Late July 25, the Centers for Medicare & Medicaid Services (CMS) proposed a new payment model that would bundle payment to acute care hospitals for heart attack and cardiac bypass surgery services. In addition, the proposed rule would expand the existing Comprehensive Care for Joint Replacement (CJR) model to include surgical treatments for hip and femur fractures other than joint replacement.

Under both the new cardiac bundled payment model and the expanded CJR model, the hospital in which the initial services are provided would be held accountable for the quality and costs of care for the entire episode of care from the time of the hospital stay through 90 days post-discharge. The cardiac model would be mandatory for hospitals in 98 geographic areas across the country; the CJR expansion would apply to the existing 67 geographic areas already participating in that model.

The new mandatory payment models proposed by CMS yesterday represent additional efforts by the Administration to attempt to coordinate patient care across multiple settings. America’s hospitals already are participating in many programs to redesign care delivery to better serve patients. However, the proposed cardiac bundle is the third mandatory demonstration project that CMS has issued in a little over a year. Further, the agency is layering this new program on hospitals already working to implement CJR; at the same time, it proposes to expand and further complicate CJR – less than four months after it began and before evaluating its results. We are concerned that the agency is putting the success of these critical programs at risk. Hospitals are under a tremendous burden to help ensure these complex models work for patients.

Details of the proposed rule follow.
EXPANSION OF CJR MODEL

CMS proposes to expand the current CJR model to include additional Medicare-severity diagnosis-related groups (MS-DRGs) related to hip fractures. Specifically, as of July 1, 2017, the agency would add episodes initiated by a beneficiary admission to an inpatient prospective payment system (PPS) hospital for MS-DRGs 480, 481 and 482. These episodes would be governed by the same parameters set forth below for the Cardiac Bundled Payment Model, which, other than the timeline and MS-DRGs, appears to be very similar to the existing CJR program. One exception to the similarity is that CMS does not propose to waive the skilled nursing facility (SNF) three-day rule for these hip fracture episodes due to evidence of higher mortality rates with shorter-than-average hospital stays.

The AHA is very concerned that, not only did CMS fail to exclude hip fractures from the original CJR model, as we had advocated, but it now proposes to add additional hip fracture episodes. Furthermore, it still does not propose to apply a comprehensive risk-adjustment methodology to these or other CJR episodes.

CARDIAC BUNDLED PAYMENT MODEL

Participation in the Cardiac Bundled Payment Model: CMS proposes that participating hospitals would be the episode initiators and bear financial risk. Specifically, the agency proposes to require inpatient PPS hospitals in 98 metropolitan statistical areas (MSAs) to participate in the model. Selection of the specific MSAs will not be made until the final rule. Certain hospitals participating in the Bundled Payment for Care Improvement program would be excluded. However, CMS notes that MSAs participating in the CJR model also would be eligible to participate in the cardiac model.

Episode of Care: CMS proposes to test the cardiac model for four-and-a-half years, beginning July 1, 2017 and ending Dec. 31, 2021 (see Table 1 below). An episode would begin with a beneficiary’s admission to an inpatient PPS hospital for either an acute myocardial infarction (AMI) or a coronary artery bypass graft (CABG). The episode would end 90 days after the date of discharge from the hospital. It would include the surgical procedure, if applicable, and inpatient stay, as well as all related

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1 MS-DRG 480 is “Hip and femur procedures except major joint with major complication or comorbidity (MCC),” MS-DRG 481 is “Hip and femur procedures except major joint with complication or comorbidity (CC)” and MS-DRG 482 is “Hip and femur procedures except major joint without CC or MCC.”
2 AMI episodes would be initiated for patients with admissions for MS-DRGs 280 - 282 or MS-DRGs 246-251 with an AMI International Classification of Diseases (ICD)-Clinical Modification (CM) diagnosis code in the principal or secondary diagnosis code position.
3 CABG episodes would be initiated for patients with admissions for MS-DRGs 231 - 236.
care covered under Medicare Parts A and B within 90 days of discharge. Unrelated services would be excluded from the episode.

### Table 1: Performance Years for Cardiac Bundled Payment Model

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Calendar Year</th>
<th>Episodes Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2017</td>
<td>Episodes that begin on or after July 1, 2017 and end on or before Dec. 31, 2017</td>
</tr>
<tr>
<td>2</td>
<td>2018</td>
<td>Episodes that end from Jan. 1, 2018 through Dec. 31, 2018</td>
</tr>
<tr>
<td>3</td>
<td>2019</td>
<td>Episodes that end from Jan. 1, 2019 through Dec. 31, 2019</td>
</tr>
<tr>
<td>4</td>
<td>2020</td>
<td>Episodes that end from Jan. 1, 2020 through Dec. 31, 2020</td>
</tr>
<tr>
<td>5</td>
<td>2021</td>
<td>Episodes that end from Jan. 1, 2021 through Dec. 31, 2021</td>
</tr>
</tbody>
</table>

**Payment Methodology:** CMS proposes to use a retrospective payment methodology with one-sided risk in the first year of the program (meaning, no hospital would be penalized in year 1), and two-sided risk in subsequent years. Under the rule, all providers would continue to receive payment under fee-for-service (FFS) Medicare. After the completion of a performance year, services furnished to beneficiaries in that year’s episodes would be grouped into episodes and aggregated. CMS would compare the participating hospitals’ total episode payments to their “target price.” If total episode payments were below the target price, Medicare would pay the hospital the difference in the form of a “reconciliation payment.” If spending was in excess of the target price, the hospital would pay Medicare the difference.

In order to determine reconciliation payments, CMS would set a target price equal to a hospital’s hospital-specific and regional blended historical payments minus a percent discount that would vary depending on its quality score (see Table 2 as well as “Linking Performance to Quality” below for more information). Hospitals would keep any savings they achieve in excess of this percent discount, again subject to quality performance. In order to determine repayments to Medicare, CMS also would set a target price equal to a hospital’s hospital-specific and regional blended historical payments minus a percent discount that would vary depending on the hospital’s quality score. Hospitals would not be subject to repayments in year 1 or the first quarter of year 2. However, in the second through fourth quarters of year 2 and years 3 through 5, they would bear risk for spending above this percent discount.
Table 2: Discount Factor by Performance Year

<table>
<thead>
<tr>
<th>Quality Score</th>
<th>Reconciliation Discount</th>
<th>Year 1 and Quarter 1 of Year 2</th>
<th>Quarters 2-4 of Year 2 and Year 3</th>
<th>Years 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below acceptable</td>
<td>N/a</td>
<td>2.0%</td>
<td>3.0%</td>
<td></td>
</tr>
<tr>
<td>Acceptable</td>
<td>3.0%</td>
<td>N/a</td>
<td>2.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Good</td>
<td>2.0%</td>
<td>N/a</td>
<td>1.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Excellent</td>
<td>1.5%</td>
<td>N/a</td>
<td>0.5%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

As an example, Hospital A has a quality score that is categorized as “excellent;” therefore, its reconciliation discount is 1.5 percent. This discount is applied to Hospital A's hospital-specific and regional blended historical payment of $50,000, which yields a target price of $49,250 ($50,000 minus the discount of $750). If Hospital A's actual spending is $48,000, it would receive a reconciliation payment of $1,250 ($49,250 minus $48,000).

Stop-loss and Stop-gain Policies: CMS proposes to set limits on both hospitals’ repayment responsibility to Medicare and their reconciliation payments. Regarding hospitals’ repayment responsibility, in year 2 of the program, the agency proposes to set a stop-loss limit equal to 5 percent of a hospital's target price multiplied by its number of episodes. For example, if a hospital's target price is $50,000 and it had 20 episodes, its repayment risk to Medicare would be capped at 5 percent of $50,000 x 20, or $50,000. The agency proposes to increase this stop-loss limit to 10 percent in year 3 and 20 percent in years 4 and 5 of the program.

 CMS proposes additional protections to limit repayment responsibility for sole-community hospitals, Medicare-dependent hospitals and rural referral centers. Specifically, it proposes to reduce stop-loss limits to 3 percent in year 2, and 5 percent in years 3 through 5. Under the example above with a target price of $50,000 and 20 episodes, these hospitals’ repayment risk would be limited to $30,000 (3 percent) in year 2 and $50,000 (5 percent) in years 3 through 5.

The agency also proposes to set a stop-gain limit equal to 5 percent of a hospital’s target price multiplied by its number of episodes in years 1 and 2; 10 percent in year 3; and 20 percent in years 4 and 5. For example, if a hospital’s target price is $50,000 and it had 20 episodes, its reconciliation payments from Medicare in year 1 would be capped at 5 percent of $50,000 x 20, or $50,000.

Linking Performance to Quality: Similar to the CJR model, CMS proposes to tie each hospital’s level of reconciliation payment or repayment responsibility to a composite quality score, as shown in Table 2 above. To assign hospitals to a quality category, CMS
proposes to calculate a quality composite score for each model using the following measures. Unless otherwise noted, all of the measures are currently reported as part of the hospital inpatient quality reporting program; this would not entail new data collection by hospitals.

AMI:
- 30-day mortality following AMI hospitalization;
- Excess days in acute care after hospitalization for AMI;
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); and
- Voluntarily-reported hybrid 30-day mortality eMeasure – This measure entails the voluntary submission of certain data elements from electronic health records that would be combined with Medicare claims data to calculate performance

CABG:
- 30-day mortality following CABG hospitalization; and
- HCAHPS

Gainsharing: Participating hospitals would be allowed to share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating providers and suppliers. Participants also could share financial accountability for increased episode spending with collaborating providers and suppliers. **However, any financial arrangements to share savings or financial accountability would need to comply with applicable fraud and abuse laws, unless the Department of Health and Human Services provides a waiver of those laws, which we will vigorously advocate for.**

Waivers: CMS does not propose any waivers to the Civil Monetary Penalty law or the federal Anti-kickback or physician self-referral (“Stark”) statutes, but states that it will consider the need for or scope of waivers to these laws when it is reviewing comments on this rule.

CMS does not propose to waive the home health (HH) “homebound” requirement, but does propose to waive the “incident to” rule to allow a beneficiary who does not qualify for HH services to receive post-discharge visits in his or her home any time during the episode. The agency also proposes to waive the geographic site requirement that limits telehealth payment to services furnished within rural areas, and to waive the practice site requirement to allow telehealth visits from the beneficiary’s home.

In addition, CMS would waive, beginning April 1, 2018, the SNF three-day rule, but only for AMI episodes and only if the SNF is rated an overall of three stars or better in the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. CMS is not proposing to waive the three-day rule for CABG episodes, stating that it
would be clinically inappropriate for this condition due to the much longer lengths of stay.

**Beneficiary Choice and Incentives:** Beneficiaries would not be able to opt out of the proposed models. However, CMS notes that this does not limit the ability of beneficiaries to choose among Medicare providers, or the range of services available to the beneficiary. The proposed model would allow participant hospitals to recommend preferred providers, but only within the constraints of current law.

In addition, CMS proposes to allow certain in-kind patient engagement incentives under the models, subject to certain conditions. For example, there must be a reasonable connection between the item or services and the beneficiary’s medical care, and it must be a preventive care item or advance a clinical goal for the beneficiary.

**Advanced Alternative Payment Model (APM) Status:** CMS proposes to create two tracks for this model – one that would qualify as an advanced APM under proposed Medicare Access and CHIP Reauthorization Act regulations, and one that would not. To participate in the advanced APM track, hospitals would need to attest to use of certified electronic health record technology.

**CARDIAC REHABILITATION INCENTIVE PAYMENTS**

CMS also proposes to test a payment methodology designed to encourage the use of cardiac rehabilitation services. Specifically, CMS would make incentive payments to hospitals caring for beneficiaries with a heart attack or bypass surgery based on their utilization of cardiac rehabilitation and intensive cardiac rehabilitation services in the 90-day care period following hospital discharge. These payments would be available to hospital participants in 45 geographic areas that were not selected for the cardiac care bundled payment models, as well as 45 geographic areas that were selected for the cardiac care bundled payment models. This test would cover the same five-year period as the cardiac care bundled payment models.

Standard Medicare payments, as well as existing coverage limitations for cardiac rehabilitation services, would continue to apply to providers participating in the model.

**NEXT STEPS**

Comments on the proposed rule will be due 60 days after it is published in the Federal Register, which CMS anticipates will be July 26. Watch for a more detailed analysis of the proposed rule in the coming weeks. The AHA will reach out to members to seek their input to inform our comments to CMS on their behalf.

If you have further questions, contact Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.