

PUBLICATION

New Bundled Payments Are a Go... For Now

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CMS issued a final rule on January 3, 2017, implementing three new episode payment models (EPMs) and a Cardiac Rehabilitation (CR) incentive payment model under the authority of the Center for Medicare & Medicaid Innovation (CMMI or Innovation Center). The rule, entitled, [Advancing Care Coordination Through Episode Payment Models \(EPMs\); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model \(CJR\)](#), also provides clarifications to the CJR model already in place for consistency with the new EPMs.

The mandatory models included in the final rule were developed by CMMI. President Trump's administration has been critical of the Affordable Care Act (ACA), which established CMMI, as well as the mandatory programs developed by CMMI. This causes some uncertainty about the future of many of these programs, including the EPMs and CJR. On January 20, 2017, White House Chief of Staff Reince Priebus issued a [memorandum](#) that affects regulations not yet submitted to or published by the Federal Register, as well as regulations published in the Federal Register but not yet effective as of the date of the memo. According to the Priebus memo, all pending regulations will be delayed for at least 60 days to allow the new administration to review and determine the future disposition of each regulation. The 60-day delay is the minimum time at this point; it may be extended. Additionally, considering discussions surrounding the administration's intention to repeal and replace the ACA, many programs established by CMMI may be under threat as well. The potential for upheaval causes uncertainty for the hospitals participating in these programs, but until CMS issues alternate guidance or the administration takes formal action to further delay or modify the mandatory nature of the bundled programs, participant hospitals should continue to plan for implementation.

Participation in the final bundled payment rule programs is mandatory for the hospitals located in the selected Metropolitan Statistical Areas (MSAs). CMS separately published a list that identifies the MSAs considered for the bundled payment programs and the programs, if any, for which each MSA has been selected. Hospitals should consult this chart to ensure they are prepared to implement any programs that may begin this year.

Episode Payment Model

Under the final rule, acute care hospitals receiving payment under the Inpatient Prospective Payment System that are located in selected MSAs are required to participate in retrospective EPMs for Medicare fee-for-service beneficiaries receiving care during Acute Myocardial Infarction (AMI) and Coronary Artery Bypass Graft (CABG) episodes. The Surgical Hip and Femur Fracture Treatment (SHFFT) model will be implemented in CJR MSAs. An EPM episode for AMI, CABG or SHFFT is initiated by an inpatient admission to a participating hospital and ends 90 days post discharge. An episode of care includes the inpatient stay and related care covered under Medicare Parts A and B, including hospital care, post-acute care and physician services, provided within 90 days of discharge. CMS will continue to pay participating hospitals, providers and suppliers according to the current Medicare fee-for-service rates for the service provided. The inpatient hospital bears the responsibility for coordinating the beneficiary's care during the episode and, depending on outcomes, would either receive a reconciliation payment reflecting the savings achieved or would be responsible for repaying CMS for costs above the established targets.

As discussed in our [summary of the proposed rule for EPMs](#), CMS hopes that these models will improve quality of care for beneficiaries while reducing Medicare spending during episodes of treatment of AMI, CABG

and SHFFT through financial accountability. Under these new models, a hospital in which a patient is admitted for care due to a heart attack, bypass surgery or surgical hip/femur fracture treatment would be accountable for the cost and quality of care provided to Medicare fee-for-service beneficiaries during the inpatient stay and for the 90-day period after discharge. The final rule makes some modifications to the program but does not go as far as many commenters had hoped. The following is a summary of some of the key provisions in the final rule:

Effective Date and Downside Risk

The EPM program's proposed effective date of July 1, 2017, is unchanged in the final rule, although the future of these programs under the new administration remains to be seen. The five-year performance period will continue through December 31, 2021. The AMI and CABG EPMs will be implemented in 98 MSAs and the SHFFT EPM is mandatory in the same 67 MSAs currently participating in the CJR model.

Some changes in the final rule address concerns raised by commenters. To provide hospitals with additional time to become successful in these new models, CMS delayed downside risk for AMI, CABG and SHFFT models until performance year 3, beginning on January 9, 2019. The final rule also provides the option of downside risk beginning in performance year 2 (January 1, 2018) for hospitals wishing to offer collaborating suppliers participation in an Advanced Alternative Payment Model (APM) as part of the Quality Payment Program under MACRA. The stop-loss and stop-gain limits and applicable discount factors were altered to correspond with this change.

Inpatient-to-Inpatient Transfers

Although CMS remains concerned about inappropriate inpatient-to-inpatient transfers that may result, the agency has adopted a simplified policy regarding initiation and attribution of AMI and CABG episodes that involve a patient transfer at the beginning of AMI care. Generally, attribution of an AMI or CABG episode looks to the hospital that discharges the beneficiary under an AMI MS-DRG, PCI MS-DRG with AMI ICD-CM diagnosis code or CABG MS-DRGs. If that hospital is an AMI or CABG model participant, that episode of care is attributed to it. If that hospital is not an EPM participant, regardless of where the patient was transferred from (participant or non-participant hospital) the beneficiary's care is not attributed to an AMI or CABG episode.

Payment Policy Waivers

To encourage coordinated care in an efficient manner and improve communication and treatment consistency for beneficiaries, consistent with the current bundled payment programs at CMMI, certain existing payment system requirements are waived under the EPMs. These include: a waiver of the requirement for a three-day inpatient hospital stay prior to admission for a covered skilled nursing facility (SNF) stay under certain conditions beginning in performance year 3 for the AMI model; allowing payment for certain telehealth services provided to a beneficiary in his or her home; and allowing payment for certain types of physician-directed home visits for non-homebound beneficiaries. Notably, with respect to the SNF 3-day waiver, the final rule attaches potential financial liability to the participant hospital if the waiver requirements are not met (i.e., if a beneficiary is discharged to a non-qualifying SNF and proper notification regarding the financial responsibility for non-covered services is not provided). As discussed below, this financial liability has been added to the CJR program as well.

Sharing Arrangements

Consistent with the current bundled payment programs and the goal of facilitating coordination among providers, the final rule provides a mechanism for participant hospitals to enter into certain financial arrangements with collaborating providers, suppliers, other hospitals and Accountable Care Organizations

(ACOs) who are engaged in care redesign with the hospital to share savings that are generated under the program. Under these arrangements, a participant hospital may share with collaborating entities payments received from Medicare as a result of reduced episode spending and hospital internal cost savings. The downside of these arrangements may be shared as well, with the participant hospital holding collaborating entities responsible for their portion of increased episode spending as applicable.

Although requested by commenters, no waivers of any fraud and abuse requirements are established in the final rule. CMS notes that any such waivers for purposes of testing these models would be issued by CMS and the HHS Office of the Inspector General (OIG) in separate rulemaking.

Quality Measures

Consistent with other bundled payment programs, CMS is tying payment to quality for the EPMs. The participant hospital's performance in certain quality metrics, as well as effective cost saving measures, will impact the retroactive reconciliation payment to a hospital or repayment to CMS once two-sided risk is in place in performance year 3. Hospitals and other providers and suppliers continue to be paid under traditional Medicare fee-for-service during a performance year. The actual episode payment is calculated by combining the Medicare claims payments for services furnished to an eligible beneficiary during an episode. The actual episode payment will then be reconciled against an established EPM quality-adjusted target price. If positive, the amount of this calculation is paid to the EPM participant as a "reconciliation payment" provided the participant achieved a quality category of "acceptable" or higher. If the calculation results in a negative amount the participant hospital is required to make a "Medicare repayment" beginning with episodes ending in performance year 3 of the EPMs. This is a modification from the proposed rule, under which repayment would have started in the beginning of the second quarter in performance year 2.

The quality measures include:

AMI

- MORT-30-AMI: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization (National Quality Forum NQF #0230)
- AMI Excess Days: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (acute care days include emergency department, observation and inpatient readmission days)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPHS) Survey (NQF #0166), linear mean roll-up (HLMR) scores like CJR
- Successful voluntary reporting Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization (NQF #2473) (Hybrid AMI Mortality)

CABG

- MORT-30-CABG: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following CABG (NQF #2558)
- HCAPHS Survey (NQF #0166), HLMR scores like CJR
- Successful voluntary reporting of the Society of Thoracic Surgeons (STS) CABG composite score (NQF #0696) is a comprehensive NQF-endorsed composite measure and will be weighted at ten percent of the composite quality score for those hospitals that report this voluntary measure

SHFFT

- Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Complications: Hospital Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA and/or TKA (NQF #1550)

- HCAPHS Survey (NQF #0166)
- Successful Voluntary Reporting of Patient-Reported Outcomes

CJR Updates

The CJR program has been in place since April 1, 2016. Similar to the EPMS, CJR is a retrospective bundled payment model for lower extremity joint replacement (LEJR) procedures focused on improving quality of care for beneficiaries while providing cost-effective treatment. The program remains in place in the same 67 MSAs, with the addition of the SHFFT EPM implementation in the same 67 areas beginning July 1, 2017. Some of the final rule's modifications are rather significant for CJR and others are meant merely to provide consistency among EPM models and CJR.

One of the more significant changes to the CJR model is the expansion of the list of parties eligible for sharing arrangement collaboration. The list of CJR collaborators now also includes, but is not limited to, Accountable Care Organizations, physician group practices, therapy group practices and critical access hospitals. As of July 1, 2017, the term *collaborator agreement* will no longer be used under CJR, but is being replaced by *sharing arrangements*, which include financial arrangements between CJR participant hospitals and collaborators. Additionally, the regulations now permit an expansion of distribution arrangements. Previously, CJR limited distribution arrangements to individual physician group practice members who furnished a billable service to a CJR beneficiary during the performance year, with a limit on the amount the physician could receive. The updated CJR regulations now permit gainsharing payments to be distributed in any manner that complies with the physician group practice exception to the physician self-referral (Stark) law. This change permits distributions even to physicians who did not care for CJR beneficiaries during the performance year and is not subject to the same limitation on payment to the physician.

Similar to the EPMS, CMS is developing two tracks for the CJR program, with one that will allow CJR to qualify as an Advanced APM under the Quality Payment Program by including attestation to the use of certified electronic health information technology functions. Participation in the qualifying track does not impact any of the other requirements under the CJR model.

A participant hospital's use of the SNF 3-day waiver is updated to comply with the requirements under EPMS. This notable change makes participant hospitals financially liable for SNF stays if the requirements of the beneficiary notification for use of the waiver are not followed. The notification requires that if a beneficiary does not have a qualifying inpatient admission and is discharged to a SNF that does not have a rating of three stars or better on the Five-Star Quality Rating System, the hospital must provide notice to the beneficiary of his or her financial liability for the SNF services. If such notice is not provided, the participant hospital is liable financially.

Other revisions include clarification on the exclusion of beneficiaries participating in selected ACOs and changes to the target pricing methodology to include reconciliation and repayment amounts for performance years 3, 4 and 5. CMS included revisions to the quality adjustment to incorporate improvement as well as absolute performance. These changes to the CJR model require participant hospitals to review their current programs to ensure they will meet these modifications when they become effective on July 1, 2017.

Cardiac Rehabilitation Incentive

The Cardiac Rehabilitation Incentive Payment Model (CR) is meant to encourage beneficiary utilization of cardiac rehabilitation/intensive cardiac rehabilitation services during the first 90 days following an AMI or CABG episode of care. Participants will include acute care hospitals in 90 selected geographic areas, 45 of which are also MSAs selected for the AMI and CABG models. In doing this, CMS seeks to evaluate the impact of cardiac rehabilitation on patient outcomes following these procedures both in conjunction with the EPMS as well as on its own. The performance period for the CR model is the same as the EPMS; the first performance period will

begin on July 1, 2017, and will continue for five performance years, ending on or about December 31, 2021. It is estimated that 1,320 hospitals will participate in the CR model.

Under the CR model, the incentive payment is meant to facilitate efforts to coordinate cardiac rehabilitation and support beneficiary adherence to the cardiac rehabilitation treatment plan to improve cardiovascular fitness. The CR incentive will be paid retrospectively to hospitals based on the total cardiac rehabilitation services used by beneficiaries attributed to the participant hospitals. The two-part CR incentive payment includes: \$25 per cardiac rehabilitation service for each of the first 11 services paid for by Medicare during the care period for an AMI or CABG care episode; an increase to \$175 per service after 11 services paid by Medicare for the beneficiary during the care period for an AMI or CABG episode.

In response to commenters, CMS has expanded some flexibility to the CR program. First, the final rule includes a waiver to the definition of *physician* as applied to practitioners eligible to supervise cardiac rehabilitation services in participant hospitals so that non-physician practitioners can perform supervisory physician functions for CR services. Also, the beneficiary engagement incentives under the CR model are expanded to include the incentives permitted under the EPM and CJR programs.

Comments

The regulations freeze imposed by the new administration is not unusual for the beginning of a new presidency. However, the discussions surrounding the future of the ACA as a whole, as well as many of its individual provisions, raises the uncertainty level. It is unclear when CMS will provide further guidance on the future of CMMI and more specifically these mandatory programs. Many hospitals have already implemented CJR and must now prepare to adjust their programs based on the new guidance issued in this final rule to ensure that they remain compliant. Other hospitals will prepare to implement new programs without knowing whether the program will be in place as of its intended effective date or whether the programs will remain mandatory. In the meantime, providers are faced with the challenge of preparing for the start of the new mandatory bundled programs, a resource and time intensive process, amidst uncertainty around what the future may hold. In an effort to prepare for the programs without official change to the current timeline and/or structure, a review of a hospital's performance under the quality measures CMS has included in the models can provide a glimpse into how the hospital may most effectively implement such a program when, or if, the regulations are effective.