The U.S. Centers for Medicare & Medicaid Services (CMS) published a proposed rule last week regarding the cancellation of three bundled payment models and an incentive payment model while also reducing the scope of a third type of payment model. These models were mandatory for hospitals in certain geographic areas. The current administration had delayed the implementation of these models until January 1, 2018.

Specifically, the proposal seeks to eliminate three models collectively referred to as the Episode Payments Models (EPMs) as well as the Cardiac Rehabilitation (CR) incentive payment model. The EPMs and the CR incentive payment models were designed as mandatory payment models to test the effects of bundling complex cardiac and orthopedic care that the federal government believes could benefit from improvement in care coordination and other care redesign efforts. The EPMs specifically targeted acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment episodes of care. Under the CR incentive payment model, acute care hospitals in certain geographic areas would receive retrospective incentive payments based on beneficiary utilization of cardiac services in the first 90 days following an AMI or CABG episode of care. CMS considered altering the design of the EPMs and the CR incentive payment model to allow for voluntary participation and to take into account other feedback on the models, but concluded that the redesign would not give providers enough time to prepare before the January 1, 2018, start date.

CMS has also dialed back the Comprehensive Care for Joint Replacement (CCJR) model by reducing the number of geographic areas that will be subject to mandatory participation. Approximately 470 hospitals are expected to continue their participation under the CCJR model, including about 60 to 80 hospitals that will voluntarily participate. This group represents less than half of the 800 hospitals that would have originally participated. This reduction doesn’t come without a financial impact: the model is now expected to save $204 million rather than $294 million over the next three years.

CMS described some of the comments that it received related to the mandatory models:

Specifically, many commenters were opposed to the mandatory participation requirements, arguing that the mandatory nature of these models would force many providers who lack familiarity, experience, or proper infrastructure to quickly support care redesign efforts for a new bundled payment system. Many commenters were concerned that the mandatory nature of these models might harm patients and providers before CMS knows how these models might affect access to care, quality or outcomes in various locations.

The context of this proposed rule is important for two reasons.
First, the proposal follows an earlier proposed rule published by CMS earlier this summer that would allow Medicare to pay for hip and knee replacement surgeries performed in ambulatory surgical centers (ASCs). The movement of these highly profitable surgeries out of hospitals and into ASCs could arguably dampen hospitals’ bundled payment initiatives by discouraging hospitals from investing in the tools and resources to participate in the models.

Second, these changes come in the context of a radical revamping of the way in which Medicare pays physicians. As we have discussed previously, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will incentivize physicians to participate in value-based care models. While the most recognizable of these care models is the accountable care organization (ACO), removal of the targeted models will likely impact the industry’s participation in MACRA. The three EPMs are all considered to be “Advanced APMs” under MACRA—an important designation that makes its participants eligible for certain bonuses and reporting exemptions. This point was not lost on CMS, which states in its proposal that it expects to develop new voluntary bundled payment models during CY 2018 that would be designed to meet the Advanced APM criteria. The open question is whether this movement from mandatory to voluntary models will stymie the move away from fee-for-service care and toward value-based care. Statistics related to the Medicare Shared Savings Program have demonstrated that physicians are wary of taking on downside risk, with over 90% of providers participating in ACOs that have no downside risk.

Comments on the proposed rule are due by October 15, 2017.

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