PUBLICATION

What's Next Now that Mandatory EPM and Cardiac Rehabilitation Payment Models Have Been Terminated?

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CMS released its Final Rule canceling the Episode Payment Model (EPM) and Cardiac Rehabilitation Incentive Payment Model (CR Incentive Payment Model). This was an expected result following August's proposed rule to cancel both models. The Final Rule also implements revisions to the current Comprehensive Care for Joint Replacement Model (CJR), most notably partially shifting from a mandatory program to a voluntary program for certain Metropolitan Statistical Areas (MSAs). Lastly, CMS included an Interim Final Rule for Extreme and Uncontrollable Circumstances Policy for CJR to address increased episode cost attributable to natural disasters. CMS is seeking public comment on this Interim Final Rule with a comment deadline of January 30, 2018.

Health care providers interested in pursuing care redesign, improving quality care and care coordination, and pursuing bundled payment models can remain optimistic for 2018 despite these cancelations. Throughout the Final Rule, CMS expressed its position that the continued testing and evaluation of innovative payment models aimed at improving quality and outcomes, reducing costs, and promoting transparency is important and remains a focus of CMS. The Final Rule suggested CMS and the Innovation Center will present additional models and changes that will improve the Medicare reimbursement environment for many health care providers, including those involved in CJR, Advanced Alternative Payment Models (APMs), and others.

What's Happening Now?

As anticipated, CMS canceled the EPM and the CR Incentive Payment Model. Under those models, CMS established bundled payment programs for acute myocardial infarction, coronary artery bypass graft, surgical hip/femur fracture treatment, and cardiac rehabilitation. CMS suggested in the Federal Register back in February 2017 that these models might be significantly delayed, modified, or canceled. The cancellation was first announced in the August Proposed Rule (which we summarized in: *CMS Cancels EPM and Cardiac Rehabilitation Incentive Program While Revising CJR in New Proposed Rule*). In finalizing the cancelation, CMS noted that it was in the best interest of providers and beneficiaries to more fully develop and improve upon these models. Curiously, CMS observed that the CR Incentive Payment Model might be revisited in a different, voluntary model later, after soliciting stakeholder feedback about the best way to approach cost-efficient cardiac rehabilitation, which may exclude intensive cardiac rehabilitation services.

On the positive side, health care providers who planned to make changes to care delivery or who have already implemented changes in anticipation of these models may continue their efforts and stand to be well-positioned for future bundled payment programs. CMS noted that any investment in care coordination and quality improvement is a benefit to both providers and beneficiaries.

What's Happening Next for CJR and other bundled payment models?

CJR

The Final Rule included several revisions to CJR. These changes take effect on January 1, 2018:

1. **Shift to Voluntary Participation for Certain MSAs:** Thirty-three (33) of the 67 MSAs used for CJR will now become voluntary, which means that all hospitals located in the 33 voluntary MSAs will need

to opt in to continue as participants in the CJR program. These 33 MSAs were selected because the lower extremity joint replacement (LEJR) episode payments were lower than the other 34 MSAs and thus providers would have less of an opportunity to show overall episode payment improvement. CMS included a list of the 33 voluntary MSAs in the Final Rule. Hospitals that do not opt in will no longer be required to comply with CJR.

To assist hospitals with opting in, CMS posted detailed instructions with an opt-in template at its website, https://innovation.cms.gov/Files/x/cjr-voluntary-optin-fillableletter.pdf. Individual hospitals must opt in by January 31, 2018. An opt in is required to participate in all three of the remaining years of CJR, which means participation would begin February 1, 2018, and continue through December 31, 2020. This is a one-time opt-in event in an effort to minimize confusion and risk of gaming the system.

2. **Shift to Voluntary Participation for Rural and Low Volume Hospitals:** Rural and low volume hospitals located in the remaining 34 mandatory CJR MSAs are no longer required to participate in CJR. Rural and low volume hospitals in those MSAs that want to continue in CJR will also need to opt in by January 31, 2018 (see above). Similar to the hospitals in voluntary MSAs, this opt in commits the hospital for the remaining three years of CJR. The Final Rule also confirmed that "low volume hospitals" had fewer than 20 lower extremity joint replacement episodes during the three-year period from 2012 to 2014, and that "rural hospitals" would include only those hospitals identified by CMS as rural hospitals before January 31, 2018. To assist hospitals, CMS included tables of the mandatory MSAs and the eligible low volume hospitals in the Final Rule. All other hospital participants in the 34 mandatory MSAs are required to complete the remaining three years of CJR. The Final Rule contains a summary of the CJR participation requirements in Table 4

3. **Clarification of Impact of Hospital Reorganization on the Reconciliation Process:** CMS also addressed the impact of a hospital reorganization (i.e., acquisition, merger, divestiture or other reorganization) on the annual reconciliation process. In an effort to provide further clarity and transparency, CMS added language to 42 C.F.R. § 510.305(d)(1) that specifies that where the reorganization event results in the issuance of a new participant hospital CCN, separate reconciliations will occur. This means that separate reconciliation calculations will occur for episodes before and after the reorganization event that resulted in the new CCN.

4. **Ability to Qualify as an Advanced APM Participant:** Physicians, non-physician practitioners, and therapists who participate in CJR can also participate as a Qualifying APM Participant (QP) without being a CJR Collaborator. CJR participant hospitals will be able to create a clinician engagement list of physicians, non-physician practitioners, and therapists who are not CJR collaborators but have a contractual relationship with the CJR hospital that is based, at least in part, on supporting the CJR hospital's quality or cost goals under CJR.

   Currently only CJR collaborators on an Affiliated Practitioner List are eligible for this consideration. The Affiliated Practitioner List includes those eligible clinicians who entered into a contractual, financial arrangement with the Advanced APM entity (the participant hospital for CJR purposes). Individual professionals on the Affiliated Practitioner List are eligible clinicians who supported the Advanced APM's quality or cost goals and therefore qualify as a QP.

   CMS has determined that it will consider both a clinician financial arrangement list and a clinician engagement list as Affiliated Practitioner Lists. CMS will use these lists to determine which professionals are QPs. This is important because QPs qualify for participation in an Advanced APM under the Quality Payment Program (QPP) and enjoy the benefits of QPP without having to

participate in the administratively tedious Merit-based Incentive Payment System (MIPS) or another Advanced APM. Clinicians who become QPs in an Advanced APM are eligible to receive a five percent lump sum increase in their Medicare claim reimbursement. In doing so, CMS has acknowledged that the work performed by clinicians in a contractual relationship with Advanced APMs is valuable to the success of the APM and deserves consideration for the QPP.

5. **Composite Score:** CMS also provided clarification on year 1 subsequent reconciliation calculations. The initial reconciliation for performance year 1 of CJR was conducted in early 2017. Initial reconciliation calculations were made in the fall of 2017 to accommodate the appeals process. CMS is now planning to conduct the reconciliation calculation for performance year 1 of the CJR model in the first quarter of 2018. CMS has warned that although this reconciliation may result in additional amounts being paid to some participants, others may have additional amounts to repay. To address this, CMS will combine these reconciliation results with the performance year 2 initial reconciliation results to offset the amounts as appropriate.

   The impact to the reconciliation calculations is the result of changes to the CJR model included in the EPM final rule. Although it would have been more favorable to have the improvements to the CJR model quality measures and composite quality score methodology effective at the start of performance year 1 initial reconciliation, the provisions were delayed until May 20, 2017. As a result, Sections 510.305 and 510.315 in effect on April 17, 2017, differ from those currently in effect. The use of the new provisions may result in a range of upward or downward payment adjustments for participant hospitals.

Bundled Payment Models

Despite the cancelation of EPM and the CR Incentive Payment Model, CMS explained that the Innovation Center would continue to evaluate and develop other bundled payment programs during calendar year 2018. These programs will be designed to qualify as Advanced APMs, which would allow participants to qualify for participation in the QPP without meeting the MIPS criteria.

In addition to the changes to CJR, CMS commented on the new direction for the Innovation Center. CMS explained that the Innovation Center will focus on new designs to "reduce burdensome requirements and unnecessary regulations to the extent possible" and suggested strongly that each new bundled payment model will be an Advanced APM model that will follow this approach. This is consistent with recent action by CMS whereby CMS issued a Request For Information seeking public input on future model design.

Hospitals and health care providers involved in the Bundled Payment for Care Improvement (BPCI) initiative are also expecting the end to the BPCI initiative in September 2018. Despite stakeholders' comments requesting a separate opt in or opt out mechanism for those BPCI hospitals located in CJR MSAs, CMS explained that it expected BPCI hospitals located in mandatory MSAs to transition into CJR. Other hospitals located in voluntary MSAs and low volume or rural hospitals in mandatory MSAs would not be given an opportunity to opt in; however, CMS noted that it expects the Innovation Center to release other bundled payment model opportunities later in 2018.

Wasn't there something about Extreme and Uncontrollable Circumstances?

CMS also issued an Interim Final Rule to address for the increased episode costs as a result of natural disasters that occurred during the 2017 CJR performance year and which could also apply in future performance years. This extreme and uncontrollable circumstances waiver would apply to those hospitals located (a) in a county, parish, territory, or tribal government declared under the federal Stafford Act, and (b) in an "emergency area" and "emergency period" set forth in a waiver presented by CMS under Section 1135 of

the Social Security Act. For hospitals that qualify for the waiver, CMS will cap the actual episode spending amounts at the target amounts for those episodes.

The spending cap waiver differs depending on when the episode began in relation to the start of the emergency period and whether the LEJR episode was a fracture or a non-fracture episode. For a non-fracture LEJR episode, an episode qualifies for the spending cap waiver if it began 30 days prior to and including the date of the emergency period. This is because CMS believes that the greatest period of excess cost would most likely occur for those patients who were already admitted and then needed to be transported, or experienced other additional costs, because of the natural disaster occurring during the inpatient admission. CMS also believed that non-fracture LEJR episodes would likely not occur after a natural disaster as these types of episodes were generally planned in advance and would be postponed and rescheduled as necessary.

The spending cap waiver applies to 30 days before, after, and on the date of the emergency period for fracture LEJR episodes. This is because fracture LEJR episodes were considered to be emergency or unplanned and CMS did not want to provide hospitals a disincentive to postpone necessary care for these types of episodes.