Shape of Bundled Payments Is in Doubt; For Now, CJR Moves Forward

Hospitals don’t have to read tea leaves to see that mandatory bundled payment programs, including cardiac payment bundles and the Comprehensive Joint Replacement (CJR) model, probably won’t stay in their current form, and they may soon become voluntary and possibly disappear. Already CMS, on March 21, delayed the expansion of the CJR model and the effective date of the newest kid on the block, the cardiac bundled payment program, until Oct. 1 (82 Fed. Reg. 14464). Both these bundled payment programs are mandatory for certain hospitals, but HHS Secretary Tom Price has long indicated his preference for voluntary participation.

“Prior statements by Secretary Price call into question whether the programs will go forward as mandatory programs,” says Robert Jagielski, compliance director for clinical integration at MedProVidex, a subsidiary of Dignity Health, a California-based health system.

However, the delay doesn’t affect hospitals already deep into the CJR program that went live April 1, says Washington, D.C., attorney Daniel Hettich, with King & Spalding. That program applies to hip and knee replacements at 800 hospitals in 35 states. Only the expansion of the CJR program to femur fractures and other hip surgeries, which was announced in a Dec. 20, 2016, regulation, is on hold, he says. The CJR expansion was unveiled with the mandatory cardiac bundled payment program.

Compliance in this area will be in suspended animation until it’s clear what CMS will do with mandatory bundled payment programs now that there is new leadership, Jagielski says. “Hospitals are set up to meet the requirements of the program—to report on measures and produce results and documentation. You are working closely with operations so you can document and audit them,” he says. “If the programs are going to change, everything goes on hold. You will wait and see. We can’t move forward until we know the rules we are playing under.”

Waivers Still Apply

However, because the original CJR program continues for the time being, its fraud and abuse waivers still apply, Hettich says. The waivers allow hospitals to distribute gainsharing payments to physicians and post-acute providers without violating the anti-kickback or Stark laws, as long as hospitals satisfy the criteria set forth by CMS and the HHS Office of Inspector General. There’s also a waiver from the civil monetary penalty (CMP) law that bars beneficiary inducements (RMC 12/7/15, p. 1).

Meanwhile, the implementation dates of the newer bundled payment programs may be put off even more. The March 21 CMS notice in the Federal Register asked for industry feedback on a delay until Jan. 3, 2018—and there are indications the programs will be revamped.

The delay was a result of the 60-day freeze on new regulations ordered by the Trump administration in January, Jagielski says. “I would not draw any inference, positive or negative, from the fact that the regulation was delayed other than the reason stated in the preamble to the delayed rule, which is to avoid unnecessary administrative
costs and burdens in the event that changes come,” he says.

The bundled-payment models hold hospitals financially accountable through application of rewards or penalties based on how Medicare’s actual 90-day spending for the hospital patients compares to a “target price” set by CMS. In the five-year CJR model, for example, the clock starts with admission for MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities) and ends 90 days after discharge from the hospital.

Medicare pays hospitals and their “collaborators”—physicians, physician practice groups and various post-acute care (PAC) providers (e.g., skilled nursing facilities and home health agencies)—on a fee-for-service basis. In addition, hospitals that hit a “target” price set by CMS and meet quality, efficiency and patient satisfaction goals get a bonus. If they charge Medicare more than the target price, they have to fork over some money. Notably, Hettich points out, the “target price” includes a built-in discount or savings to Medicare of up to 3%. CMS and the HHS Office of Inspector General also jointly published fraud and abuse waivers to clear the way for hospitals to share with physicians the rewards they may reap if they reduce costs and improve quality and to give patients incentives to promote engagement with their care.

In the Dec. 20 regulation, CMS announced bundled payments for cardiac episodes of care. They are mandatory for inpatient care and up to 90 days after for heart attack and bypass surgery patients at hospitals in 98 metropolitan areas. There’s also a mandatory payment bundle for cardiac rehab. They were supposed to start in July.

“It’s not a surprise the regulations were delayed because Tom Price, before he was secretary, was extremely critical of mandatory bundled payment programs,” Hettich says. Price, a physician, was one of 179 House members who signed a September letter to Andy Slavitt, then-acting administrator of CMS, and Patrick Conway, M.D., then chief medical officer and director of the Center for Medicare and Medicaid Innovation. “Until recently, the tests and models developed by CMMI were implemented, as intended, on a voluntary, limited-scale basis where no state, healthcare provider, or health insurer had any obligation to participate,” the letter stated. But CMS crossed the line with mandatory bundled payments, they said. “These mandatory models overhaul major payment systems, commandeer clinical decision-making, and dramatically alter the delivery of care.” The House members asked CMS to immediately quit implementing the mandatory models.

Now that Price is in charge, odds are he will make his wish come true, Hettich says.

Whether bundled payment programs are mandatory or voluntary, Jagielski notes that “hospitals have already invested resources in care coordination teams and open communication with post-acute care providers in teaming up. If the programs continue as voluntary, hospitals that put all those steps in place and can come in under target price can do it on a voluntary basis.” And it’s always possible they will disappear, Hettich says, although there’s bipartisan support for moving to value-based purchasing.

“You still want to engage your providers to continue to be ready to participate in the models when the final regulations come out because Tom Price still sees there is value in them,” he says. “Everyone should be working toward value-based programs and getting ready for the transition regardless of the form it takes, whether it’s through ACOs or other initiatives.

A lot of compliance in these programs is aimed at ensuring they meet Medicare conditions of participation and are able to report on quality measures and fulfill documentation requirements (RMC 12/19/16, p. 1), Jagielski says. “We can’t move forward until we know what the rules are,” he says. “Operations are impacted by the fact this program could be restructured with different requirements and that has an impact. You take a breather and wait until guidance comes up.”

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