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CMS has cancelled its Medicare hip fracture and cardiac bundled payment and incentive payment models that were scheduled to begin on January 1, 2018, acknowledging criticism from stakeholders that the models needed work and were not ready for prime time. At the same time, CMS has finalized changes to its Comprehensive Care for Joint Replacement Model, making participation voluntary for hospitals in almost half of the selected geographic areas, including all low-volume and rural hospitals (Final rule, 82 FR 57066, December 1, 2017).

Program cancellations. The Final rule cancels the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) Incentive Payment Model and rescinds all related regulations. The EPM Final rule (82 FR 180), issued in January 2017, established three Medicare bundled payment models for acute myocardial infarction, coronary artery bypass graft, and surgical hip/femur fracture treatment. Those models focused on complex cases where care coordination offered the potential for improved patient outcomes. The January 2017 Final rule also established the CR Model. Commenters complained, among other reasons, that these mandatory models could harm patients and providers before CMS could learn how the models might affect care access, quality of care, or patient outcomes. Apparently, CMS was listening, agreeing that implementation of the model on January 1, 2018, might not be in the beneficiaries’ or providers’ best interests.

The EPM and CR models were created under Soc. Sec. Act sec. 1115A by the Center for Medicare and Medicaid Innovation, an initiative rising out of the Affordable Care Act (ACA) (P.L. 111-148) sec. 3021. CMS notes that its Innovation Center intends to develop new bundled payment models for 2018. Thus, those providers that intended to participate in the now-cancelled bundled payment models in 2018 would still have an opportunity to do so. CMS says that the Innovation Center may also revisit the cancelled EPM and CR Models, as they gain more experience in what works and does not work in bundled payment models.

CJR Model. CMS has also finalized its proposal to make participation in the Comprehensive Care for Joint Replacement (CJR) Model voluntary for all hospitals in 33 of the 67 metropolitan statistical areas beginning in performance year 3 (2018). Participation will also be voluntary for low-volume and rural hospitals in all 67 metropolitan areas. In addition, the rule implements technical refinements and clarifications for certain CJR Model payment, reconciliation, and quality provisions, and it finalizes proposed changes to the criteria for the Affiliated Practitioner List to broaden the CJR Advanced Alternative Payment Model (Advanced APM) track.

The CJR Model was introduced on April 1, 2016. The calendar year 2017 is its second performance year. Under current rules, all hospitals in the 67 selected geographic areas are required to participate in the CJR Model through December 31, 2020, unless the hospital is an episode initiator for a lower-extremity joint replacement episode under certain conditions. The CJR Model has demonstrated potential for improving care while reducing costs. The rule was made mandatory to allow further testing (and better data) in a wide range of locations across a large geographic area. After public comment, however, CMS has decided to limit its participation mandate to 34 of the 67 areas, other than low-volume or rural hospitals. A low-volume hospital is one that has fewer than 20 lower-extremity joint replacement episodes across the three years of data used to calculate performance year 1 CJR episode target prices. Participation in the other 33 geographic areas will be voluntary.

Disaster relief. CMS has also issued an interim final rule on providing flexibility for performance year 2 (2017) in determining episode spending for CJR participant hospitals located in areas impacted by extreme weather.
The interim final rule applies to hospitals in those areas affected by Hurricane Harvey, Hurricane Irma (101 hospitals in Harvey and Irma paths), Hurricane Nate (12 hospitals), and the California wildfires of August, September, and October (22 hospitals). Hurricane Maria is not part of this interim final rule because the CJR Model is not in operation in areas that Hurricane Maria affected. Under current CJR Model rules, participating hospitals that have episode costs that exceed the target price for the performance year owe CMS 5 percent of the loss. The rule exists to give hospitals an incentive to control costs. CMS acknowledges, however, that extreme weather conditions sometimes raise costs, such as by requiring expensive air ambulance transports or prolonged inpatient stays. If relief from the penalty is not granted, CMS says, hospitals may be inadvertently given an incentive to place cost considerations above patient safety. Cancelling the penalty altogether is not the answer either. Thus, CMS has determined that capping the actual episode spending at the target amounts for those episodes would be the best way to protect both beneficiaries and hospitals.

Those wishing to comment on the interim final rule may do so by January 30, 2018. Both the final and interim final rules are effective on January 1, 2018.