hospital identified by CMS as having fewer than 20 LEJR episodes in total across the three years from which data were derived to create historic LEJR episode payments, and
- Rural hospital: an IPPS hospital that is in a rural area or rural census tract or has been reclassified as a rural hospital.[9]

CMS proposes that low-volume and rural hospitals would be automatically excluded from continued mandatory CJR model participation. CMS also notes that any new hospital with a new CMS Certification Number (CCN) coming into existence after the voluntary participation election period (section III.4.b of this summary) would not be required and/or eligible to join the CJR model. Finally, CMS indicates that the mandatory participation status for an entity formed in a reorganization event (e.g., merger) operating under an established CCN will remain unchanged by the event.

4. Voluntary CJR Model Participation (Opt-in)

a. Eligibility

CMS proposes that three hospital groups would be eligible for CJR model participation on a voluntary basis:

[9] The proposed rule refers to 42 CFR 500.2 for a definition of rural that in turn refers to 42 CFR 412 for more detail.

- all hospitals in mandatory MSAs that become voluntary MSAs with CJR model redesign;
- low-volume hospitals in continued mandatory MSAs (Table 3 in the proposed rule); and
- rural hospitals in continued mandatory MSAs.

b. Election to Opt-in

CMS proposes that hospitals in the above groups would each have a one-time opportunity to elect to participate voluntarily in the redesigned CJR model for PYs 3, 4, and 5. Each hospital would be required to notify CMS of its election to participate (opt-in). CMS proposes a CJR model voluntary participation election period beginning January 1, 2018, and ending January 31, 2018. A hospital electing to opt-in must submit a voluntary participation election letter to CMS during this period. For hospitals who properly opt-in, there would be no CJR model episode disruption in PY2. Hospitals eligible for voluntary participation who do not notify CMS of an election to remain in the CJR model would be withdrawn automatically and permanently from the model effective February 1, 2018. For such hospitals, all PY3 episodes up to and including February 1 would be canceled and no future episodes initiated; there would be no PY3 reconciliation payment or repayment amount. CMS considered whether adopting a voluntary election period ending December 31, 2017 (before PY3 begins), would be less confusing or less burdensome to hospitals than the proposed January 1-31, 2018, election period. CMS rejected the alternative, believing that hospitals would have insufficient time to make an informed voluntary participation election by the deadline, given the timeline of the current rulemaking process. **However, CMS seeks comment on the proposed and alternative voluntary election periods**. In summary, CMS believes that the opt-in voluntary election approach as proposed would be less burdensome and less ambiguous for hospitals than an opt-out approach. **CMS seeks comment about the adoption of an opt-in approach versus an opt-out approach.**

c. Voluntary Participation Election Letter

CMS proposes that a properly submitted voluntary participation election letter also would serve as the hospital's CJR model participant agreement with CMS; the agency intends to create a template letter. Along with hospital identification and contact information, the proposed letter would include certifying statements that the hospital will comply with all CJR model requirements (and all other laws and regulations applicable to model participation), and that any data or information submitted to CMS will be accurate, complete, and truthful. CMS further proposes that the letter must be signed by the hospital administrator, chief financial officer, or chief executive officer. Once CMS receives a timely and valid letter, the hospital would be required to participate in all activities related to the CJR model for the remainder of the model's duration, unless the hospital's participation is terminated sooner.[10] **CMS seeks feedback on the certifications proposed for inclusion in the voluntary participation election letter.**

d. Voluntary Participation Proposal Impact

CMS states its commitment to recognizing investments already made by current CJR model participant hospitals while the agency pursues reducing mandatory participation burden. CMS

[10] The proposed rule is otherwise silent about termination from the model. Reasons for CMS to terminate a hospital from the model are discussed in the CJR final rule (e.g., non-compliance with documentation requirements).

believes that concentrating mandatory participation on high cost MSAs allows the Innovation Center to focus on areas where the potential impacts of care coordination and care redesign are greater. The foregoing considerations were key drivers in CMS' decision-making about the feasibility and appropriate level of CJR model mandatory participation. In addition, financial impact analysis disclosed the following:

- The proposed changes in mandatory participation reduce previously estimated Medicare program savings from CJR model testing by $90 million.
- Making CJR model participation voluntary in all 67 current MSAs eliminates Medicare program savings and likely would increase costs.
- Making participation mandatory for the 34 high cost MSA cohort and not allowing any voluntary participation produces a reduction in projected Medicare savings of $30 million.

5. Required CJR Model Evaluation Participation

CMS notes that, regardless of the proposed changes to the CJR model, valid conclusions about the impact and generalizability of the model will be possible only if a robust data set is generated. The risk of poor participant cooperation with evaluation activities may be greater where the model is voluntary rather than mandatory. CMS, therefore, proposes that the agency may take remedial action for failure to participate in evaluation activities conducted by CMS and/or its contractors. Potential remedial action for evaluation activity non-compliance would be applicable to participant hospitals, and/or one of their collaborators, collaboration agents, or downstream collaboration agents. **CMS seeks comment on this proposal for remedial action.**

6. Incentivizing CJR Model Participation

The CJR model as proposed will include a mix of voluntary and mandatory participants. CMS seeks ways to encourage potential voluntary participants to opt-in to the revised CJR model, as well as to incentivize all participants to advance LEJR episode care improvements, innovation, and quality. Relatedly, CMS reprises the total limit on gainsharing payments by hospitals[11] and notes that limits also apply to distribution arrangements and downstream distribution arrangements. **CMS solicits comments on the CJR model gainsharing caps and appropriate alternatives.**

C. Maintenance of ICD-CM Codes Used in CJR Model Quality Measures

CMS perceives that it may have inadvertently led CJR model providers to believe that ICD-CM codes mentioned in discussing the Hip/Knee Complications measure in the EPM final rule[12] were being defined as exclusive and as applicable for the duration of the CJR model, rather than subject to periodic updates, as is routinely done for all CMS quality programs. CMS now

[11] Total payments to physicians, non-physician practitioners, physician group practices, and non-physician practitioner group practices must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule for items and services furnished during the PY in which savings are generated (§510.500(c)(4)).
[12] See 82 FR 389.

proposes to clarify that participants must use the applicable ICD-CM code set that is updated and released annually by CMS.[13]

D. CJR Model Reconciliation Following a Hospital Reorganization Event

CJR model annual reconciliation calculations are hospital-specific and the quality-adjusted target price is specific to the relevant performance year. CMS proposes to clarify the conduct of reconciliation calculations that apply when a participant hospital undergoes a reorganization event such as acquisition, merger, or divestiture.

- Separate reconciliation calculations (during both initial and subsequent reconciliations for a given PY) are made for each predecessor participant hospital for episodes where anchor hospitalization admission occurred before the effective date of the reorganization event.
- Reconciliation calculations (during both initial and subsequent reconciliations for a given PY) are made for each new or surviving participant hospital for episodes where the anchor hospitalization admission occurred on or after the effective date of the reorganization event.

E. Postoperative Telehealth Visit Price Adjustment for Practice Expense

In the CJR final rule, CMS waiver authority was used to allow payment for postoperative visits made to beneficiary's residence via telehealth technology; visits are reported with HCPCS codes G9481-G9489. Pricing for the G-codes has not included practice expense (PE) payment, as CMS believed PE expenses to be marginal or already paid for under other codes. CMS has been convinced by stakeholders that in fact PEs accrue during the telehealth visits. CMS, therefore, proposes to price CJR model postoperative home telehealth visits using facility-level PE values for the corresponding in-person visits. The PE payment would be added to the work and malpractice payments for the corresponding services to set G-code pricing. The telehealth service descriptors and corresponding Current Procedural Terminology codes are listed in Table 5 in the proposed rule.

F. Clinician Engagement Lists

Some CJR model hospitals participate in an Advanced Alternative Payment Model (APM) track (Track 1), allowing certain clinicians delivering LEJR episode care to beneficiaries, to accrue credit towards reaching QP status and earning payment incentives. Track 1 CJR model hospitals must attest to their use of Certified Electronic Health Record Technology and must periodically provide clinician financial arrangements lists to CMS. The list is a type of "Affiliated Practitioner list", by which CMS identifies clinicians potentially eligible for QP status. Each listed clinician is engaged in a contractual (sharing) arrangement with the hospital to support the quality and/or cost goals of the CJR model.

Responding to stakeholders, CMS proposes to create a "clinician engagement list" to capture any provider whose arrangement with the hospital is not financially linked to the CJR model but is tied to model quality and/or cost goals. CMS proposes to consider the clinician engagement list

[13] The code set is posted at https://www.cms.gov/medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html .

as a type of Affiliated Practitioner list, to be submitted to CMS simultaneously with the clinician financial arrangements list. The engagement list must contain identifying information and contractual start and end dates for each clinician listed. For each clinician, the hospital must also maintain documentation of contracts and any other information describing CJR model-related activities; the documentation must be retained at least 10 years in a manner readily accessible for CMS or other auditors. Hospitals without any clinicians on an Affiliated Practitioner list (clinician financial arrangements list and/or clinician engagement list) must so attest to CMS.

G. Quality Composite Score Use During CJR Model Reconciliation for PY1

Initial reconciliation calculations for CJR model hospitals for PY1 were completed in the first quarter of 2017 in accordance with the CJR final rule; the process includes use of the hospital's composite quality score. The PY1 subsequent reconciliation calculation will be conducted in early 2018. Changes to the model's composite quality score determination were finalized in the EPM final rule but their effective date was delayed until May 20, 2017 (thereby not available for the PY1 initial reconciliation process). The changes cause more generous criteria to be used in determining the quality improvement score.[14] CMS seeks a strategy for transitioning to the situation where the initial and subsequent reconciliation calculations will use identical composite quality score determinations. CMS proposes a transition that begins with use of the amended quality scoring for PY1 subsequent reconciliation; this is likely to increase the expected differential between the PY1 initial and subsequent results.[15] CMS describes an alternative of delaying the transition until the initial PY2 reconciliation; both PY1 reconciliations would utilize the same quality scoring and reconciliations for PY2 (and beyond) would use the same, amended quality scoring. A transition that occurs across years (e.g., PY1 identical but different from PY2 approaches) likely would require a crosswalk to ensure consistent quality measurement and would be more complicated than a transition made between PY1 calculations. **CMS seeks comment on its transition proposal and the alternative to change across years.**

H. Use of CMS Price (Payment) Standardized Detailed Methodology

In response to stakeholder questions, CMS proposes clarifications for describing use of the CMS Price (Payment) Standardized Detailed Methodology in the calculation of target prices and actual episode spending. This methodology, taken from the Hospital Value Based Purchasing (HVBP) program, allows accounting in hospital-specific formulas for special payments (e.g., indirect graduate medical education). Wording changes are proposed to emphasize that the approach used in the CJR model is derived from but then modified when compared to the HVBP approach, and that actual episode payments are standardized. (See §510.300(b)(6) and §500.2.)

IV. Regulatory Impact Analysis (82 FR 39327-39331)

This rule does not reach thresholds for economic significance or major rule. CMS anticipates no effect on beneficiary freedom of choice. CMS believes the rule allows focused continuation of

[14] Under the amended quality scoring, improvement points are awarded for an increase of 2 deciles rather 3 deciles as originally required.

[15] Other factors in the differential include accounting for CJR model overlap with other CMS models and for post-episode spending adjustments.

the CJR model with a reduced mandatory scope while still allowing meaningful model evaluation. Going forward, CMS intends to focus resources towards developing new voluntary models. Table 6 in the proposed rule, reproduced below, summarizes the estimated impact of proposed CJR model revisions over the remaining years of the model. This impact analysis builds upon that presented in the EPM final rule; modifications include:

- updating for a smaller mandatory participant cohort concentrated on higher cost MSAs
  - a decrease in mandatory hospital count from about 700 to about 400 is expected;
- adjustments for hospitals that may opt-in to voluntary participation, a cohort concentrated on lower cost MSAs
  - 60-80 hospitals are expected to opt-in;
- assuming no low-volume and one rural hospital across all MSAs will opt-in; and
- accounting for provider risk aversion, particularly for two-sided risk-bearing.

CMS assumed that no shifting of LEJR episodes from remaining CJR model hospitals to low-volume or other non-participant hospitals would occur; **CMS seeks comment on this assumption.** CMS projects that the hospital participant total will be 450-470 for PYs 3, 4, and 5.

TABLE 6: COMPARISON OF INITIAL ESTIMATE OF THE IMPACT ON THE MEDICARE PROGRAM OF THE CJR MODEL WITH REVISED ESTIMATES

(Figures are in $ millions, negative values represent savings)

Year	2018	2019	2020	TOTAL
Initial CJR estimate	-61	-109	-294	**-294**
Revised CJR estimate	-38	-77	-204	**-204**
Change	22	32	90	**90**

Note: The initial estimate includes the changes to the CJR model as finalized in the EPM final rule (82 FR 603). The 2016 and 2017 initial estimates are not impacted by the changes to the CJR model in this proposed rule. The total column sums the effects for 2018-2020. Totals do not necessarily equal the sums of rounded components.