American Hospital Association

Special Bulletin

Wednesday, August 16, 2017

CMS PROPOSES TO CANCEL NEW CARDIAC BUNDLE, EXPANSION OF HIP/KNEE BUNDLE, AND SCALE BACK CJR

This bulletin is five pages and includes two appendices.

The Centers for Medicare & Medicaid Services (CMS) Aug. 15 proposed to cancel the cardiac and surgical hip and femur fracture treatment (SHFFT) bundled payment models. These programs had been scheduled to begin Jan. 1, 2018. In addition, the agency proposed to scale back the Comprehensive Care for Joint Replacement (CJR) model by giving certain participant hospitals a one-time option to choose whether to continue their participation.

The AHA is supportive of bundled payment models as programs that hold great promise in transforming care delivery through improved coordination and financial accountability. We believe participation in alternative payment models should be voluntary, and are pleased that CMS has proposed partial voluntary participation in the CJR program. However, we are concerned that cancellation of the cardiac and SHFFT programs may be disruptive to those providers who have expended valuable resources and who wish to participate in these programs on a voluntary basis.

Details of the proposed rule follow.

CANCELLATION OF CARDIAC, SHFFT AND CARDIAC REHABILITATION INCENTIVE PAYMENT MODELS

On Dec. 20, 2016, CMS finalized a new payment model to bundle payment to acute care hospitals for heart attack and cardiac bypass surgery services. It also expanded the existing CJR model to include surgical treatments for hip and femur fractures other than joint replacement. In addition, the agency finalized a program to test a payment methodology designed to encourage the use of cardiac rehabilitation services. These programs were initially scheduled to begin on July 1, 2017; however, the agency subsequently issued several rules that delayed their start dates until Oct. 1, 2017, and then again until Jan. 1, 2018.

CMS now proposes to cancel these programs completely. As such, hospitals would not participate and the model would no longer have the potential to qualify as an advanced alternative payment model (APM) under the Medicare Access and CHIP Reauthorization Act (MACRA).

CHANGES TO THE CJR PAYMENT MODEL

On April 1, 2016, CMS began to test a new model that bundles payments to acute care hospitals for hip and knee replacement surgery – the CJR model. The model was implemented in 67 geographic areas across the country and was mandatory for most hospitals in those areas. However, the agency now proposes to scale back the CJR program, beginning Jan. 1, 2018. Specifically, the CJR model would continue on a voluntary basis only in 33 of 67 areas. These 33 metropolitan statistical areas (MSAs) are listed in Appendix A; CMS chose them because they encompass the lowest-cost lower extremity joint replacement episodes among the 67 MSAs. In the other 34 MSAs (listed in Appendix B), which encompassed the highest-cost lower extremity joint replacement episodes, participation would remain mandatory. However, the agency would allow voluntary participation for low-volume and rural hospitals in these 34 MSAs.

Definition of Low-volume Hospital. CMS proposes to define a low-volume hospital as a hospital currently participating in the CJR model that has fewer than 20 lower-extremity joint replacement episodes in total across the three years of data that the agency used to calculate CJR target prices in performance year 1. The agency provides a list of low-volume hospitals on pp. 26 – 28 of the display copy of the rule. These hospitals would be automatically withdrawn from participation in the CJR model, effective Feb. 1, 2018, unless they proactively opted in (see "Procedures for Opting-in to Voluntary Participation" below).

Definition of Rural Hospital. CMS proposes to define a rural hospital as one with a CMS Certification Number (CCN) primary address in one of the 34 mandatory participation areas. These hospitals would be automatically withdrawn from participation in the CJR model unless they proactively opted in (see "Procedures for Opting-in to Voluntary Participation" below). The agency states that a hospital's change in rural status after the end of the opt-in period would not change its participation requirements. For example, if a hospital located in one of the 34 mandatory participation areas became rural after the opt-in period, it would still be required to participate in CJR.

Procedures for Opting-in to Voluntary Participation. CMS proposes a one-time participation election period for all hospitals with a CCN primary address located in the 33 voluntary participation areas, as well as for low-volume and rural hospitals located in the 34 mandatory participation areas. The agency anticipates that the election period would be open from Jan. 1, 2018 through Jan. 31, 2018; however, these dates could change based on the timing of publication of the final rule.

Based on this timing, CMS would need to receive a hospital's written participation election letter by Jan. 31, 2018 in order for it to opt in to the program. Such hospitals would then be required to participate in the CJR program through the end of the model. Hospitals not opting in would be withdrawn from the model effective Feb. 1, 2018, and all of their completed and ongoing episodes from performance year 3 (which begins Jan. 1, 2018) would be cancelled.

The agency intends to provide templates for the written participation election letter, which would include the hospital's name, address, CCN, contact information, and other information. In addition, if a hospital would like for its CJR participation to qualify as an advanced APM under MACRA, it must attest to using certified electronic health record technology.

NEXT STEPS

The proposed rule will be published in the Aug. 17 *Federal Register*. AHA staff continue to review and analyze it. If you have further questions, contact Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.

Appendix A: CJR Voluntary Participation MSAs

Albuquerque, NM
Athens-Clarke County, GA
Bismarck, ND
Boulder, CO
Buffalo-Cheektowaga-Niagara Falls, NY
Cape Girardeau, MO-IL
Carson City, NV
Charlotte-Concord-Gastonia, NC-SC
Columbia, MO
Decatur, IL
Denver-Aurora-Lakewood, CO
Durham-Chapel Hill, NC
Flint, MI
Gainesville, GA
Indianapolis-Carmel-Anderson, IN
Kansas City, MO-KS
Lincoln, NE
Madison, WI
Milwaukee-Waukesha-West Allis, WI
Modesto, CA
Naples-Immokalee-Marco Island, FL
Nashville-Davidson-Murfreesboro-Franklin, TN
Norwich-New London, CT
Ogden-Clearfield, UT
Portland-Vancouver-Hillsboro, OR-WA
Saginaw, MI
San Francisco-Oakland-Hayward, CA
Seattle-Tacoma-Bellevue, WA
South Bend-Mishawaka, IN-MI
St. Louis, MO-IL
Staunton-Waynesboro, VA
Topeka, KS
Wichita, KS

Appendix B: CJR Mandatory Participation MSAs

Akron, OH
Asheville, NC
Austin-Round Rock, TX
Beaumont-Port Arthur, TX
Cincinnati, OH-KY-IN
Corpus Christi, TX
Dothan, AL
Florence, SC
Gainesville, FL
Greenville, NC
Harrisburg-Carlisle, PA
Hot Springs, AR
Killeen-Temple, TX
Los Angeles-Long Beach-Anaheim, CA
Lubbock, TX
Memphis, TN-MS-AR
Miami-Fort Lauderdale-West Palm Beach, FL
Monroe, LA
Montgomery, AL
New Haven-Milford, CT
New Orleans-Metairie, LA
New York-Newark-Jersey City, NY-NJ-PA
Oklahoma City, OK
Orlando-Kissimmee-Sanford, FL
Pensacola-Ferry Pass-Brent, FL
Pittsburgh, PA
Port St. Lucie, FL
Provo-Orem, UT
Reading, PA
Sebastian-Vero Beach, FL
Tampa-St. Petersburg-Clearwater, FL
Toledo, OH
Tuscaloosa, AL
Tyler, TX