American Hospital Association

Special Bulletin

Friday, December 1, 2017

CMS CANCELS NEW CARDIAC BUNDLE AND EXPANSION OF HIP/KNEE BUNDLE; SCALES BACK CJR

This bulletin is five pages and includes two appendices.

The Centers for Medicare & Medicaid Services (CMS) Nov. 30 issued a final rule cancelling 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 finalized its proposal 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. As this transition moves forward, the AHA will continue to urge CMS to give hospitals the flexibility and predictability they need to improve care coordination and efficiency and deliver better value for their patients and communities. While we generally support the provisions final rule, we are pleased that the agency has signaled that it will soon announce new voluntary payment bundles that will qualify as advanced alternative payment models. Doing so will allow hospitals to not only capitalize on the work many of them already have done to prepare for such models, but to also partner with clinicians to provide better, more efficient care.

Details of the final 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.

However, in the Nov. 30 rule, CMS finalized its proposal to cancel these programs completely. Hospitals will no longer participate and the model will 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 has now finalized its proposal to scale back the CJR program, beginning Feb. 1, 2018. Specifically, the CJR model will 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 will remain mandatory. However, the agency will allow voluntary participation for low-volume and rural hospitals in these 34 MSAs.

Definition of Low-volume Hospital. CMS finalized its proposal 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. 49 – 53 of the display copy of the final rule. These hospitals will be automatically withdrawn from participation in the CJR model, effective Feb. 1, 2018, unless they proactively opt-in (see "Procedures for Opting-in to Voluntary Participation" below).

Definition of Rural Hospital. CMS will define a rural hospital as one with a CMS Certification Number (CCN) primary address in one of the 34 mandatory participation areas. These hospitals will be automatically withdrawn from participation in the CJR model unless they proactively opt-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 will 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 will still be required to participate in CJR.

Procedures for Opting-in to Voluntary Participation. CMS finalized its proposal to implement 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 election period will be open from Jan. 1, 2018 through Jan. 31, 2018.

CMS must receive a hospital's written participation election letter by Jan. 31, 2018 in order for it to opt in to the program. Such hospitals will then be required to participate in the CJR program through the end of the model. Hospitals not opting in will 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) will be cancelled.

The agency provides a template and further instructions for submitting a written participation election letter on its website.

Significant Hardship Policy. As urged by the AHA, CMS also sets forth an interim final policy to provide some flexibility in determining episode spending for CJR hospitals located in areas impacted by "extreme and uncontrollable circumstances," such as Hurricane Harvey, Hurricane Irma and the California wildfires. The agency is concerned that prudent patient care management in hospitals affected by these and other disasters may have involved, for example, potentially expensive air ambulance transport or prolonged inpatient stays when other alternatives were not practical, and does not want to penalize hospitals for providing such services.

CMS lists the counties, parishes, and tribal governments that have met the criteria for the CJR policy on extreme and uncontrollable events on pgs. 115-116 of the display copy of the final rule. For hospitals located in these areas, CMS will cap the actual spending for a given episode at the target amount if that episode began during a specified time period. For non-fracture episodes, which are typically planned admissions, that time period will be 30 days prior to and including the date that the emergency period began. For fracture episodes, which are often emergent, unplanned admissions, that time period will be 30 days before, on or up to 30 days after the date the emergency period began.

CMS will notify providers for whom this policy will apply for performance year 2 (and subsequent performance years, if and when the policy is invoked) via the initial reconciliation reports that it delivers to providers upon completion of the reconciliation calculations, which are initiated beginning two months after the close of the performance year.

FOR FURTHER QUESTIONS

If you have further questions, please 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
St. Louis, MO-IL
San Francisco-Oakland-Hayward, CA
Seattle-Tacoma-Bellevue, WA
South Bend-Mishawaka, IN-MI
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