Medicare Advancing Care Coordination through Episode Payment Models (EPMs)

Payment Rule Summary — FINAL RULE
Program Years: July 1, 2017 – December 31, 2021

Overview and Resources

On December 20, 2016, the Centers for Medicare and Medicaid Services (CMS) published a final rule for the Advancing Care Coordination through Episode Payment Models (EPMs). The model is effective for episodes that start on or after July 1, 2017 and end by December 31, 2021.

A copy of the *Federal Register* (FR) final rule and other resources related to the three new EPMs are available on the CMS website at https://innovation.cms.gov/initiatives/epm/ .

A brief summary of the major sections of the final rule and changes from the proposed rule is provided below.

Model Overview and Scope

Federal Register pages 184-196

CMS finalized its proposal to implement three distinct EPMs focused on episodes of care for AMI (Acute Myocardial Infarction), CABG (Coronary Artery Bypass Graft), and Surgical hip/femur fracture treatment (SHFFT) excluding lower extremity joint replacement. AMI, CABG, or SHFFT model episodes begin with an inpatient admission to a participant hospital and assigned to one of the following MS-DRGs upon discharge:

- For AMI model: AMI MS-DRGs 280-282 and those Percutaneous Coronary Intervention (PCI) MS-DRGs 246-251 also containing AMI diagnosis codes;
- For CABG model: CABG MS-DRGs 231-236; and
- For SHFFT model: SHFFT MS-DRGs 480-482.

Episodes end 90 days after the date of inpatient discharge from a participant hospital. Episodes include the inpatient stay and all related care covered under Medicare Parts A and B during the 90 days post discharge.

The start date is July 1, 2017 with a duration of 5 program years (first year will be 6-month period from July 1, 2017 to December 31, 2017).

For SHFFT episodes, CMS is using the same 67 metropolitan statistical areas (MSAs) as the Comprehensive Care for Joint Replacement (CJR) program. For the AMI and CABG models, CMS selected 98 MSAs from a list of 293 eligible MSAs through a random sampling methodology. Any eligible beneficiary who receives inpatient AMI, CABG or SHFFT care at a hospital in a chosen geographic area will be automatically included in the applicable EPM.

Mandatory MSAs

Federal Register pages 221-240

The SHFFT model is being implemented in the same 67 MSAs as the CJR model since the infrastructure currently being established for the CJR model presents significant advantages for implementation of the SHFFT model. CMS selected CJR MSAs based on low BPCI saturation and high Lower Extremity Joint Replacements (LEJR) volumes. The SHFFT MSAs can be found on the CMS website at https://innovation.cms.gov/initiatives/cjr.

The AMI and CABG EPMs models are being implemented in the same geographic areas, but not necessarily the same areas as the CJR model. CMS selected 98 MSAs through simple random selection from a pool of 293 MSAs meeting inclusion criteria. A list of the final 98 MSAs can be found on *Federal Register pages 239-240*.

This results in four categories of MSAs:

- MSAs where only the CJR and SHFFT model episodes are implemented (50 MSAs);
- MSAs where only the CABG and AMI model episodes are implemented (81 MSAs);
- MSAs where the CJR and SHFFT as well as AMI and CABG models are implemented (17 MSAs); and
- MSAs where neither CJR nor any of the new EPMs are implemented.

CMS finalized its proposal to maintain the same cohort of selected hospitals throughout the 5-year performance periods of the EPMs, regardless of additions or removals of counties from MSAs over time.

Concurrent Models

Federal Register pages 330-332

There are a number of payment innovation models, demonstrations, pilots, etc. that could potentially overlap the EPMs. CMS outlines how overlaps between EPM beneficiaries that are also included in other models and programs are handled.

Overlap with ACOs: CMS is excluding beneficiaries in EPM episodes from being included in certain Innovation Center ACO models.

- Beneficiaries prospectively assigned to the Next Generation ACO model, Shared Savings Program ACO Track 3, and Comprehensive End Stage Renal Disease (ESRD) Care Initiative with downside risk for financial losses will be **excluded** from EPMs.

- Beneficiaries in all other ACOs will be **included** in EPMs. CMS will attribute savings achieved during an EPM episode to the EPM participant, and include EPM reconciliation payments for ACO aligned beneficiaries as ACO expenditures.

BPCI Overlap: CMS finalized that current BPCI awardees, located in EPM mandatory MSAs and participating in Models 2 or 4 for the hip and femur procedures will be excluded from the SHFFT model. BPCI awardees participating in BPCI cardiac episodes (AMI, PCI, and CABG) will also be excluded from participation in the corresponding EPM episodes.

Inclusions / Exclusions – Beneficiaries, Episodes, Hospitals, Claims

Federal Register pages 332-336

Beneficiaries: Episodes will be initiated only for beneficiaries that meet the following criteria;

- Enrolled in Medicare Part A and Part B for the duration of the episode.
- Eligibility for Medicare is not based on end-stage renal disease
- Not enrolled in any managed care plan.
- Not covered under a United Mine Workers of America health care plan.
- Medicare is their primary payer.
- Not prospectively assigned to one of the following:
    - an ACO in the Next Generation ACO model;
    - an ACO in a track of the Comprehensive ESRD Care Model incorporating downside risk for financial losses; or
    - a Shared Savings Program ACO in Track 3 (addition in final rule).
- Not under the care of an attending or operating physician, as designated on the inpatient hospital claim, who is a member of a physician group practice that initiates BPCI Model 2 episodes at the EPM participant for the MS-DRG that would be the anchor MS-DRG under the EPM.
- Not already in any BPCI model episode.
- Not already in an AMI; SHFFT; CABG; or CJR model episode.

Episodes: Episodes will be canceled if;

- A beneficiary dies at any time during the 90-day episode. This is a change from the proposed rule in which episodes are canceled only if a beneficiary dies during the anchor admission; the change was made in order to maintain program consistency with CJR.
- The beneficiary initiates any BPCI model episode at any time during an EPM episode.

Hospitals: All acute care hospitals located in the selected MSAs that are paid under the Inpatient Prospective Payment System (IPPS) (including Sole Community Hospitals and Medicare Dependent Hospitals that may be reimbursed at a hospital-specific rate) and are **not** currently participating in Models 2 or 4 of BPCI for major joint or cardiac episodes are included in the program. Hospitals outside of the designated MSAs cannot participate.

Claims: All Part A and B services related to the DRGs for AMI, PCI CABG, and SHFFT (listed above) are included in the 90-day episode. Unrelated readmissions are defined by DRG and unrelated Part B services are defined by diagnosis code. CMS' list of unrelated services can be found on their website: https://innovation.cms.gov/initiatives/epm/. All claims for Skilled Nursing Facility, Home Health Agency, Inpatient Psychiatric Facility, and Inpatient Rehabilitation Facility services are included. Claims for services that begin during the episode period and end after the 90-days will be prorated to include only the portion of payments attributable to the episode period.

PBPM Payments: As with CJR, CMS is excluding per-beneficiary per-month (PBPM) payments for the Oncology Care Model (OCM) and Medicare Care Choices Model (MCCM) from EPM episodes. CMS will include PBPM payments for new programs in EPM reconciliation calculations if it is determined that the services paid for by the PBPM payments are (1) not excluded from an EPM model's episode definition;(2) rendered during the episode; and (3) paid for from the Medicare Part A or Part B Trust Funds.

Payment

Federal Register pages 298-299

Overview: Episode targets will be set prospectively and CMS will continue to pay all providers according to the Medicare FFS payment systems. At the end of each performance year (PY), the total FFS payments will be combined to calculate an actual episode payment and then be compared to a quality-adjusted target price, resulting in one of two outcomes:

- If the total target price is higher than the total FFS payments, a reconciliation payment will be paid to the participant; or
- If the total FFS payments are higher than the target price, the participant will repay CMS.

CMS is limiting how much a participant can gain or lose overall in each performance period (details on page 6). CMS is delaying the requirement for downside risk (DR) until PY 3 with an option to voluntarily assume DR in PY 2.

Targets: Participants will be notified of target prices prior to the beginning of each performance period. CMS will set target prices for each AMI, PCI, CABG and SHFFT MS-DRG using historical episode payments based on episode "**Anchor DRG**" (see *Anchor DRG* below) and presence/absence of a readmission for CABG.

Targets for the first two program years will reflect a three-year baseline period of CY 2013-CY 2015. The baseline period will be updated bi-annually: CYs 2015 – 2017 for program years 3 and 4 and CYs 2017 – 2019 for program year 5. Every hospital will receive its own set of target prices for each program year that will reflect a phased-in blend of hospital-specific and census region data. The regional component of the blend will increase over time as follows:

- Program years 1 and 2 –one-third regional and two-thirds hospital-specific;
- Program year 3 – two-thirds regional and one-third hospital-specific;
- Program years 4 and 5 – 100% regional.

CMS finalized its plan to use 100% regional prices for participants with volumes below a threshold in the baseline period. The thresholds by EPM are:

- 50 SHFFT episodes (MS-DRGs 480-482)
- 75 AMI episodes (MS-DRGs 280-282); 125 PCI episodes (MS-DRGs 246-251 also containing AMI diagnosis codes)
- 50 CABG episodes (MS-DRGs 231-236)

As with CJR, baseline historical episodes will be trended to the PY using individual Medicare payment system updates (i.e. IPPS, OPPS, IRF PPS, and SNF PPS). Since Medicare payment system updates become effective at two different times of the year (FFY and CY), CMS calculates one set of EPM-benchmark and quality-adjusted target prices for EPM episodes initiated between January 1 and September 30 and another set for EPM episodes initiated between October 1 and December 31.

Discount: To guarantee Medicare program savings, CMS reduces target prices by a discount factor. The discount factor applies to both reconciliation and repayment and varies based on quality performance (see *Quality Measures and Reporting* below).

Target Composition: Episodes generally follow the same construct as CJR episodes; starting with an anchor acute care admission and including all related Medicare claims 90 days post discharge. CMS makes adjustments for AMI and PCIs with transfer admissions, AMI and PCI episodes including a CABG readmission, and CABG episodes with AMI. CMS eliminated its "price DRG", or chaining, proposal and reverts back to "anchor DRG" episode assignments with modifications for acute transfers.

- **Anchor DRG:** Episodes begin with a discharge under one of the AMI, PCI, CABG or SHFFT MS-DRGs. The episode anchor DRG will depend on the presence or absence of an acute transfer between two participant hospitals.
    - ❖ If an episode does not include a transfer in the anchor period, the anchor DRG is the initial AMI, PCI, CABG or SHHFT MS-DRG.
    - ❖ If a beneficiary is discharged from a participant hospital (A) with AMI, CABG, or PCI MS-DRG, transferred to another participant acute inpatient hospital (B), and subsequently discharged with an AMI, PCI or CABG MS-DRG, the anchor DRG is the MS-DRG from the hospital B stay and the episode begins with the hospital B admission.
    - ❖ If a transfer discharge results in an MS-DRG other than an AMI, PCI or CABG or there is a transfer to a non-participating hospital the episode is cancelled.

Both historical and performance period episodes are assigned an anchor DRG that determines the target for performance period episodes and how baseline episodes are stratified for target calculation.

Sample Scenario: Patient is admitted and discharged from Hospital A for AMI MS-DRG 281; is transferred to Hospital B for PCI MS-DRG 246.

Hospital A <u>and</u> B are EPM Participants

	Included in Episode			
	Start of Episode →	End of Episode		
Hospital A	**Hospital B**	**Post Discharge Period**	**Hospital Attribution**	**Anchor DRG**
MS-DRG 281	**MS-DRG 246**	**90 Days**	**Hospital B**	**MS-DRG 246**

Hospital A is NOT an EPM Participant and Hospital B is an EPM Participant

	Included in Episode			
	Start of Episode →	End of Episode		
Hospital A	**Hospital B**	**Post Discharge Period**	**Hospital Attribution**	**Anchor DRG**
MS-DRG 281	**MS-DRG 246**	**90 Days**	**Hospital B**	**MS-DRG 246**

Hospital A is an EPM Participant and Hospital B is NOT an EPM Participant

Hospital A	Hospital B	Post Discharge Period	**Hospital Attribution**
MS-DRG 281	MS-DRG 246	90 Days	**Episode Canceled**

- **AMI and PCI episodes including a CABG readmission:** CMS adds an additional amount to the target price for AMI/PCI episodes with CABG readmissions during the 90-day post discharge period. This add-on is the average baseline anchor admission (Part A and Part B services) price for the corresponding CABG MS-DRG that results in an additional 54 unique target prices.
- **CABG episodes with AMI**: CMS notes CABG average episode spending during the post discharge period is considerably higher for those beneficiaries who also had AMI diagnosis on the anchor claim. Therefore, CMS further stratifies CABG targets
  - ❖ Anchor component will be stratified by CABG DRG (6 possible target values);
  - ❖ Post-discharge component will be stratified by and presence/absence of an AMI ICD–CM diagnosis code on the anchor inpatient claim and presence/absence of major complication or comorbidity (MCC) in the anchor DRG (4 possible target values).

  This results in 12 possible targets for CABG episodes.

Calculation of Historical EPM Episode Payments: In performance years three through five, CMS is including both EPM and BPCI reconciliation payments and repayments when calculating EPM-episode payments to update EPM-episode benchmarks and quality-adjusted targets. The effect of this rule is to limit the decrease in overall spending to the discount factor.

Reconciliation and repayment: Actual Medicare spending for EPM episodes will be reconciled retrospectively, following the end of each program/calendar year, with a subsequent true-up one year later to account for claims lag. Hospitals that produce Medicare program savings below the

discounted target price will be eligible to receive reconciliation payments if they also achieve at least an "acceptable" performance rating on the composite quality measure (see *Quality Measures and Reporting* below). Beginning with PY 3 episodes, hospitals that produce financial results exceeding the target will be responsible for repaying overages to Medicare.

Hospitals that are deemed "Below Acceptable" on the composite quality measure will not be eligible to receive reconciliation payments, regardless of financial performance.

High cost episodes: EPM participants are protected from the impacts of individual episodes with extremely high costs with the application of a high cost threshold. Any episode payments in excess of the two standard deviations from the episode regional mean will not count toward either target or performance period calculations. For SHFFT and AMI/PCI episodes without CABG readmission, CMS is calculating and applying the threshold for each anchor DRG.

Thresholds for AMI/PCI episodes with CABG readmissions and CABG episodes:

- **CABG readmission:** CMS finalized its plan to apply the ceiling separately to the payments during the CABG readmission and all other payments during the episode.
- **CABG episodes**: CMS finalized its plan to apply ceilings separately to the payments that occurred during the anchor hospitalization of the CABG model episode and to the payments that occurred after the anchor hospitalization and to apply the same stratification of the post-anchor period that is used to set targets. This results in six anchor thresholds and four post-admission thresholds.

Limitations on losses and gains: To protect participants from large repayment amounts and to limit their financial exposure, CMS finalized stop-loss and stop-gain limits based on actual EPM-episode payments. These limits will be applied at the individual AMI, CABG and SHFFT model level. A summary of these limits is below:

Year	Risk Level	Target Price (hospital-specific /regional split)	Discount Range for Calculating Reconciliation	Discount Range for Calculating Repayment	Stop-Gain/ Stop-Loss
PY 1	Upside Only	2/3 hospital 1/3 regional	1.5% - 3.0% *	N/A *	Stop-gain: 5%
PY 2	Voluntary Two-Sided	2/3 hospital 1/3 regional	1.5% - 3.0% *	0.5% - 2.0% *	Stop-gain: 5% Stop-loss (voluntary): 5%
PY 3	Two-Sided	1/3 hospital 2/3 regional	1.5% - 3.0% *	0.5% - 2.0% *	5% for both
PY 4	Two-Sided	100% regional	1.5% - 3.0% *	0.5% - 2.0% *	10% for both
PY 5	Two-Sided	100% regional	1.5% - 3.0% *	1.5% - 3.0% *	20% for both

* Discount percentage applies to target price and varies based on quality performance and program year. See "Quality Measures and Reporting" below.

Although rural counties are excluded from these models, rural hospitals (SCH, MDH and RRC) located in the mandatory MSAs will have a lower stop-loss limit for every EPM model. Specifically, the stop-

loss limit is 3% in Q2 2018 – Q4 2019 and 5% for the remaining years. In the final rule, CMS added these same stop-loss protections to "EPM volume protection hospitals." EPM volume protection hospitals are those with a baseline volume at or below the 10th percentile for hospitals located in EPM eligible MSAs. This eligibility is evaluated for each EPM model separately (AMI, CABG, SHFFT).

Quality Measures and Reporting
Federal Register pages 353-405

EPM participants' quality performance will be assessed at reconciliation. Points for quality performance and improvement will be awarded for each episode measure and aggregated to develop a composite quality score to determine the participant's quality category. Performance will constitute the majority of available points in the composite quality score, with improvement points available as "bonus" points for the measure. The quality measure performance periods are available on *Federal Register* pages 404-405.

The quality measures for the SHFFT model are the same measures selected for the CJR model:

- THA/TKA Complications: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (National Quality Forum [NQF] #1550)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)
- Voluntary THA/TKA PRO measure: Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) voluntary patient reported outcome (PRO) and limited risk variable submission

The quality measures for the AMI model are:

- MORT-30-AMI: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following AMI Hospitalization (NQF #0230)
- AMI Excess Days: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (acute care days include emergency department, observation, and inpatient readmission days)
- HCAHPS Survey (NQF #0166)
- Hybrid AMI Mortality Voluntary Data Submission (NQF #2473)

The quality measures for the CABG model are:

- MORT-30-CABG: Hospital 30-Day, All-Cause RSMR Following CABG (NQF #2558)
- HCAHPS Survey (NQF #0166)
- *Final Rule Addition*: Society of Thoracic Surgeons' (STS) Composite CABG Voluntary Data Submission (NQF #0696)

The chart below describes how the quality composite scores will affect reconciliation payments and repayments:

Quality Category	**AMI Composite Quality Score**	**CABG Composite Quality Score**	**SHFFT Composite Quality Score**	**Eligible for *Reconciliation* Payments**	**Eligible for *Quality Incentive Payment* ***	**Discount for Calculating *Reconciliation*** (All Program Years)	**Discount for Calculating *Repayment*** (Years 2(DR)** 3 and 4)	**Discount for Calculating *Repayment*** (Year 5)
Below Acceptable	< 3.6	< 2.8	< 5.0	No	No	3.0%	2.0%	3.0%

Acceptable	≥ 3.6 and < 6.9	≥ 2.8 and < 4.8	≥ 5.0 and < 6.9	Yes	No	3.0%	2.0%	3.0%
Good	≥ 6.9 and ≤ 14.8	≥ 4.8 and ≤ 17.5	≥ 6.9 and ≤ 15.0	Yes	Yes	2.0%	1.0%	2.0%
Excellent	> 14.8	> 17.5	> 15.0	Yes	Yes	1.5%	0.5%	1.5%

* Eligibility for the "Quality Incentive Payment" reduces the discount applied to target price for calculating reconciliation payments and repayment in all years.
**DR = Downside risk; Voluntary in Performance year 2.

Data Sharing

Federal Register pages 508- 517

CMS will provide participants with three years of baseline period claims data for episodes attributed to the hospital prior to the start of the program (July 1, 2017) and performance period data on a quarterly basis. Participants must request their data; it will not be provided automatically.

For episodes in the baseline and performance periods, data will be available in two formats:

- Beneficiary-level raw claims data
- Summary beneficiary claims data containing information by category of service for all SHFFT, AMI and CABG episodes, including the procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90-days after discharge.

Policy Waivers

Federal Register pages 483-508

Certain policy waivers are available only for beneficiaries that are part of an EPM episode of care.

SNF Three-Day Rule

CMS finalized its plan to waive the three-day hospital stay required for SNF payment beginning with anchor hospitalizations discharged on or after October 4, 2018, for AMI episodes only, when clinically appropriate. Use of this waiver requires that the SNF have an overall quality rating of three stars or better on the Nursing Home Compare website for at least seven of the most recent 12 months at the time of the beneficiary's SNF admission.

CMS does *NOT* waive this requirement for CABG or SHFFT episodes. The mean hospital length of stay for CABG discharges is well above three days, which indicates that early discharge to SNF is not clinically appropriate.

Post-Discharge Home Visits

CMS is maintaining the homebound requirements for home care services. However, CMS waives the "incident to" rule, which allows an EPM beneficiary that does *not* qualify home health services to receive post-discharge visits in his or her place of residence during the episode:

- AMI Model: up to 13 home visits;

- CABG Model: up to 9 home visits;
- SHFFT Model: up to 9 home visits.

CMS is allowing practitioners to bill for services provide by licensed clinical staff, such as nurses, when provided under general supervision of a physician or non-physician practitioner.

Telehealth Services

CMS waives the *geographic site* requirement for telehealth services. This allows beneficiaries located in any region to receive services related to the episode via telehealth, as long as they continue to meet all other Medicare requirements for telehealth.

CMS waives the *originating site* requirements if the telehealth service is provided in the beneficiary's place of residence during the episode. Current rules require the beneficiary to receive telehealth services in one of eight eligible types of sites.

Under this waiver, CMS creates nine new HCPCS G-codes to report the home telehealth evaluation and management (E/M) visits. *Federal Register* pages 497-499.

Financial Arrangements

Federal Register pages 433-483

The EPM rule holds hospital participants financially responsible for AMI, CABG, and SHFFT model episodes and, only EPM participants would be directly subject to reconciliation payments or repayments.

Hospitals can enter into financial arrangements with "EPM collaborators," providers that furnish direct care during EPM episodes (including ACOs) and intend to share in reconciliation payments and/or repayments.

Gainsharing Payment

Gainsharing payments fall into two categories: reconciliation payments and internal cost savings. Gainsharing is voluntary for the hospital, but if agreed to, the hospital must provide these payments annually. Gainsharing cannot be predicated on the volume/value of referrals. Gainsharing payments made to physicians or physician group practices are capped at 50% of the total Medicare amount approved under the Physician Fee Schedule for services furnished by the physician to EPM beneficiaries during the performance year in which the EPM participant accrued the internal cost savings or earned the reconciliation payments.

Alignment Payment

EPM collaborators can share in downside risk or "repayment." Payments to hospitals under such an arrangement are called alignment payments. Alignment payments from an EPM collaborator other than an ACO cannot exceed 25% of the total amount owed to CMS. Alignment payments from an ACO cannot exceed 50% of the amount owed to CMS. The total amount of alignment payments that a hospital receives from all collaborators cannot exceed 50% of the amount owed to CMS.

Beneficiary Protections

Federal Register pages 410-431

Beneficiaries *cannot* opt out of an EPM episode and their claims data will be made available to EPM participants. The only way for beneficiaries to "opt out" is to seek care from a provider that is not in a mandatory EPM market area.

Beneficiaries must be made aware that they are part of an EPM program. CMS finalized its plan that hospitals must provide written notice upon admission to the participant hospital or as soon as is reasonable practical, but no later than discharge from the EPM participant hospital accountable for the EPM episode. Written notice must explain the EPM model, patient protections, how to access care records, and continuing freedom of choice.

CMS requires that participant hospitals must provide patients with "a complete list of all available post-acute care options in the service area consistent with medical need, including beneficiary cost-sharing and quality information." Hospitals are not prevented from recommending preferred providers in accordance with existing law.

Additionally, CMS will monitor participant claims data for systematic delaying of care or other behavior that compromises beneficiary access to care.

Alternative Payment Models (APMs) for EPMs

Federal Register pages 203-211

MACRA authorizes new physician payment models to qualify for financial rewards through the Quality Payment Program (QPP). Under the QPP Advanced APM track, participating clinicians can qualify for bonus payments beginning in 2018 if the following criteria are met:

1. EPM Collaborator agreement includes at least one outcome measure if an appropriate measure is available on the Merit-Based Incentive Payment System (MIPS) list of measures for that specific performance period. The outcome measures meeting this requirement are:
    - AMI Model- Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization (NQF #0230);
    - CABG Model- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG (NQF #2558); and
    - SHFFT- Hospital-level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA (NQF #1550);
2. The level of marginal risk must be at least 30% of losses in excess of expected expenditures; and total potential risk must be at least 3% of expected expenditures; and
3. Clinicians use Certified Electronic Health Record Technology (CEHRT). Clinicians must attest to meeting the definition as specified by CMS. In addition, each EPM participant is required to submit a *clinician financial arrangement* list no more often than quarterly. This list must include information on each EPM collaborator, collaboration agent, and downstream collaboration agent.

Cardiac Rehabilitation Incentive Payment Model

Federal Register pages 563-594

Background

This design of this program is to encourage the use of Cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) services that have been shown to significantly improve patient outcomes following AMI or CABG but remain underutilized. CMS cites barriers to CR utilization as "low beneficiary referral rates (particularly of women, older adults, and ethnic minorities); lack of strong physician endorsement of CR to their patients; lack of awareness of CR; the financial burden on beneficiaries due to coinsurance and lost work; lack of accessibility of CR program sites; the Medicare CR requirement for physician supervision; and inadequate insurance reimbursement."
Other barriers include the fact that CR/ICR services must be provided in a physician office or hospital outpatient setting and are covered by Medicare part B. Current regulations require a physician to be immediately available and accessible to provide assistance and direction at all times.

CR sessions are limited to a maximum of two one-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare Administrative Contractor. ICR program sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

Model Participants

CMS selected participants from the pool of 293 MSAs eligible for the AMI/CABG EPM. CMS randomly selected 45 MSAs from the final 98 EPM MSAs (EPM-CR MSAs) and 45 from the remaining 195 MSAs that were eligible but not selected for EPM (FFS-CR MSAs). Listings of MSAs included in the CR model are found on Tables 53 and 54 in the Federal Register. *Federal Register pages 570-571*.

Services and Performance Years

Physician fee schedule (PFS) with a place of service code of '11' and outpatient PPS (OPPS) paid claims that count towards incentive payments must contain the following HCPCS codes:

- 93797: Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
- 93798: Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
- G0422: Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise (per session)
- G0423: Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise (per session)

Any CR/ICR services paid by Medicare during AMI and CABG EPM model episodes or AMI and CABG care periods (for CR/ICR participants not in the EPM model) would result in an incentive payment. For participants not in the EPM model, CMS defines "**AMI/CABG Care Periods**" equal to the AMI and CABG model episode definitions.

All **AMI/CABG model episodes** and **AMI/CABG care periods** must begin on or after July 1, 2017 and end on or before December 31, 2021.

Incentive Payments

CMS finalized its two-tiered, per-service payment to incentivize the initiation of service and also to incentivize meeting the service utilization benchmark of 12 visits. The incentive payment for the first 11 CR/ICR services is $25; for the 12th and subsequent services, the incentive payment would increase to $175. CMS does not cap to the amount of services because the Medicare program already contains coverage limits for CR/ICR.

CR/ICR incentive payments are separate and distinct from AMI/CABG EPM program reconciliation payments and repayments. CMS will be making CR/ICR incentive payments without stop-gain limits and not allowing the inclusion of CR/ICR incentive payments in EPM sharing arrangements. Additionally, incentive payments are excluded from the EPM episode spending and target calculations.

CMS will make retrospective CR/ICR payments on an annual basis using the same timeframe as the EPM reconciliations.

Data Sharing

CMS will issue annual summary reports to participants at the same time as EPM reconciliation reports. The summary reports will include attributed service volumes and calculation of incentive payments. Detailed claims for CR/ICR will already be included in the requested claims data for AMI/CABG EPM participants. For participants not part of the EPM program, claim level data must be requested and would include the inpatient admission for CABG or AMI, and the carrier and outpatient claims containing the CR/ICR services during the 90-days post discharge timeframe.

Beneficiary Incentives for Non-EPM Participants

In addition to increasing care-coordination and increasing the medically necessary utilization of CR/ICR services, the goal of the program is address the lack of accessibility of CR/ICR sites. The EPM program allows participants to provide in-kind patient engagement incentives and beneficiary transportation to CR/ICR services and the same benefits should be afforded to CR/ICR participants not part of the AMI/CABG EPMs. CMS is allowing these participants to provide the same in-kind patient engagement incentives as long as they meet all the requirements specified in the final rule. *Federal Register pages 591-592.*

Provider and Supplier

As discussed above, current regulations require that a physician be available and accessible in order to meet the requirements of a CR or ICR program. CMS finalized its proposal to waive this requirement and allow a physician assistant, nurse practitioner or clinical nurse specialist to perform the functions of a supervisory physician, prescribe exercise, and establish, review and sign an individualized treatment plan every 30 days.

CJR Adjustments

Federal Register pages 520-563

Included in the EPM rule are a number of modifications to the CJR model that align CJR policies with the SHFFT model, most notably:

Calculation of Historical EPM Episode Payments: Currently the CJR model excludes reconciliation payments and repayments from target prices. Beginning with PY 3, CJR will now include CJR and BPCI reconciliation payments in the baseline when calculating the regional portion of CJR target prices.

Overlap with ACOs: For CJR episodes beginning on or after July 1, 2017, CMS is excluding beneficiaries that are prospectively assigned to a Next Generation ACO, a Shared Savings Program ACO participating in Track 3, or ESRD Seamless Care Organization (ESCO) in the Comprehensive ESRD Care initiative in tracks with downside risk for financial losses.

Advanced Payment Models (APMs): Starting performance year 2 of the CJR model, CMS is adopting two different tracks for CJR. In Track 1, CJR participants would meet the criteria for Advanced APMs and in Track 2 participants would not meet the criteria. The current CJR model meets the quality and financial requirements for Track 1 APMs. In order for the CJR model to meet the criteria to be an Advanced APM, CMS is requiring participant hospitals to attest to their use of CEHRT to participate in Track 1 of the CJR model.