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Vizient Office of Public Policy and Government Relations

Regulatory Update: CMS Proposed Rule: Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models & Changes to Comprehensive Care for Joint Replacement Payment Model

August 16, 2017

On Tuesday, August 15, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule cancelling the implementation and creation of three new mandatory episode payment models (EPMs) and a Cardiac Rehabilitation (CR) incentive payment model. The proposed rule rescinds prior regulations pertaining to the models.

Additionally, CMS proposes to make changes to provisions of the Comprehensive Care for Joint Replacement (CJR) model, including giving certain hospitals that were selected for participation in CJR a "one-time option" to choose whether to continue participating in the model. CMS proposes that the CJR model would continue on a mandatory basis in 34 of the 67 selected metropolitan statistical areas (MSAs) – except for low-volume and rural hospitals – and continue on a voluntary basis in the remaining 33 MSAs.

CMS is seeking comment on these proposals, as well as the alternatives considered. Comments are due October 16, 2017.

Background

This proposed rule pertains, in part, to EPMs for services surrounding acute myocardial infarction (AMI),coronary artery bypass graft (CABG) and surgical hip/femur fracture treatment (SHFFT). Additionally, the CR model was intended to test the use of CR and intensive cardiac rehabilitation (ICR) services for beneficiaries hospitalized for treatment of an AMI or CABG for 90 days post-hospital discharge. These payment models were originally proposed on Aug. 2, 2016 and finalized by the Obama administration on Dec. 20, 2016. Vizient's previous summaries on EPM rulemaking can be found on the Public Policy section of our website.

The Trump administration, however, issued a memorandum that directed agencies to postpone the effective dates of regulations that had been published in the Federal Register but had not yet taken effect. Accordingly, CMS previously delayed the effective date of the final rule from Feb.18 until March 21, 2017 then later issued an interim final rule with comment period (IFC) further delaying the effective date of the rule to May 20, 2017 and moving the applicability (model start) of the EPMs to Oct.1, 2017 (and also seeking comment on whether a longer delay would be appropriate).

Considering the length of episodes in the models, the agency thought it would be preferable for participants to have at least 6 months for the first payment year – and furthermore, less burdensome to align with the calendar year. On behalf of our members, Vizient's Office of Public Policy and Government Relations submitted a comment letter to CMS to provide input on the proposed further delay. We offered support for CMS's proposal to further delay the model start date until Jan. 1, 2018; this message was reiterated by other major provider groups that provided feedback. CMS later issued a final rule delaying the effective date implementing the creation and testing of three new EPMs and CR incentive payment model, until Jan. 1, 2018. Although CMS suggested that future rulemaking to make policy modifications to the models was imminent, they specified that they would not withdraw these models altogether or delay them indefinitely.

Summary

CMS is proposing to cancel the three new EPMs (AMI, CABG, SHFFT) and the Cardiac Rehabilitation (CR) incentive payment model, which were scheduled to go into effect on Jan. 1, 2018. Based on stakeholder feedback, CMS determined that certain elements regarding the design of these programs, chiefly, the mandatory nature of the models – should be "improved and more fully developed" before they begin. CMS is also concerned that implementing mandatory episode payment models could hinder the agency's ability to engage providers, specifically hospitals, in future voluntary models.

CMS considered alternatives to their proposal to cancel the models such as allowing for voluntary participation, but given the extensive restructuring that would be required, including model design, payment methodologies, financial arrangement provisions, and/or quality measures, CMS did not feel there was sufficient time for providers to prepare and be ready for the planned Jan. 1, 2018 start date. If, at a later time, CMS implements these or similar models, on a voluntary basis, they would *not* use the notice and comment rulemaking process. Rather, the agency would use methods similar to those they have used to implement other voluntary models (e.g., soliciting applications and securing agreements for participation).

Further, CMS notes that moving forward with the models as they are currently designed would not be in the best interest of providers or beneficiaries and notes that stakeholder comments expressed concerns "about the provider burden and challenges" the new models present. CMS does not believe that the proposal to cancel the EPMs and CR incentive payment model will result in any costs for providers, but the agency does acknowledge that hospitals that may have made improvements in care in anticipation of these models may delay or cease further investment, which could result in a potential reversal of quality improvements. The agency cites stakeholder feedback, and the lack of time to consider model improvements prior to the start date as outweighing "the potential reversal of any recent improvements in care potentially made by some hospitals." **CMS is seeking public comment on their proposal to cancel the EPMs and CR incentive payment model, as well as any alternatives considered.**

If CMS finalizes this proposal to cancel the EPMs and CR incentive payment model, providers that are interested in participating in new bundled payment models *may* still have the option to do so during calendar year (CY) 2018 "via new voluntary bundled payment models." The CMS Innovation Center (CMMI) plans to build on the Bundled Payments for Care Improvement (BPCI) initiative and develop new voluntary bundled payment model(s) during CY 2018 that would be designed to meet the criteria to qualify as an Advanced APM. In addition, CMS notes that they may reconsider the CR incentive payment model in the future as a possible voluntary program.

Proposed Changes to the CJR Model Participation Requirements

The first performance period for the CJR model began on April 1, 2016 and is currently in its second performance year. At this time – with some exceptions – hospitals in the 67 MSAs selected for participation in the CJR model must participate in the model through performance year 5, or Dec. 31, 2020.

CMS is proposing to revise certain participation requirements for the CJR model in order for the agency to continue evaluating its impact and effects. CMS is proposing that the CJR model would continue on a mandatory basis in half of the MSAs (34 of the 67), with an exception for low-volume and rural hospitals, and continue on a voluntary basis in the remaining MSAs (33 of the 67). The 34 mandatory participation MSAs (identified in Table 1 of the proposed rule) and 33 voluntary participation MSAs (identified in Table 2 of the proposed rule) are proposed for performance years 3, 4, and 5 (2018, 2019, and 2020, respectively).

Unless an exclusion applies (e.g., certain hospitals that participate in the BPCI initiative), CMS is proposing that participant hospitals in the 34 mandatory participation MSAs that are not low-volume or rural – would continue to be required to participate in the CJR model. CMS is also proposing that hospitals in the 33 voluntary participation MSAs and hospitals that are low-volume or rural would have a "one-time opportunity to notify CMS, in the form and manner specified by CMS, of their election to continue their participation in the CJR model on a voluntary basis (opt-in) for performance years 3, 4, and 5." Those hospitals that do not make a participation election (due to CMS between Jan. 1 and 31, 2018) would be withdrawn from the CJR model. CMS considered an alternative, opt-out approach where hospitals would be required to participate in the CJR model unless written notification to withdraw the hospital from the hospital was provided to CMS. The agency will provide a letter template for hospitals that choose to opt-in to reduce the burden of this approach. **CMS is seeking comment on the proposed opt-in approach, as well as the alternative opt-out approach.**

The agency considered an alternative voluntary participation election period, ending Dec. 31, 2017 but decided against this proposal. Given the expected timing of the final rule being issued, the agency does not believe that hospitals would have sufficient time to make a voluntary participation election by Dec. 31, 2017. Based on timing considerations, CMS could modify the dates of the voluntary participation election period. **CMS is seeking comment on the proposed voluntary election period and alternative date of Dec. 31, 2017 – or if a later period may be preferable.**

CMS is proposing to exclude and automatically withdraw low-volume hospitals from participation in the CJR model in the proposed 34 mandatory participation MSAs (as identified in Table 3 of the proposed rule) effective

Feb. 1, 2018. CMS is proposing that if a hospital's rural status changes after the end of the voluntary participation election period, it would not change the hospital's CJR model participation requirements (i.e., participation in the CJR model would be required, even if they subsequently become a rural hospital.) **CMS is seeking comment on the impact of their proposals on small rural hospitals.**

CMS is proposing that each physician, non-physician practitioner, or therapist who is not a CJR collaborator but does have a contractual relationship with the participant hospital (based at least in part on supporting the quality or cost goals of the participant hospital during a CJR model performance year) would be added to a clinician engagement list. Additionally, CMS is proposing that the clinician engagement list would also be considered an Affiliated Practitioner List for purposes of the Quality Payment Program (QPP), and would be used by CMS to identify eligible clinicians for whom the agency would make a QP determination based on services furnished through the Advanced APM track of the CJR model. **The agency is seeking comment on this proposal – and is particularly interested in stakeholder feedback about approaches to information submission, "including the periodicity and method of submission to CMS that would minimize the reporting burden on participant hospitals while providing CMS with sufficient information about eligible clinicians to facilitate QP determinations."**

CMS is also seeking comment on ways to further incentivize eligible hospitals to elect to continue participating in the CJR model, and to further incentivize all participant hospitals to advance care improvements, innovation, and quality for beneficiaries throughout lower extremity joint replacement (LEJR) episodes. While CMS is not currently proposing any changes to gainsharing caps **the agency is seeking comment on the current gainsharing requirement and any alternative gainsharing caps that may be appropriate to apply to physicians, non-physician practitioners, physician group practices (PGPs), and non-physician practitioner group practices (NPPGPs).**

What's Next?

Comments are due on Oct. 16, 2017. Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern.

As always, it is possible that we'll see substantial shifts between the proposed and final rule based on public comments and further analysis by CMS. Look for another detailed summary from our office when the final rule is released.

Additional Resources

Chelsea Arnone, Regulatory Affairs and Government Relations Director in Vizient's Washington, D.C. office can be reached at (202) 354-2608, and is monitoring this rule and other regulatory developments. Please reach out to her if you have any questions or if Vizient can provide any assistance as you consider these issues.