Medicare Advancing Care Coordination through Episode Payment Models (EPMs)

Payment Rule Summary — PROPOSED RULE
Program Years: July 1, 2017 – December 31, 2021
August 2016

Overview and Resources

On July 26, 2016, the Centers for Medicare and Medicaid Services (CMS) published a proposed payment rule for the Advancing Care Coordination through Episode Payment Models (EPMs). The model program, if adopted as final, would be effective for discharges on or after July 1, 2017 unless otherwise noted.

A copy of the *Federal Register* (FR) with this proposed rule and other resources related to the 3 new EPMs are available on the CMS website at https://innovation.cms.gov/initiatives/cardiac-rehabilitation/. Comments on all aspects of the proposed rule are due to CMS by October 3, 2016 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "5519-P". Page numbers noted in this summary are from the version of the proposed rule published in the *Federal Register*.

A brief summary of the proposed rule is provided below.

Model Overview and Scope

Federal Register pages 50800-50804

CMS is proposing 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. An AMI, CABG, or SHFFT model episode would 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 would end 90 days after the date of inpatient discharge from and include the inpatient stays and all related care covered under Medicare Parts A and B during the 90 days.

The start date is proposed at 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).

CMS is proposing to use the same 67 metropolitan statistical areas (MSAs) as the Comprehensive Care for Joint Replacement (CJR) program for SHFFT episodes. For AMI and CABG, CMS is proposing to select 98 MSAs from a list of 294 through a random sampling methodology; the 98 will be identified in the final rule. Any eligible beneficiary who receives AMI, CABG or SHFFT care at a hospital in a chosen geographic area will be automatically included in the applicable EPM.

The proposed EPMs are very similar in design to Model 2 of the Medicare Bundled Payments for Care Improvement (BPCI) demonstration program as well as the Comprehensive Care for Joint Replacement (CJR) model.

Mandatory MSAs

Federal Register pages 50815-50829

The SHFFT model is proposed to be 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 proposed MSAs can be found in **Table 1** below.

CMS is proposing to implement the AMI and CABG EPMs models together in the same geographic areas, but not necessarily the same areas as the CJR model. CMS is proposing to select 98 MSAs through simple random selection from a pool of 294 MSAs meeting inclusion criteria. A list of the eligible 294 MSAs is available on page 50817 of the *Federal Register;* the final 98 MSAs have not yet been published.

This results in 4 categories of MSAs:

- MSAs where only the CJR and SHFFT model episodes will be implemented;
- MSAs where only the CABG and AMI model episodes will be implemented;
- MSAs where the CJR as well as AMI, CABG, and SHFFT models will be implemented; and
- MSAs where neither CJR nor any of the new EPMs will be implemented.

CMS proposes 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 50867-50872

There are a number of payment innovation models, demonstrations, pilots, etc. that could potentially overlap the proposed EPMs. CMS outlined proposals to account for overlap where EPM beneficiaries are also included in other models and programs.

Overlap with ACOs: CMS proposes to exclude beneficiaries in the proposed EPMs' episodes from being included in certain Innovation Center ACO models; beneficiaries from EPMs who are aligned to ACOs in the Next Generation ACO model and End Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) in the Comprehensive ESRD Care initiative in tracks with downside risk for

financial losses. Other CMS programs, such as the Medicare Shared Savings Program and other ACO or total cost of care initiatives, will not result in exclusion of beneficiaries from EPMs.

As with CJR, 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 is proposing that current BPCI awardees, located in EPM mandatory MSAs and participating in Models 2 and 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, Hospitals, Claims

Federal Register pages 50832-50834, 50840-50842

Beneficiaries: Episodes will be initiated only for beneficiaries enrolled in both Medicare FFS Part A and Part B for the entire length of the episode. Beneficiaries eligible for ESRD coverage, those enrolled in Medicare Advantage plans or having a primary payer other than Medicare, and those already in any BPCI model episode are excluded. An EPM episode will be cancelled if a beneficiary dies during the anchor admission or the beneficiary initiates any BPCI model episode at any time during the proposed episodes.

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 MSAs cannot participate.

Claims: All Part A and B services related to the DRGs for AMI, CABG, and SHFFT (listed above) are included in the 90-day episode. 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. Unrelated readmissions are defined by DRG and unrelated Part B services are defined by diagnosis code. These DRGs and services mirror the unrelated DRGs and services in the BPCI program. All claims for Skilled Nursing Facility, Home Health Agency, Inpatient Psychiatric Facility, and Inpatient Rehabilitation Facility services are included.

Payment

Federal Register pages 50834-50856

Overview: CMS is proposing to test the AMI, CABG, and SHFFT EPMs for 5 performance years (PY)s beginning July 1, 2017. Episode targets will be set prospectively and CMS will continue to pay all providers according to the Medicare FFS payment systems. However, at the end of each 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 beginning with episodes ending in the second quarter of PY 2.

CMS proposes to limit how much a participant can gain or lose overall in each performance period. CMS is proposing to phase in the requirement for repayment to CMS until Q2 of PY 2. Lastly, CMS is proposing to further limit the risk of high payment cases for all participants and for special categories of participants.

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 and SHFFT MS-DRG using historical episode payments based on episode "**Price DRG**" (see *Price DRG* below).

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 regional 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 proposes to use 100% regional prices for participants with low volume 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)

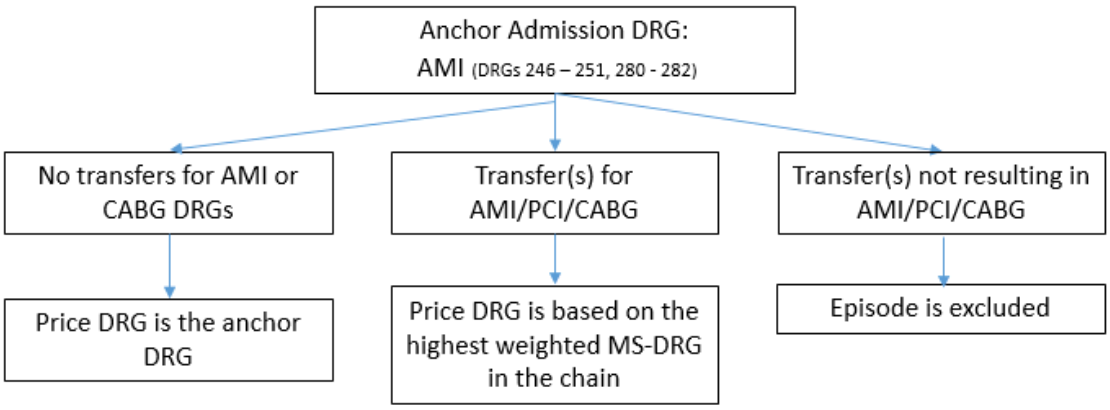
As with CJR, baseline historical episodes will be trended to the PY using individual Medicare payment system updates (i.e. IPPS, OPPS, IRF PPS, SNF PPS). Since Medicare payment system updates become effective at two different times of the year (FFY and CY), CMS will calculate one set of EPM-benchmark 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 proposes to reduce 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 will 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 is proposing adjustments for AMI and PCIs with transfer admissions, AMI and PCI episodes including CABG readmission and CABG episodes with AMI.

- **Price DRG:** Episodes begin with a discharge under one of the AMI, PCI, CABG or SHFFT MS-DRGs. The MS-DRG of this anchor admission is the "anchor DRG." For CABG and SHFFT anchor DRGs, the **Price DRG** equals the anchor DRG. For AMI and PCI anchor DRGS, the **Price**

DRG will depend on the presence or absence of an acute transfer or "chained hospitalization." If a beneficiary is discharged with AMI or PCI MS-DRG, transferred to another acute inpatient hospital, and subsequently discharged with an AMI, PCI or CABG MS-DRG, the **Price DRG** is the highest weighted MS-DRG in the chain. If an AMI/PCI episode does not include a transfer or the anchor MS-DRG is a CABG or SHHFT MS-DRG, the **Price DRG** equals the anchor DRG. If a transfer discharge results in an MS-DRG other than an AMI, PCI or CABG the episode is excluded. See the chart below for a complete description:



Both historical and performance period episodes will be assigned a **Price DRG** that determines the target for performance period episodes and how baseline episodes will be stratified for target calculation. Episodes containing chained hospitalizations are attributed to the anchor admission hospital.
Sample Scenario: Patient is admitted and discharged from Hospital A for AMI MS-DRG 280; is transferred to Hospital B for PCI MS-DRG 246.

Hospital A is an EPM Participant

Included in Episode					
Start of Episode →		End of Episode			
Anchor DRG (Hospital A)	**Price DRG (Hospital B)**	**Post Discharge Period**	**Performance Period Hospital Attribution**	**Performance Period Episode Assignment for Reconciliation**	**Baseline Period Episode Assignment for Benchmark/Target Calculation**
MS-DRG 280	**MS-DRG 246**	**90 Days**	**Hospital A**	**MS-DRG 246**	**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	**Anchor DRG = Price DRG Hospital B**	**Post Discharge Period**	**Performance Period Hospital Attribution**	**Performance Period Episode Assignment for Reconciliation**	**Baseline Period Episode Assignment for Benchmark/Target Calculation**
MS-DRG 280	**MS-DRG 246**	**90 Days**	**Hospital B**	**MS-DRG 246**	**MS-DRG 246**

- **CABG readmission:** CMS proposes to add 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.
- **CABG episodes**: 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 is proposing to create targets by further stratifying CABG targets into four possible scenarios. CABG admissions with and without an AMI ICD–CM diagnosis code on the anchor inpatient claim and whether the price MS–DRG is a CABG MS–DRG with major complication or a CABG MS–DRG without major complication or comorbidity.

Calculation of Historical EPM Episode Payments: CMS is proposing to *include* both EPM reconciliation payments and repayments when calculating EPM-episode payments to update EPM-episode benchmark and quality-adjusted target prices. The effect of this rule is to limit the decrease in overall spending to the discount factor. Additionally, CMS is proposing to include BPCI Net Payment Reconciliation Amounts when updating EPM episode benchmark and quality-adjusted target prices.

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 episodes that start on April 1, 2018, 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 will be 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 proposes to calculate and apply the threshold for each price DRG.

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

- **CABG readmission:** CMS proposes to apply the ceiling separately to the payments during the CABG readmission and all other payments during the episode.
- **CABG episodes**: CMS proposes 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. This results in six anchor thresholds and four post-admission thresholds.

Limitations on losses and gains: To protect participants from large repayment amounts CMS is proposing the same stop-loss limits as implemented in the CJR model. Additionally, CMS is proposing to limit their exposure with stop-gain limits. 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
July 1, 2017 – March 31, 2018	Upside Only	2/3 hospital 1/3 regional	1.5% - 3.0% *	N/A *	Stop-gain: 5%
April 1, 2018	Two-Sided	2/3 hospital 1/3 regional	1.5% - 3.0% *	0.5% - 2.0% *	Stop-gain: 5% Stop-loss: 5%
CY 2019	Two-Sided	1/3 hospital 2/3 regional	1.5% - 3.0% *	0.5% - 2.0% *	10% for both
CY 2020	Two-Sided	100% regional	1.5% - 3.0% *	1.5% - 3.0% *	20% for both
CY 2021	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. Specifically, the stop-loss limit is 3% in 2Q2018 - 4Q2018 and 5% for the remaining years.

Quality Measures and Reporting

Federal Register pages 50897-50911

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 EPM participant's quality category for the episode. Performance will constitute the majority of available points in the composite quality score, with improvement points available as "bonus" points for the measure. The proposed quality measure performance periods are available on *Federal Register* pages 50910-50911.

The proposed 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 proposed for the AMI model are:

- MORT-30-AMI: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (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) using linear mean roll-up (HLMR) scores as implemented in CJR Voluntary submission of the Hybrid AMI Mortality (NQF #2473)

The quality measures proposed for the CABG model are:

- MORT-30-CABG: Hospital 30-Day, All-Cause RSMR Following Coronary Artery Bypass Graft Surgery (NQF #2558)
- HCAHPS Survey (NQF #0166)

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)** and 3)	**Discount for Calculating *Repayment*** (Years 4 and 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; Performance year 2 has no downside risk or repayment responsibility until second quarter which begins April 1, 2018.

Data Sharing

Federal Register pages 50944-50984

CMS proposes to 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 50931-50944

CMS will provide certain policy waivers only for beneficiaries that are part of an EPM episode of care.

SNF Three-Day Rule

CMS proposes to waive the three-day hospital stay required for SNF payment beginning April 1, 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

CMS is *NOT* proposing to 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 proposes *not* to waive the homebound requirements for home care services. However, CMS proposes to waive the "incident to" rule, which will allow an EPM beneficiary that does *not* qualify for 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

Telehealth Services

CMS proposes to waive the *geographic site* requirement for telehealth services. This will allow 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 proposes to waive 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 proposes to create nine new HCPCS G-codes to report the home telehealth evaluation and management (E/M) visits.

Financial Arrangements

Federal Register pages 50925-50930

CMS is proposing to use the same general framework as CJR to hold hospital participants financially responsible for AMI, CABG, and SHFFT model episodes. Only EPM participants would be directly subject to reconciliation payments or repayments.

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

Gainsharing Payment

CMS proposes that gainsharing payments would 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 (PGPs) 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

CMS proposes that 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 50913-50915

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 proposes that hospitals must provide written notice upon admission to the participant hospital or immediately following the decision to schedule a procedure or provide services which would result in a patient being discharged to any beneficiary that meets the EPM criteria. Written notice must explain the EPM model, patient protections, how to access care records, and continuing freedom of choice.

CMS proposes to require 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.

Advanced Payment Models (APMs) for EPMs

Federal Register pages 50913-50915

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

- Include 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 level of marginal risk must be at least 30% of losses in excess of expected expenditures; and total potential risk must be at least 4% of expected expenditures; and
- Physicians use Certified Electronic Health Record Technology (CEHRT).

CMS proposes to allow two different tracks for EPMs:

- Track 1 – Physicians meet the QPP Advanced APM criteria; or
- Track 2 - Physicians do *NOT* meet the QPP Advanced APM criteria.

To meet the QPP Advanced APM requirement, at least one outcome measure must be included if an appropriate measure is available on the QPP MIPS list of measures. CMS proposes the following three outcome measures in the EPMs:

- 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)

Those EPM participants that meet the CEHRT use requirement must attest to meeting the definition as specified by CMS. In addition, each EPM participant would be 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 50973-50989

Background

CMS proposes an incentive program 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 2 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 is proposing to select participants from the pool of 294 MSAs eligible for the AMI/CABG EPM. CMS will select randomly select 45 MSAs from the final 98 EPM MSAs (EPM-CR MSAs) and 45 from the remaining 196 MSAs that were eligible but not selected for EPM (FFS-CR MSAs).

Services and Performance Years

Physician fee schedule (PFS) and outpatient PPS (OPPS) paid claims that will 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)

CMS proposes 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 is proposing a 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 propose a 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 is therefore proposing to make CR/ICR incentive payments without stop-gain limits and not allow the inclusion of CR incentive payments in EPM sharing arrangements. Additionally, incentive payments are excluded from the EPM episode spending and target calculations.

CMS is proposing to make retrospective CR/ICR payments on an annual basis using the same timeframe as the EPM reconciliation.

Data Sharing

CMS is proposing to 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 beneficiary transportation to CR/ICR services and the same benefits should be afforded to CR/ICR participants not part of the AMI/CABG EPM. CMS is proposing to allow these participants to provide transportation as a beneficiary engagement incentive.

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 is proposing 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 Proposed Adjustments

Federal Register pages 50950-50973

Included in the EPM proposed rule are a number of modifications to the CJR model which will 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. CMS is proposing to now include CJR and BPCI reconciliation payments when calculating the regional portion of CJR target prices.

Overlap with ACOs: For CJR episodes beginning on or after July 1, 2017, CMS is proposing to exclude beneficiaries that are prospectively aligned to a Next Generation ACO 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 proposing to adopt 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 proposed criteria. The current CJR model meets the quality and financial requirements for Track 1 AMPs. In order for the CJR model to meet the proposed criteria to be an Advanced APM, CMS is proposing to require participant hospitals to use CEHRT (as defined in section to participate in Track 1 of the CJR model.

Table 1 – Mandatory SHFFT MSAs

MSA	MSA Title
10420	Akron, OH
10740	Albuquerque, NM
11700	Asheville, NC
12020	Athens-Clarke County, GA
12420	Austin-Round Rock, TX
13140	Beaumont-Port Arthur, TX
13900	Bismarck, ND

14500	Boulder, CO
15380	Buffalo-Cheektowaga-Niagara Falls, NY
16020	Cape Girardeau, MO-IL
16180	Carson City, NV
16740	Charlotte-Concord-Gastonia, NC-SC
17140	Cincinnati, OH-KY-IN
17860	Columbia, MO
18580	Corpus Christi, TX
19500	Decatur, IL
19740	Denver-Aurora-Lakewood, CO
20020	Dothan, AL
20500	Durham-Chapel Hill, NC
22420	Flint, MI
22500	Florence, SC
23540	Gainesville, FL
23580	Gainesville, GA
24780	Greenville, NC
25420	Harrisburg-Carlisle, PA
26300	Hot Springs, AR
26900	Indianapolis-Carmel-Anderson, IN
28140	Kansas City, MO-KS
28660	Killeen-Temple, TX
30700	Lincoln, NE
31080	Los Angeles-Long Beach-Anaheim, CA
31180	Lubbock, TX
31540	Madison, WI
32820	Memphis, TN-MS-AR
33100	Miami-Fort Lauderdale-West Palm Beach, FL
33340	Milwaukee-Waukesha-West Allis, WI
33700	Modesto, CA
33740	Monroe, LA
33860	Montgomery, AL