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CMS Aims to Nix Obama-Era Payment Models

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In a proposed rule published Tuesday, August 15, 2017, the Centers for Medicare & Medicaid Services (CMS) announced its intention to roll back a handful of payment models introduced under the Obama Administration. If implemented, the rule would cancel the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) Incentive Payment Model, each currently set to begin next year. The rule would also cut the number of mandatory participation locations in the Comprehensive Care for Joint Replacement (CJR) Model from 67 to 34.

These payment models were originally put in place by CMS as a part of its aim to shift away from the traditional fee-for-service payment model utilized under Medicare, and move towards value-based care models. As described below, the CJR Model and the EPMs each utilize “bundled payments,” whereby providers would earn a fixed amount for a given course of treatment for a particular condition, as opposed to the traditional fee-for-service model, which compensates providers for the volume of services rendered. The CR Incentive Payment Model also seeks to encourage value-based care by utilizing retrospective incentive payments for certain cardiac rehabilitation services, with the aim of keeping patients healthy and out of the hospital. Each model works as follows:

- The CJR Model, which began on April 1, 2016 and will run for five years, tests bundled payments and quality measurements for episodes of care associated with hip and knee replacements. Under this model, participating hospitals are financially responsible for the quality and cost of a CJR episode of care, and incentives are awarded for greater coordination of care across hospitals, physicians, and post-acute care providers. Most hospitals in 67 current geographic locations across the country are required to participate in the program.
- The EMPs currently established by CMS utilize bundled payments for three major health conditions: (i) acute myocardial infarction, (ii) coronary artery bypass graft and (iii) surgical hip/femur fracture treatment excluding lower extremity joint replacement. For the first two conditions, participation in the program will be mandatory for most hospitals in 98 geographic areas, while the latter condition will be mandatory for most hospitals in the same 67 current geographic locations designated for the CJR model. The EPMs are currently set to begin on January 1, 2018 and will continue for five performance years.

- Under the CR Incentive Payment Model, hospitals may use incentive payments to coordinate cardiac rehabilitation and support beneficiary adherence to the cardiac treatment plan to improve cardiovascular fitness. Specifically, the model uses a two-part payment system with reimbursement starting at $25 per cardiac rehabilitation service initially and increasing to $175 after the first 11 sessions. The model is currently set to run under the same timeline established for the EPMs, and will operate in 45 geographic areas where the cardiac care EPMs are being utilized, along with 45 areas not covered by the EPMs.

While CMS has estimated there would be significant healthcare spending savings as a result of these payment models – close to $300 million in savings from the CJR Model alone – the Trump Administration has viewed them as being too burdensome on providers. According to CMS Administrator Seema Verma, the scaling back of these programs will allow CMS to "test and evaluate improvements in care processes that will improve quality, reduce costs, and ease burdens on hospitals."

Several major interest groups in the healthcare provider space have applauded CMS' decision to roll back the models. According to William Maloney, MD of the American Academy of Orthopaedic Surgeons, "imposing mandatory models on surgeons and facilities that lack the familiarity, experience, or infrastructure required has serious unintended consequences. Reducing the geographic area for CJR while leaving a voluntary option significantly remedies this issue." In a press release, Bruce Siegel of America's Essential Hospitals also welcomed the proposed rule, stating that hospitals "need more time before facing another demonstration and the potential for mandatory participation in two models simultaneously."

Others in the industry have expressed displeasure with the proposed rule, viewing it as a setback in the effort to control healthcare costs and incentivize high-quality care, and skeptical that voluntary value-based payment models from CMS will function effectively. "There are going to be a lot of physicians out there who think they are getting a pass," said Dr. John Bulger, chief medical officer for Geisinger Health Plan, an HMO which focuses on value-based care. Also critical of the decision were Jason Furman, chairman of the White House Council of Economic Advisors under President Obama, and Dr. Bob Kocher, special assistant to President Obama for health care and economic policy in 2009 and 2010, who jointly voiced their opposition to the proposed rule in an Wall Street Journal op-ed.

While the proposed scaling back of these programs certainly represents a significant healthcare policy decision by the Trump Administration, it still remains unclear how the Administration will approach value-based payment models in the future, if it indeed implements the rule. The fact that CMS is aiming to cancel EPMs and CR Incentive Payment Model instead of making the models voluntary suggests that developing and implementing value-based payment models will not be a priority under current CMS leadership. Nevertheless, even if the proposed rule is implemented, the CJR Model still remains in place, and if it achieves the amount of savings originally estimated to be generated from it, perhaps that could have impact on the Trump Administration's decision-making in the future.

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