Value-Based Payment NEWS

CMS Proposed Rule to Axe Value Programs Despite Lower Costs, Same Quality

The Centers for Medicare & Medicaid Services released a proposed rule on August 15th: "CMS proposes changes to the Comprehensive Care for Joint Replacement Model, cancellation of the mandatory Episode Payment Models and Cardiac Rehabilitation Incentive payment model." The canceled programs have been delayed twice recently, but were due to take effect in January.

- The move to cancel the programs comes despite research showing that hospitals participating in bundled payment programs have cut costs, without sacrificing quality.
- Indeed, a 2016 analysis by Avelere found that 85% percent of the institutions that have been required to participate in the cardiac bundles wouldn't experience gains or losses greater than $500,000 a year, and that those that spent more than the regional average would face the heaviest losses.

As well, notes physician Ronald Hirsch MD FACP CHCQM, in a post on the racmonitor.com website, "there is some important collateral damage to consider," too. The rule that contains the cancellation proposal "also contains the cardiac rehabilitation incentive model, which was going to increase reimbursement for cardiac rehabilitation, an intervention CMS felt was underused in patients after cardiac bypass surgery and acute myocardial infarction," he wrote. "And because you apparently cannot just cancel one part of a rule, it appears that this cardiac rehabilitation incentive program must be eliminated in order for CMS to stop the expansion of the episode payment program." Other reports also point out that that included a 5% bonus for physicians participating in the cardiac bundles or the expanded CJR model, because they qualify as Advanced Alternative Payment Models under MACRA.

The cardiovascularbusiness.com website notes that "opinion in the industry has been mixed," as "several groups, like the Federation of American Hospitals, [argue] that CMS and the Center for Medicare and Medicaid Innovation doesn't have the authority to force providers to participate in any payment model," while others, like Pennsylvania's Geisinger Health System, "support delaying the bundles until 2018, but say making them voluntary would limit the 'generalizability of program results'." So far, the American College of Cardiology declines to comment "until the final rule has come out for us to review."

Doctor Group Seeks MA Participation, Advanced APM Link

The California Association of Physician Groups has a few words to say about the Centers for Medicare & Medicaid Services' proposed fee updates in MACRA's Quality Payment Program. "The quickest, simplest way to enhance the APM portfolio is to count qualifying risk contracts between plans and physician groups in MA as Advanced APMs," CAPG says in a letter to CMS. Now, bonus-eligible Advanced APMs include CMS Innovation Center demonstration projects and Medicare Shared Savings Program accountable care organizations, CAPG points out; they must participate in a quality program comparable to MIPS, use certified electronic health records technology and bear more than nominal financial risk or be a qualifying medical home. And they must meet a certain threshold of Part B revenue or patients. Here are a dozen highlights from the group's comments related to the changes CMS has proposed:

[1] CAPG members' preferred Advanced APM is prepaid capitation, because it "best aligns incentives to provide high-quality, coordinated care" and "allows members to deploy proven techniques and innovative approaches."

[2] CMS should create a Medicare Advantage Advanced APM demonstration project -- using Section 1115A of the Social Security Act – that enables clinicians to qualify for the MACRA 5% bonus and exempts them from MIPS.

[3] CMS can [then] use waiver authority to modify the revenue test to include MA revenue; in addition, or in the alternative, CMS could use the patient count threshold without a waiver.

[4] Any process CMS adopts should "minimize reporting burdens on physicians and physician groups."

[5] The Innovation Center may need to deploy additional waiver authority to address "Stark law" concerns.

[6] Requiring individual clinicians to "submit all of their payment information every year" to CMS will "serve as a barrier to participation."

(continued on page 2)