CMS PROPOSES SIGNIFICANT CHANGES TO THE CJR MODEL AND THE CANCELLATION OF THE AMI, CABG AND SHFFT EPISODE PAYMENT MODELS

On August 15, 2017, CMS released for public inspection a proposed rule that would:

1. Cancel the AMI, CABG and SHFFT episode payment models that are currently scheduled to begin on January 1, 2018.
2. Cancel the cardiac rehabilitation incentive payment program that is currently scheduled to begin on January 1, 2018.
3. Revise various aspects of the CJR model, including:

    (i) Giving certain hospitals originally selected for participation in the CJR model a one-time option to choose whether to continue their participation in the model; and

    (ii) Expanding eligibility for "Qualifying APM Participant" ("QP") status under the CJR Advanced APM track.

The proposed rule was officially published in the Federal Register on August 17, 2017. CMS will accept written comments concerning the proposed rule for 60 days following the proposed rule's official publication.

As noted, the proposed rule would modify the CJR model in various ways. Two of CMS's key proposals are summarized as follows.

GIVING CERTAIN HOSPITALS A ONE-TIME OPTION TO CHOOSE WHETHER TO CONTINUE IN CJR

CMS proposes that the CJR model would continue on a mandatory basis for hospitals participating in CJR in 34 of the 67 MSAs where CJR has been implemented. However, a hospital meeting the definition of "rural hospital" under the current CJR regulations that is located in one of the 34 mandatory participation MSAs will be automatically and permanently withdrawn from participation in CJR, effective as of the beginning of CJR's third performance year (i.e., calendar year 2018), unless the hospital notifies CMS, any time between January 1, 2018 through January 31, 2018, of its decision to continue in CJR. In other words, rural hospitals located in the 34 mandatory participation MSAs will have to "opt-in" to CJR if they want to continue in the model beyond CJR's second performance year (i.e., calendar year 2017). Click here to view Tables 1, 2 and 3 found in the proposed rule. **Table 1 is the list of the 34 mandatory participation MSAs**.

Akin to rural hospitals, a hospital meeting the definition of a "low-volume" hospital that is located in one of the 34 mandatory participation MSAs will be automatically and permanently withdrawn from participation in CJR, effective as of the beginning of CJR's third performance year, unless the hospital notifies CMS, any time between January 1, 2018 through January 31, 2018, of its decision to continue in CJR. Table 3 in the above link is a non-exclusive list of hospitals, located in one of the 34 mandatory participation MSAs, that CMS has preliminarily identified as meeting the definition of a low-volume hospital. Pursuant to the proposed rule, a low-volume hospital is a hospital identified by CMS as having fewer than 20 LEJR episodes in total across the three historical years of data used to calculate the hospital's episode target prices for CJR's first performance year (i.e., April 1, 2016 through December 31, 2016).

Hospitals in the remaining 33 current CJR MSAs will no longer be required to participate in CJR, effective as of the beginning of CJR's third performance year. The 33 voluntary participation MSAs are listed in Table 2 in the above link. A hospital in one of these 33 voluntary participation MSAs (some hospitals may be rural or low-volume hospitals) may elect to continue in CJR by notifying CMS between January 1, 2018 and January 31, 2018 of its election to continue with the model.

EXPANDING ELIGIBILITY FOR QP STATUS

Currently, in cases where CJR converts to an Advanced APM (for purposes of the hospital participating in CJR), only eligible clinicians that serve as "CJR collaborators" are eligible to become a QP. A "CJR collaborator" is a defined term that requires a special contractual arrangement between the participant hospital and the eligible clinician serving as the CJR collaborator.

Simply stated, an eligible clinician who qualifies as a QP: (i) is exempt from reporting MIPS performance data and from receiving a MIPS Part B payment adjustment for the applicable year; and (ii) is eligible to receive a lump sum payment equal to five percent of his/her prior year's

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payments for Part B professional services. The proposed rule would expand eligibility for QP status beyond CJR collaborators to include physicians, non-physician practitioners and therapists who, although not CJR collaborators, have contractual relationships with the participant hospital based at least in part on supporting the participant hospital's quality or cost goals under CJR (and who otherwise meet the performance criteria for QP status).

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