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CMS Bundled Payments Program Expands

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Just one year ago, the Centers for Medicare & Medicaid Services (CMS) announced the creation of a mandatory bundled payment program for major joint replacement: Comprehensive Care for Joint Replacement (CJR). Now, CMS has proposed regulations that add cardiac episodes as well as "other hip and femur procedures" to the list of mandatory bundles for hospitals in many markets.

CMS's new proposed rule mandates that healthcare organizations in 98 metropolitan statistical areas (MSAs) participate in a bundled reimbursement model for both acute myocardial infarction (AMI), managed either medically or with procedural intervention, and for coronary artery bypass graft (CABG).

Organizations that already are participating in the voluntary Bundled Payments for Care Improvement (BPCI) program in these cardiac or other hip and femur bundles can continue with their current bundles/episodes, but others in the MSA will be required to adopt the mandatory bundles. Hospitals in the CJR regions will be required to add "other hip and femur procedures" to their bundles.

The actual MSAs will be selected when the final rule is published this fall. All of the new mandatory episode payment models will begin on July 1, 2017 and continue through December 2021.

As with the CJR program, the cardiac and hip/femur mandatory initiatives include:

- Patients with Medicare Part A and B, but not Medicare Advantage patients
- Ongoing payments based on the traditional payment model, with periodic reconciliation (comparison of actual costs with target costs, factoring in a discount to CMS—see below)
- Gainsharing allowed on both internal costs and episode costs

The primary differences between BPCI and the new mandatory bundles (CJR, hip and femur, and cardiac) are:

- No choice of bundle length—90-day bundles are required.
- The target price is partly based, as before, on three years of historical cost, but is based more heavily on regional averages than with BPCI (the fourth and fifth year prices are based 100 percent on regional averages), increasing cost pressure on higher-cost organizations.

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- Payments are contingent on meeting specified quality performance targets, including clinical outcome and patient satisfaction; those with higher quality scores will have lower discounts.
- There will be no discounts to CMS in year 1 and the first quarter of year 2; discounts will range from 0.5 to 2.0 percent in the remainder of year 2 and year 3, and from 1.5 to 3.0 percent in years 4 and 5.
- There are more exclusions for conditions not related to the initial index admission, such as unrelated hospital readmissions.
- Stop-loss and gain provisions provide for no downside risk in the first year and gains or losses of not more than 5 percent of their actual total episode costs in the second year, 10 percent in the third year, and 20 percent in the fourth and fifth years.
- There will be two risk-sharing tracks, contributing to the ability of participating physicians to qualify for payment under an advanced alternative payment model (APM) under the Medicare Access and CHIP Reauthorization Act of 2015.

CMS also has proposed an incentive program to test the effectiveness of outpatient cardiac rehabilitation programs in preventing readmissions and improving outcomes. The program adds an incentive payment of $25 to providers' payment for each of the first 11 rehab sessions per episode (in addition to whatever payment would normally be received) and an incentive payment of $175 per session thereafter.

CMS's rapid expansion of mandatory bundled payment programs suggests that bundled payment models are here for the foreseeable future.

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