Advisor Live

Advancing Care Coordination Through Episode Payment Models Final Rule

January 13, 2017

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Agenda

- Applicable Hospitals
- Applicable Beneficiaries
- Episode Definitions
- Payment Methodology
- Quality Performance
- Reconciliation
- Gainsharing
- Appeal Procedures
- Data Sharing
- Payment and Legal Waivers
- Cardiac Rehab Incentive Payment
- MSSP Track 1+

Episode Payment Model (EPM)

High Level Overview of Final Rule

Proposed rule released July 25, published on August 2, *Federal Register*

Episode Payment Model (EPM) Final Rule released December 20, 2016

Establishes 3 new bundled payment models for AMI, CABG, and Surgical Hip/Femur Fracture Treatment (SHFFT)

- All Part A & B "related" services from hospital admission through 90-days post discharge
- Mandatory in select geographic areas
  - » **AMI and CABG:** 98 MSAs identified
  - » **SHFFT:** Same 67 regions as CJR
- Requires 3% discount; discount lowered based on "Good" or "Excellent" quality performance
- No repayments in FY1. None in FY2 if no downside risk is elected
- Model runs from July 1, 2017- December 31, 2021

Includes modifications to Comprehensive Care for Joint Replacement (CJR)

Creates a track in all models (EPM and CJR) to meet CEHRT requirements in order to be considered an Advanced APM under MACRA

Creates the Cardiac Rehabilitation Incentive Payment Model

- Provides incentive payments for coordination of rehabilitation services for heart attack and bypass patients
- Available to 45 MSAs within AMI/CABG models and 45 MSAs outside of AMI/CABG

EPM Overview

Triggers: **CJR: Lower extremity joint replacement - MS-DRG 469/470**
EPM-SHFFT: Surgical hip and femur fracture- MS-DRG 480-482
EPM-AMI: AMI w/o revascularization/PCI- MS-DRG 280-282/246-251;ICD-10 CM of AMI
EPM-CABG: Coronary Artery Bypass Graft- MS-DRG 231-236

Episode

Admission — **Discharge** — **90 Days**

All Medicare Part A & Part B "related" fee-for-service payments

Reconciliation payments

$$$$$$$$$$$$$$$ **Hospital repays Medicare** $$$$$$$$$$$$$$$

Above spending target

Annual Medicare spending for all EPM episodes

Below spending target

Quality Composite Score is Adequate, Good, or Excellent

CJR/SHFFT: Complications, Patient Experience, Patient-Reported Outcomes (voluntary)
CABG: Mortality, Patient Experience, STS Composite Outcomes Measure Reporting (voluntary)
AMI: Mortality, Excess Days, Patient Experience, Mortality eMeasure (voluntary)

$$$$$$$$$$$$$$$ **Reconciliation payment to hospital** $$$$$$$$$$$$$$$

Target price ≈ 3% blended discount of historical hospital costs/broader geographic region

EPM Three New Clinical Definitions

Acute Myocardial Infarction (AMI)

- Patients who receive medical therapy but no revascularization **(MS DRGs 280-282)** and includes discharges for Percutaneous Coronary Intervention (PCI) **(MS DRGs 246-251)** when a primary or secondary diagnosis code is for acute myocardial infarction.
- Target prices adjusted based on complexity of treating a heart attack
- Excludes intracardiac procedures
- NOTE: Patient in an AMI model who have a readmission (planned or unplanned) in which CABG is performed while within the AMI model 90-days post-discharge period remain in the AMI model (though a target price adjustment is made)

Coronary Artery Bypass Graft (CABG)

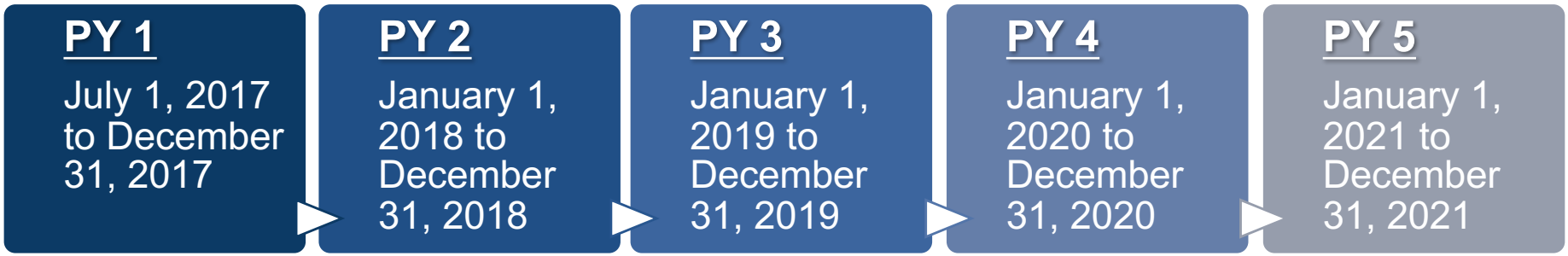
- Patients discharged with **MS-DRGs 231-236**
- Target prices adjusted based on complexity of providing bypass surgery
- Including beneficiaries undergoing elective CABG in the CABG model as well as beneficiaries with AMI who have a CABG during their initial AMI anchor hospitalization.

Surgical Hip/Femur Fracture Treatment (SHFFT)

- Patients discharged with **MS-DRGs 480-482**

EPM Performance Years

- **EPM program runs for a total of five performance years** – Starting on July 1, 2017 through December 31, 2021.
- **Similar to CJR** – The performance year an episode belongs to is a result of the episode ending date
  - **Example:** EPM Episodes beginning in December 2017 and ending in March 2018 (90-day episodes), would be part of Performance Year 2.



CAUTION: Episodes initiating after October 1st will be recognized in the following PY (except PY5).

Payment Methodology – Phased-in Risk

Target price is based on a **3% discount** and that discount may be **lowered** based on "**good**" or "**excellent**" quality performance

Target prices are adjusted for complexity (e.g. MS-DRG, timeframe, and episode service overlap)

Baseline updated every other year

Phased in risk

Model Year	Episodes Ending in Date Range	Reconciliation (Savings)	Repayments (i.e. Risk)	Stop Loss/Stop Gain*
Year 1	7/1/17 – 12/31/17	Maximum discount of 3%	No repayments	Upside only of 5%
Year 2	CY 2018		If electing to be risk-bearing, maximum discount is 2%	Upside / Optional Downside of 5%
Year 3	CY 2019		Required discount of max 2%	Upside / Downside of 5 %
Year 4	CY 2020		Required discount of max 2%	Upside / Downside of 10 %
Year 5	CY 2021		Required discount of max 3%	Upside / Downside of 20%

*Stop-loss thresholds for certain hospitals (e.g., rural, sole-community) are 3% for PY 2 (Voluntary Downside Risk), 3% for PY 3, and 5% for PY 4-5

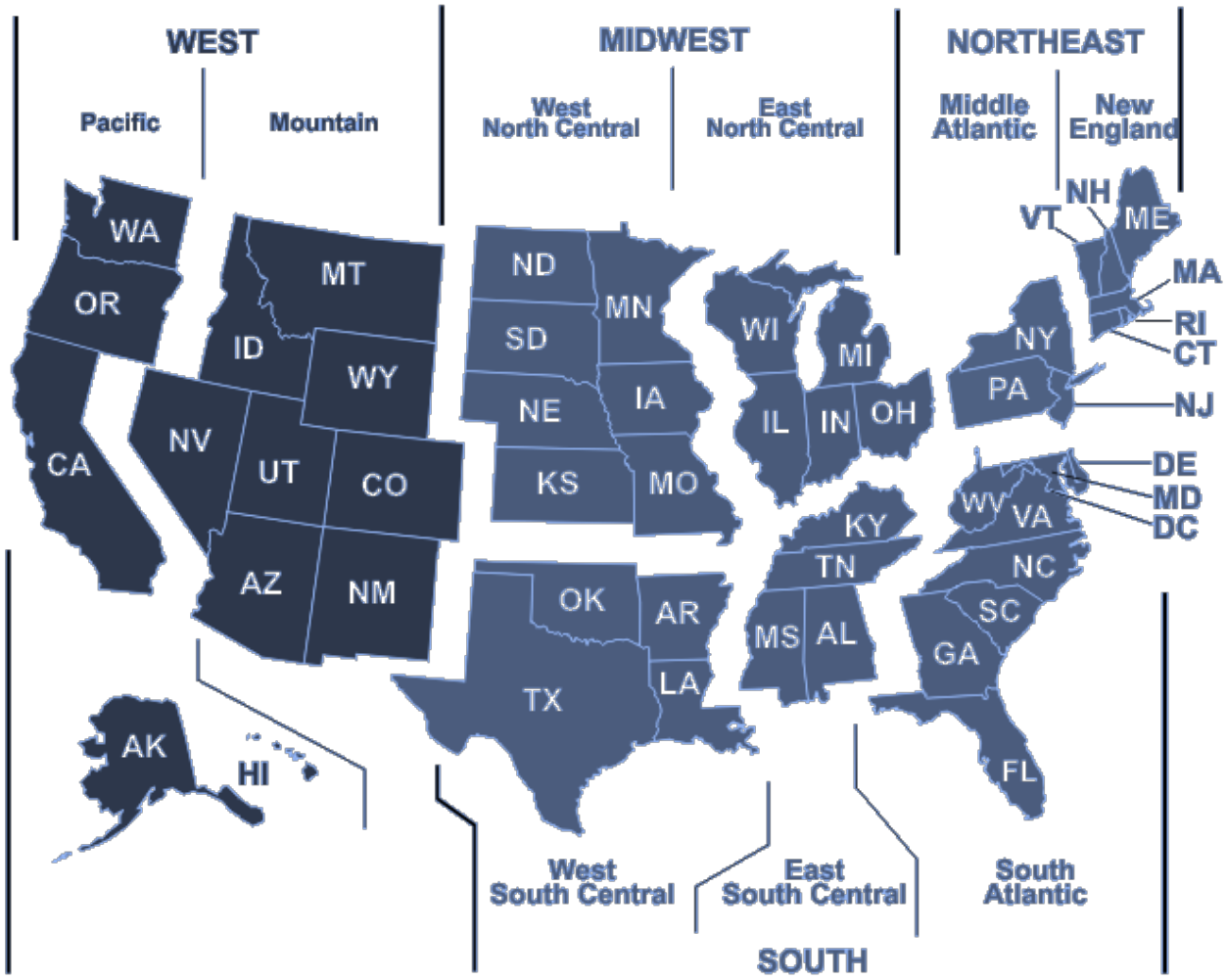
Payment Methodology (Cont.)

Baseline and Performance Period EPM Episodes Exclude:

- **Drugs that are paid outside of the EPM MS-DRGs**, (e.g., hemophilia clotting factors)
- **Technology add-on payments**
- **OPPS transitional pass-through payments** for medical devices
- **Readmissions** for oncology, trauma medical admissions, surgery for chronic conditions unrelated to EPM episode (list of MS-DRGs excluded by condition provided by CMS)
- **Unrelated** post-acute Part B services. Note: Exclusion lists are posted on the CMMI website.
- **Per Beneficiary/Per Month (PBPM) payments** through Innovation Center Programs (such as OCM MEOS payments)

Blended Target Pricing

Target prices begin as a combination of hospital-specific and US census region (regional) historical payments and transition to regional-only prices



Year 1 & 2
- 2/3 hospital
- 1/3 regional

Year 3
- 1/3 hospital
- 2/3 regional

Year 4 & 5
- 100% regional

Baselines for Price Setting

Baseline is comprised of 3 years historical data

- January 1, 2013 through December 31, 2015 for Performance Year 1
- Episode price periods apply to episodes that *initiate* during those periods except Performance Year 5.
- Prices will be communicated prior to beginning of performance periods.
- Prices will be set for each clinical definition.
- Baseline for performance years 3, 4, and 5 pricing:
  - » (ii) "episodes" beginning in 2015 through 2017 for performance years 3 and 4.
  - » (iii) "episodes" beginning in 2017 through 2019 for performance year 5.
- **NOTE:** Separate pricing for January 1st through September 30th vs. October 1st through December 31st due to Medicare payment system updates.

Inclusion of reconciliation and Medicare repayment:

- **EPM/CJR:** Include both reconciliation payments and Medicare repayments when calculating historical EPM/CJR-episode payments to update EPM/CJR-episode benchmark and quality-adjusted target prices
- **BPCI:** Include both reconciliation payments and Medicare repayments when calculating historical EPM-episode payments to update EPM-episode benchmark and quality-adjusted target prices for years 3 - 5

EPM Pricing Scenarios

Proration – Use same methodology as CJR for prorating payments for services that extend beyond 90 day post discharge (e.g., SNF stays, Re-admissions)

High cost episodes – Outlier ceilings based on regional data and by MS-DRG and sub category (e.g., AMI only vs AMI w/CABG)

<u>AMI Target Pricing</u> – Two sub categories:

- **AMI ONLY** – Set based on AMI DRG-Specific Total Episode Price
- **AMI w/CABG Readmission** – Set based on AMI DRG-Specific Total Episode Price **PLUS** Inpatient Only CABG Price (Inpatient Episode Part A and Part B costs)
- **Example**: Patient admitted with DRG 280 and readmitted with CABG DRG 231
  - » DRG 280 Total Episode Price is $30,000
  - » DRG 231 Inpatient Only CABG Price is $20,000
  - » Patient Target Price is $30,000 (**AMI Total Episode Price**) + $20,000 (**Inpatient Only CABG Price**) = $50,000

EPM Pricing Scenarios (Cont.)

<u>CABG Target Price</u> – Two sub categories:

- Separated into **Anchor Price** (Inpatient Episode Part A and Part B costs) and **Post-Anchor Price** (Part A and Part B Post-discharge costs)
  - » Anchor Price based on **Inpatient DRG**
  - » Post-Anchor Price based on presence or not of ICD-10 indicating **AMI upon Admission**
- **Example**: Patient admitted with DRG 231 w/AMI
  - » DRG 231 Anchor Price is $20,000
  - » Post-Anchor Price for DRG 231 w/AMI is $20,000
  - » Post-Anchor Price for DRG 231 w/o AMI is $15,000
  - » Patient Target is $20,000 (**Anchor**) + $20,000 (**Post-Anchor**) = $40,000 Target Price

Beneficiary Inclusions

Beneficiaries **must meet all** the following criteria:

- Enrolled in Medicare Part A and Part B during the entire episode.
- Have Medicare as their primary payer.
- Eligible for Medicare but not on the basis of end-stage renal disease (ESRD).
- Not enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations)
- Not covered under a United Mine Workers of America health plan, which provides health care benefits for retired mine workers.
- Not ***prospectively*** aligned to Next Generation ACO, MSSP Track 3 or an ACO in a track of the Comprehensive ESRD Care Initiative incorporating downside risk for financial losses. CMS to provide an on-line validation portal for identification.

Beneficiary/Other Exclusions

Beneficiary death during the EPM episodes cancels the episode

Beneficiary is in any BPCI Model episode that overlaps at any time with what would otherwise be considered an EPM episode.

AMI Transfer to Another Hospital cancels the AMI episode for the transferring hospital. An AMI episode initiates at the accepting hospital if that hospital is an AMI model participant (is in an AMI/CABG model MSA)

Initiating a new EPM episode cancels the Anchor EPM episode unless the new EPM episode is on the Anchor exclusion list

EPM episode begins with initial hospitalization – Not prior to admission

- **NOTE**: Episodes begin at admission. Services prior to admissions (e.g.. Within 72 hours) that are included in the MS-DRG payment are included in the episode but no other services prior to admission are included.
- **Example:** This is important as transfers from another hospital's ED within the three day period would not be included.

EPM Quality Measures

AMI

Required – Mortality-30 D (NQF #0230)

Required – AMI Excess Days

Required - HCAHPS (NQF # 0166)

Voluntary – Hybrid AMI Mortality (NQF #2473)

CABG

Required –Mortality (NQF #2558)

Required – HCAHPS (NQF #0166)

Voluntary - STS CABG Composite (NQF #0696)

SHFFT

Required Hip/Knee Complications (NQF #1550)

Required HCAHPS Survey (NQF #0166).

Voluntary CJR PROMs

Discount Depends on Quality Performance

Required discount of 3%.

Hospitals with “Good” or “Excellent” quality receive reduced discounts (2.0% or 1.5% for Reconciliation).

Hospitals with “Acceptable”, “Good”, or “Excellent” quality are eligible to receive a Reconciliation Payment if actual spending is less than target spending.

“Below Acceptable” Hospitals are not eligible for a reconciliation payment even if savings were achieved.

Year 1	Discount %	Eligible for Reconciliation	Repayment %
Below Acceptable	3.0	No	No Repayment in Year 1
Acceptable	3.0	Yes	
Good	2.0*	Yes	
Excellent	1.5*	Yes	

* discount lowered due to quality incentive payment

Discount Depends on Quality Performance (Cont.)

Years 2, 3, & 4	Discount %	Eligible for Reconciliation	Repayment % (Optional in Yr 2)
Below acceptable	3.0	No	2.0
Acceptable	3.0	Yes	2.0
Good	2.0*	Yes	1.0*
Excellent	1.5*	Yes	0.5*

Year 5	Discount %	Eligible for Reconciliation	Repayment %
Below acceptable	3.0	No	3.0
Acceptable	3.0	Yes	3.0
Good	2.0*	Yes	2.0*
Excellent	1.5*	Yes	1.5*

*discount lowered due to quality incentive payment

Measures: AMI

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (NQF #0230) (MORT-30-AMI)

- 3 year rolling performance period: July 1, 2014- June 30, 2017
- Cohort may be slightly different from IQR cohort
- At least 25 cases; low volume assigned to 50th percentile and not publicly reported

Excess Days in Acute Care after Hospitalization for AMI (AMI Excess Days)

- 3 year rolling performance period: July 1, 2014- June 30, 2017
- Cohort includes all hospitals in the model and may be slightly different from IQR cohort
- At least 25 cases; low volume assigned to 50th percentile and not publicly reported

HCAHPS Survey (NQF #0166)

- 4 consecutive quarters of survey data
- Data submission the same as IQR

Voluntary Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #2473) (Hybrid AMI Mortality) data submission

AMI- Voluntary Submission for Hybrid

Combines claims and EHR data to calculate a risk-standardized mortality rate following AMI

Cohort identical to current measure, enhanced with EHR data

- Five clinical data elements included in risk adjustment
  - » Age
  - » Heart Rate within 2 hours
  - » Systolic Blood Pressure within 2 hours
  - » Troponin (if measured during admission)
  - » Creatine within 24 hours
  - » Intended to reflect clinical status when first presenting for AMI
- Collecting six additional variables
  - » CCN
  - » HIC
  - » Date of Birth
  - » Gender
  - » Admission Date
  - » Discharge Date
- Report using QRDA-I; for Year 1 will make a transition format available (e.g. spreadsheet) in addition to QRDA-I

Successful submission

Year 1: 50% of qualifying AMI hospitalizations; discharges July 1- August 31, 2017
Year 2: 90%; discharges September 1, 2017- June 30, 2018
-Years 3-5: 5: 90%; full year July 1- June 30
All additional elements (able to indicate troponin test was not performed)
Submit within 60 days of end of data collection period

Not publicly reported, hospitals will receive hospital-specific reports

Quality Composite Scoring-AMI

Measure	Weight	Max Points (20)	Scoring
AMI Mortality	50%	10 1.0 improvement point*	90th percentile and above:10 80th- 90th percentile: 9.25 70th- 80th percentile: 8.50 60th- 70th percentile: 7.75 50th- 60th percentile: 7.00 40th- 50th percentile: 6.25 30th- 40th percentile: 5.5 Below 30th percentile: 0
AMI Excess Days	20%	4 0.4 improvement points*	90th percentile and above: 4 80th- 90th percentile: 3.7 70th- 80th percentile: 3.4 60th- 70th percentile: 3.1 50th- 60th percentile: 2.8 40th- 50th percentile: 2.5 30th- 40th percentile: 2.2 Below 30th percentile: 0
HCAHPS	20%	4 0.4 improvement points*	Same as above
Hybrid AMI Mortality *voluntary*	10%	2	2 points for successful submission

** Improvement points awarded for any year-over-year improvement in a participant's own measure point estimates if the participant falls into the top 10 percent of participants based on the national distribution of measure improvement.*

Measures- CABG

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558) (MORT-30-CABG)

- 3 year rolling performance period: July 1, 2014- June 30, 2017
- Cohort may be slightly different from IQR cohort
- At least 25 cases; low volume assigned to 50th percentile and not publicly reported

HCAHPS Survey (NQF #0166)

Voluntary STS CABG Composite Measure (NQF #0696)

CABG- Voluntary Submission of STS

- 11 cardiac surgery measures
  - Absence of Operative Mortality – Proportion of patients (risk-adjusted) who do not experience operative mortality.
  - Absence of Major Morbidity – Proportion of patients (risk-adjusted) who do not experience any major morbidity:
    - reoperations for any cardiac reason
    - renal failure
    - deep sternal wound infection
    - prolonged ventilation/intubation
    - cerebrovascular accident/permanent stroke
  - Use of Internal Mammary Artery (IMA) – Proportion of first-time CABG patients who receive at least one IMA graft
  - Use of All Evidence-based Perioperative Medications – Proportion of patients who receive all required perioperative medications for which they are eligible:
    - preoperative beta blockade therapy,
    - discharge anti-platelet medication
    - discharge beta blockade therapy
    - discharge anti-lipid medication
- Collected via STS Registry
  - CMS will receive data feeds directly from STS
  - EPM participants who are not part of STS Registry can submit via Secure File Transfer

Quality Composite Scoring-CABG

Measure	Weight	Max Points (20)	Scoring
CABG Mortality	70%	14 1.0 improvement point*	90th percentile and above:14 80th- 90th percentile: 12.95 70th- 80th percentile: 11.90 60th- 70th percentile: 10.85 50th- 60th percentile: 9.80 40th- 50th percentile: 8.75 30th- 40th percentile: 7.70 Below 30th percentile: 0
HCAHPS	20%	4 0.4 improvement points*	90th percentile and above:4 80th- 90th percentile: 3.7 70th- 80th percentile: 3.4 60th- 70th percentile: 3.1 50th- 60th percentile: 2.8 40th- 50th percentile: 2.5 30th- 40th percentile: 2.2 Below 30th percentile: 0
STS CABG Composite *Voluntary*	10%	2	2 points for successful submission

** Improvement points awarded for any year-over-year improvement in a participant's own measure point estimates if the participant falls into the top 10 percent of participants based on the national distribution of measure improvement.*

Measures- SHFFT

Hospital-level RSCR (complications) following elective primary THA and/or TKA (NQF #1550)

- 3 year rolling performance period: April 1, 2014-March 31, 2017
- Cohort may be slightly different from IQR cohort
- Not publicly reported if fewer than 25 cases

HCAHPS Survey measure

SHFFT- Voluntary Submission for PROM

Hospital-Level Performance Measure(s) of Patient-Reported Outcomes Following Elective Primary THA or TKA measure or both

- In development, voluntary data submission will help continue development
- Pre- and post-operative data elements (examples):
  - » Demographic info (age, DOB, admission date, discharge date, procedure date)
  - » PROMIS Global or VR-12
  - » Knee-specific PROM instrument (e.g. HOOS JR, HOOS Pain Subscale, HOOS Function)
  - » Hip-specific PROM Instrument (e.g., VR-12, PROMIS, HOOS Jr, HOOS Function)

Reporting Period:

- Year 1: Pre-operative data (10-month period)
- Year 2: Post-operative data for prior year (10-months) and pre-operative data for current year (12-month period)
- Years 3 and beyond: Pre-operative and post-operative data for a 12-month period

Successful Submission

- All required data elements
- Year 1: 60% of patients; Year 2: 70% of patients. Year 3-5: 80% of patients
- Voluntary submission must occur within 60 days of the end of the most recent 12-month period

Quality Composite Scoring- SHFFT

Measure	Weight	Max Points (20)	Scoring
Hospital-level RSCR (complications) following elective primary THA and/or TKA	50%	10 1.0 improvement point*	90th percentile and above:10 80th- 90th percentile: 9.25 70th- 80th percentile: 8.50 60th- 70th percentile: 7.75 50th- 60th percentile: 7.00 40th- 50th percentile: 6.25 30th- 40th percentile: 5.5 Below 30th percentile: 0
HCAHPS Survey	40%	8 0.8 improvement points*	90th percentile and above: 8 80th- 90th percentile: 7.40 70th- 80th percentile: 6.80 60th- 70th percentile: 6.20 50th- 60th percentile: 5.60 40th- 50th percentile: 5.00 30th- 40th percentile: 4.40 Below 30th percentile: 0
THA/TKA voluntary PRO data	10%	2	2 points for successful submission

** Improvement points awarded for substantial improvement (year-over-year improvement of 2 or more deciles in the performance distribution).*

Quality Composite Score Categories

Category	Discount Factor %	AMI	CABG	SHHFT/CJR
Below acceptable	3.0	Less than 3.8	Less than 2.2	Less than 5.0
Acceptable	3.0	3.8 to less than 6.3	2.2 to less than 3.4	5.0 to less than 6.9
Good	2.0	6.3 to less than 15.0	3.4 to less than 16.2	6.9 to less than 15.0
Excellent	1.5	Above 15.0	Above 16.2	Above 15.0

Financial Arrangements

Collaborators may include:

- Skilled nursing facilities
- Home health agencies
- Long term care hospitals
- Inpatient rehabilitation facilities
- Physician*
- Nonphysician practitioners*
- Therapist in private practice*
- Comprehensive outpatient rehabilitation facility
- Provider of outpatient therapy services
- Hospital
- CAH
- ACO

*Or group

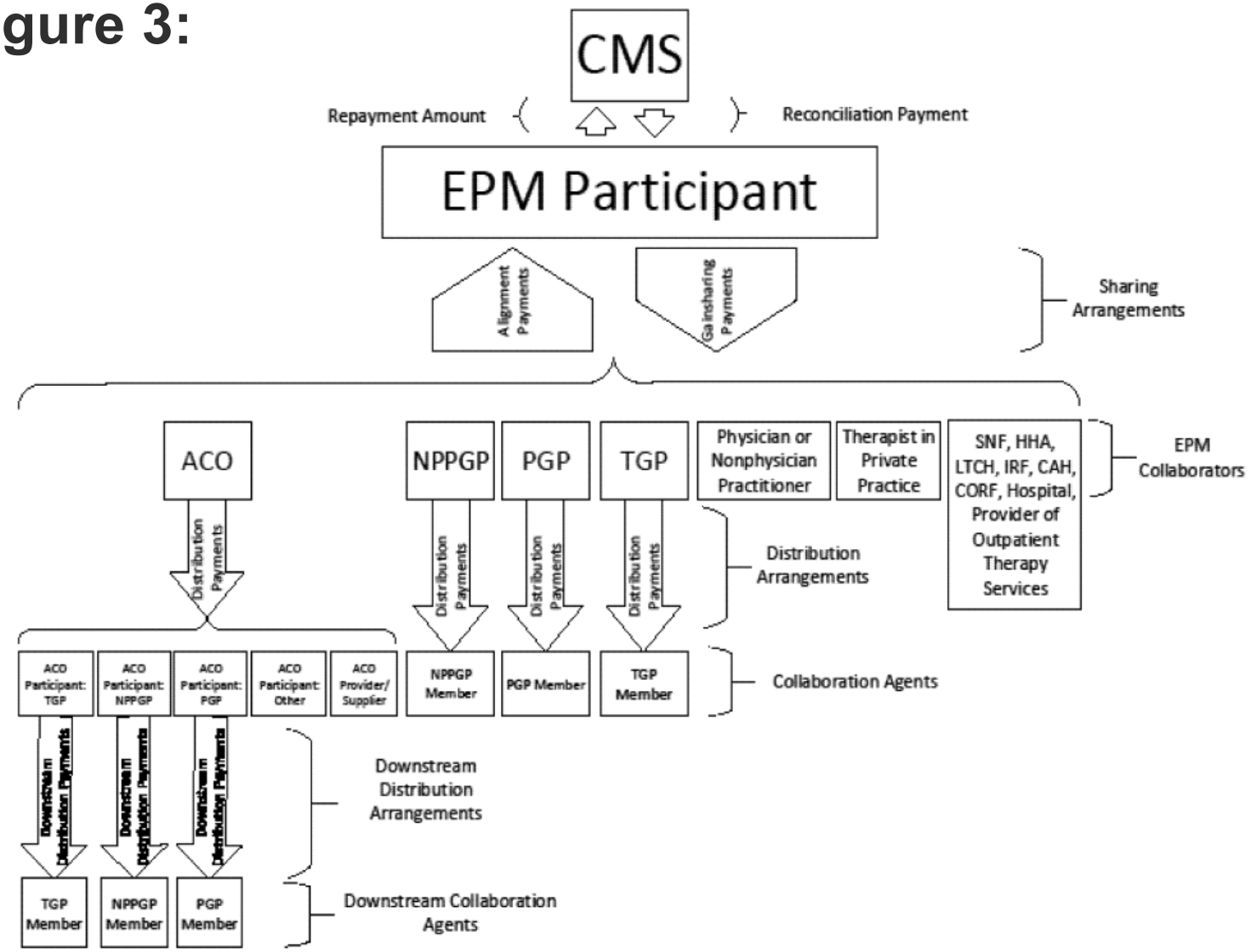
Hospitals may have “sharing arrangements” with EPM/CJR “collaborators” to share:

- reconciliation payments,
- internal cost savings, and
- alignment payments.

Must have written policies on selecting collaborators including quality metrics and not including criteria directly or indirectly based on volume or value of referrals in the past or anticipated (unless reasonable minimum services criterion).

Final EPM Financial Arrangements

Figure 3:



Sharing Arrangements

Must be dated, written agreement entered into before care, on a voluntary basis, without penalty for non-participation or risk to beneficiary access that memorializes:

- purpose and scope of the sharing arrangement.
- identities and obligations of the parties
- financial terms for payment, including the following:
  - » Eligibility criteria for a gainsharing payment.
  - » Eligibility criteria for an alignment payment.
  - » Frequency of gainsharing or alignment payment.
  - » Methodology for determining the amount of a gainsharing payment that is substantially based on quality of EPM activities.
  - » Methodology for determining amount of an alignment payment.

Must comply with all laws and regulations: beneficiary notification, enrollment requirements, have or be covered by compliance program, and cooperate with evaluation, monitoring, oversight and enforcement activities etc

Must not reduce or limit medically necessary services

Gainsharing

Gainsharing payments must:

- Be derived solely from reconciliation payments or internal cost savings, or both.
- Not be a loan or payment for referrals or other business generated from the parties.
- Not be an inducement to reduce or limit medically necessary services.
- Be determined using methodologies that use quality criteria directly related to EPM episodes of care.
- Be distributed annually.
- Be able to be recouped if they involved funds from an overpayment or were based on the submission of false or fraudulent data.

Collaborators must furnish services during episode

- PGPs/ACOs must assist with clinical activities and have at least one physician/NPP provide services to an applicable beneficiary

Methodology may vary payments based on relative contribution of collaborators activities

Cap on physicians and NPPs (individual and groups) is 50% of FFS payments related to applicable beneficiaries

Alignment Payments

- Hospitals may assign a portion of risk to “collaborators”
  - CMS will solely interact with the hospital
  - The hospital is responsible for interacting with collaborators to pay or recoup funds
- Hospitals are required to retain 50% of downside risk
- Hospitals cannot share more than 25% of repayment responsibility with any one collaborator other than ACOs, which may absorb up to 50% of the risk
- Alignment payments:
  - Can be made at any interval as agreed on by both parties;
  - Cannot be made before the Reconciliation Report reflects a negative NPRA;
  - Cannot be in the form of a loan, advance, or payment for referrals/other business generated; and
  - Cannot be *directly* account for volume or value of referrals

Table 46: Final Standards Related to "Volume or Value" for EPM Financial Arrangements

	Volume/Value Prohibition?	Scope of Volume/Value Prohibition	Citation
Collaborator selection criteria	Yes	Cannot be based *directly or indirectly* on past or anticipated referrals or business otherwise generated by, between or among: i. EPM participant ii. Collaborator iii. Collaboration agent iv. Downstream collaboration agent v. Any individual or entity affiliated with (i)-(iv)	§ 512.500(a)(3)
Opportunity to make or receive a payment	Yes	Same as for collaborator selection criteria	§ 512.500(c)(7) (gainsharing or alignment payments) § 512.505(b)(4) (distribution payment) § 512.510(b)(4) (downstream distribution payment)
Alignment Payment Methodology	Yes	Cannot *directly* account for volume or value of past or anticipated referrals or business otherwise generated by, between or among (i)-(v) above	§ 512.500(c)(14)
Gainsharing Payment Methodology	No	N/A – methodology must be substantially based on quality of care and the provision of EPM activities; may consider relative amount of EPM activities provided	§ 512.500(c)(5) (gainsharing payments)
Distribution and Downstream Distribution Payment Methodologies	No	N/A – same methodology standard as for gainsharing payments, except that amounts distributed by a PGP to a PGP member can also be determined in a manner that complies with § 411.352(g) of the physician self-referral regulations.	§ 512.505(b)(5), (6) (distribution payments) § 512.510(b)(5), (6) (downstream distribution payments)

Data Sharing- Beneficiary Level Data

Summary reports on episodes during the baseline (Jan. 1, 2013-Dec. 31, 2015) and performance periods

Includes all expenditures and claims for an EPM episode for all care covered under Medicare Parts A and B within the 90 days after discharge for those beneficiaries for applicable anchor diagnosis billed by participant

Summary reports will contain total expenditures during the episode including inpatient, outpatient, SNF, HHA, hospice, carrier/Part B and DME services

May request raw claims data including services furnished by the participant and other entities during the episode

For both formats, quarterly files and excludes substance use related patient records

Aggregate expenditure data on US Census Divisions through 90-day episode

Legal Waivers

Waivers apply to CJR only; anticipate waivers will be in place for EPM models by June 2017

Provides certain waivers of Fraud and Abuse Laws

- For gainsharing and alignment payments the model waives:
  - Federal Anti-kickback statute
  - Physician self-referral prohibitions
  - Civil monetary penalties (inapplicable due to MACRA law)
- For beneficiary incentives furnished to CJR beneficiaries during a CJR episode of care provided the program requirements are met, the model waives:
  - Beneficiary inducements CMP
  - Federal Anti-kickback statute

Beneficiary Incentives

Permits participating hospitals (not collaborators) to provide "in-kind patient engagement incentives" for free or below fair market value subject to the following conditions:

- The incentive must be provided during an episode of care.
- The item or service provided must be reasonably connected to the beneficiary's medical care during an episode and engage the beneficiary in better managing his or her own health.
- The item or service must be a preventive care item or service **or** advance one of the following clinical goals:
  - » Beneficiary adherence to drug regimens.
  - » Beneficiary adherence to a care plan.
  - » Reduction of readmissions and complications resulting from LEJR procedures.
  - » Management of chronic diseases and conditions that may be affected by the EPM cardiac or orthopedic procedure.

Beneficiary Incentives (Cont.)

- The incentive must not be tied to the receipt of items or services from a particular provider or supplier.
- The incentive must not be tied to the receipt of items or services outside the episode of care.
- The item or service may only be provided by a participating hospital directly or through an agent who is under the hospital's control and direction. In the final rule, CMS notes that if a reasonable beneficiary would perceive the item or service as being from the agent rather than the hospital, the incentive would not be treated as provided by the hospital and thus is not eligible for protection under this provision.
- The cost of the item or service may not be shifted to another federal health care program.

Beneficiary Incentive (Cont.)

Must maintain contemporaneous documentation of beneficiary incentives that exceed $25 in value

Must include the date the incentive is provided as well as the identity of the beneficiary to whom it was provided.

May provide items of technology if the value of the technology does not exceed $1,000 for any one beneficiary.

- hospital must retain ownership of the technology where the cost of the technology exceeds $100
- hospital must retrieve the technology at end of the episode and maintain documentation of the date of retrieval
- the agency will deem “documented, diligent, good faith attempts to retrieve items of technology” to meet the retrieval requirement

Payment Waivers for EPMs

Skilled Nursing Facility

- Waives the SNF 3-day rule beginning in PY3 for AMI only
- SNF must be rated 3-stars or higher to apply waiver
- Premature discharges to SNF are not allowed
- Freedom of choice for SNF without patient steering
- Hospital liable if waiver misused
- Hospital and beneficiary held harmless if beneficiary eligibility changes for CJR

Home Visits

- Waives the direct supervision rule for "incident to" services
- Licensed clinical staff to furnish visit
- Applies to beneficiaries that don't qualify for home health coverage*****
- Waives 90-day post-operative global surgical period for up to 9 visits (13 for AMI)
- Will bill HCPCS G codes (~$50)

Telehealth

- Waives geographic site and originating site requirements
- Cannot substitute for in-person home health services paid under Home Health PPS
- Must be furnished in accordance with all other coverage and payment criteria
- Will bill HCPCS G codes

Advanced APM Tracks

Creates two tracks in the AMI, CABG, SHFFT, and CJR models

- Track 1 -- allows participant to reach Advanced APM status and its eligible clinicians potentially to reach Qualifying APM Participant Status (QP)
- Track 2 -- does not support Advanced APM status or QP status

Track 1 requires that the participant hospital

- Use CEHRT and attest to CEHRT usage (attestation process details pending)
- Submit a Clinician Financial Arrangements List to CMS at least quarterly

Advanced APM Tracks (Cont.)

AMI, CABG, SHFFT, and CJR Track 1 hospitals become Advanced APMs once they assume at least 3% downside risk

- AMI, CABG, SHFFT: PY 2 Voluntary Downside Risk (2018), PY 3 All (2019)
- CJR: PY 2 (2017)

Track 1 participant hospital clinicians may reach QP status

- QP status will be assessed as individuals (not as group) by CMS at 3 "snapshots" (March 31, June 30, August 31) each year
- Potential first QP incentive payment year is 2019 for CJR, 2020 all others

MSSP ACO Track 1+

Further detail provided in EPM fact sheet about anticipated CMMI test

Request for applications expected in January for participation in 2018 as an Advanced APM

- Prospective beneficiary assignment;
- The option to elect the SNF three-day rule waiver;
- A choice of symmetrical thresholds from which to start sharing in savings or losses
- A maximum 50 percent shared savings rate;
- A fixed 30 percent loss sharing rate and the maximum level of downside risk would vary based on the composition of ACOs. Certain ACOs (including physicians or small rural hospitals) may be eligible for lower risk levels.

MSSP ACO Track 1+ (Cont.)

In 2018, a maximum loss limit of 8% of ACO participant Medicare FFS revenue or 4% of the ACO's benchmark depending on composition.

In 2019 and 2020, ACOs with lower sharing limit can opt for risk at Advanced APM levels.

MSSP Track 1 can move up; formerly Track 1 can renew as 1+; and new entrants can apply

For ACOs mid-second contract, could include regional adjustments to benchmark

Additional opportunities for ACOs to join the model test as part of the 2019 and 2020 MSSP cycles.

Cardiac Rehab for AMI and CABG

GOAL: test the cost and quality effects of providing explicit financial incentives to encourage care coordination and increased CR use during 90 days after hospitalization for beneficiaries treated for AMI or CABG

Cardiac rehab (CR)—physician-supervised program that furnishes prescribed exercise, cardiac risk factor modification, psychosocial and outcomes assessments.

- 2 one-hour sessions per day for up to 36 sessions over 36 weeks with option of additional 36 sessions if MAC approved

Intensive cardiac rehab (ICR)—physician-supervised program that furnishes cardiac rehab and has shown, in peer-reviewed published research, that improves patient's cardiovascular disease through specific outcome measurement

- Limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks

Cardiac Rehab for AMI and CABG

Timing—coincides with EPM; July 1, 2017-Dec. 31, 2021

Areas—4 matched groups by MSA: FFS-CR, FFS-non CR, EPM-CR, and EPM-non CR.

- Will select 45 MSAs from 98 finalized under EPM and another 45 from the remainder of the 293 eligible areas
- Will stratify based on percent starting I/CR, percent completing I/CR, and number of I/CR providers.

Incentive payments—will go to hospital if any provider/ supplier furnishes I/CR to applicable beneficiaries

- $25 per I/CR for up to 11 services; $175 per I/CR for 12 or more services for rest of the episode
- Paid once a aggregate amount once per performance year
- Will not be part of EPM reconciliation; cannot be in gainsharing

Waiver— allows non-physician practitioners to supervise, prescribe exercise and establish, review, and sign plans

- Will allow some beneficiary incentives such as transportation

TABLE 37: HCPCS Codes for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services

HCPCS Code	Descriptor
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

Cardiac Rehab Data Sharing

Due to narrow scope, FFS-CR participants, upon request, will receive only:

- Inpatient claims -- potential admissions for CABG and AMI MS-DRGs, plus PCI MS-DRGs if paired with an AMI ICD-CM diagnosis as a principal or secondary code, and
- Carrier and Outpatient claims -- CR/ICR services occurring in the 90-day period after discharge for treatment of AMI or for CABG surgery (AMI or CABG “care period”).

Either summary or claims-level format on a running quarterly basis on data portal.

Participants would receive data for up to the current quarter and all of the previous quarters going back to July 1, 2017.

Subsequent data would be released as often as quarterly and would include up to 6 quarters of prior data.

Important Links

Final rule

CMS fact sheet

CMS press release

Innovation Center EPM website

MSAs selected for EPM implementation

Premier's comments on EPM proposed rule

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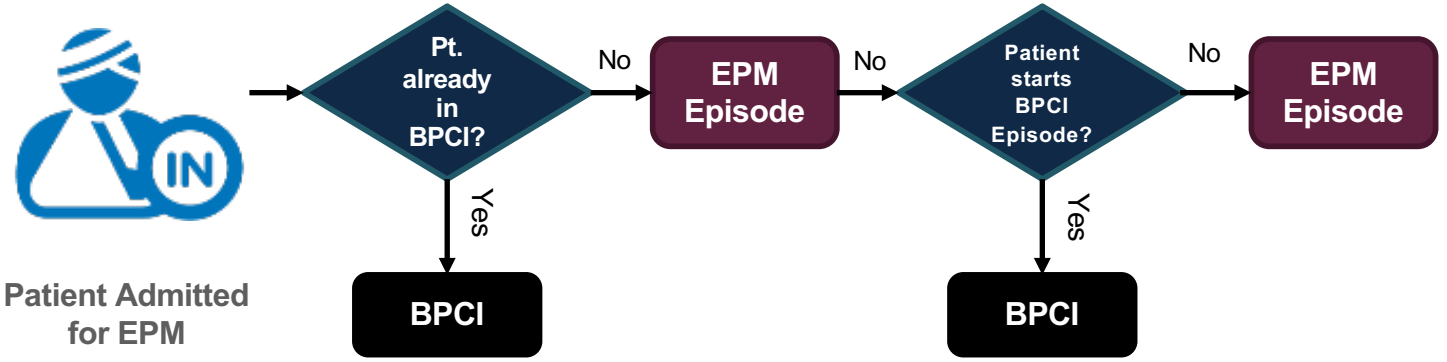
Appendix

Precedence Rules

BPCI: "*CMS believes that BPCI supports the design of the proposed EPM models*."

- **BPCI takes precedence** based on the ***patient*** initiating a BPCI episode, ***not*** the facility/PGP's participation in BPCI
- **Initiation of any BPCI episode** would cancel the EPM
  - » Readmission which starts any Model 2 episode
  - » Discharge to BPCI Model 3 CABG/AMI/SHFFT participant



Reconciliation Timeline

Timeframe for Reconciliation for EPMs

EPM Performance Year	EPM Performance Period	Reconciliation Claims Submitted By	NPRA Calculation	Second Reconciliation, ACO Overlap, and Post-Episode Spending Calculations	Calculation Amounts Included in Reconciliation Payment and Repayment Amounts
Year 1*	Episodes beginning on or after July 1, 2016 and ending through December 31, 2017	March 1, 2018	Q2 2018	March 1, 2019	Q2 2019
Year 2	Episodes ending January 1, 2018 through December 31, 2018	March 1, 2019	Q2 2019	March 1, 2020	Q2 2020
Year 3	Episodes ending January 1, 2019 through December 31, 2019	March 1, 2020	Q2 2020	March 2, 2021	Q2 2021
Year 4	Episodes ending January 1, 2020 through December 31, 2020	March 2, 2021	Q2 2021	March 1, 2021	Q2 2021
Year 5	Episodes ending January 1, 2021 through December 31, 2021	March 1, 2022	Q2 2022	March 1, 2023	Q2 2023

* Note that the reconciliation for Year 1 would not include repayment responsibility from EPM participants.

Documentation

EPM participant must:

Document the sharing arrangement contemporaneously with the establishment of the arrangement;

Maintain accurate current and historical lists of all EPM collaborators, including EPM collaborator names and addresses; update such lists on at least a quarterly basis; and publicly report current/historical lists collaborators on a webpage on the EPM participant's website; and

Have written policies for selecting EPM collaborators

Maintain and require each EPM collaborator to maintain contemporaneous documentation with respect to the payment or receipt of any gainsharing/alignment payment that includes--

- Nature of the payment (gainsharing payment or alignment payment);
- Identity of the parties making and receiving the payment;
- Date of the payment;
- Amount of the payment;
- Date and amount of any recoupment of all or a portion of an EPM collaborator's gainsharing payment; and
- Explanation for each recoupment, such as whether the EPM collaborator received a gainsharing payment that contained funds derived from a CMS overpayment on a reconciliation report, or was based on the submission of false or fraudulent data.

Documentation (Cont.)

EPM participant must keep records for the following:

- Its process for determining and verifying its potential and current EPM collaborators' Medicare participation.
- Its plan and accounting systems used to track internal cost savings; and
- Its current health information technology, including systems to track reconciliation payments, internal cost savings, gainsharing and alignment payments.

Collaborator to retain and provide access to, the required documentation in accordance with §512.110.

Distribution Arrangements

Distribution arrangements must:

- Not be conditioned on the volume or value of referrals or business generated by collaborators and participants;
- Not be an inducement to reduce or limit medically necessary services;
- Be determined substantially based on quality of care and the provision of EPM activities;
- For a collaboration agent, be based on an item or services furnished or billed for during the EPM episode in the same performance year for which the EPM participant accrued the internal cost savings or earned the reconciliation payment; and
- For a physician or NPP, not exceed 50 percent of total approved MPFS payments for services furnished to EPM beneficiaries. A similar 50 percent limit applies to PGPs.

Downstream Distributions

Downstream distributions must:

- Not be conditioned on the volume or value of referrals or business generated by collaborators and participants;
- Not be an inducement to reduce or limit medically necessary services;
- Be determined substantially based on quality of care and the provision of EPM activities or alternatively;
- Be based on services provided or billed by a downstream collaboration agent during the EPM episode in the same performance year for which the EPM participant accrued the internal cost savings or earned the reconciliation payment; and
- Not exceed 50 percent of total approved MPFS payments for services furnished to EPM beneficiaries; a similar 50 percent limit applies to PGPs.

EPM Key Changes Final Rule vs Proposed

- Elimination of AMI transfer episode initiation
- No required risk until Year 3 with optional risk-bearing in Year 2
- Prospective ACO alignment in Next Gen, Track 3, and Downside ESRD takes precedence
- Initiation of any BPCI episode cancels the EPM Episode

EPM MSAs

MSA Title	Cardiac EPM Region	CJR/SHFFT Region	Cardiac Rehab Incentive Region
Abilene, TX	Yes	No	Yes
Akron, OH	Yes	Yes	No
Albuquerque, NM	No	Yes	No
Alexandria, LA	Yes	No	Yes
Allentown-Bethlehem-Easton, PA-NJ	Yes	No	Yes
Anchorage, AK	Yes	No	No
Appleton, WI	No	No	Yes
Asheville, NC	No	Yes	No
Athens-Clarke County, GA	No	Yes	No
Atlantic City-Hammonton, NJ	Yes	No	No
Auburn-Opelika, AL	Yes	No	Yes
Austin-Round Rock, TX	Yes	Yes	No
Barnstable Town, MA	No	No	Yes
Bay City, MI	No	No	Yes
Beaumont-Port Arthur, TX	No	Yes	No
Bellingham, WA	Yes	No	Yes
Bend-Redmond, OR	Yes	No	No
Bismarck, ND	No	Yes	No
Bloomington, IL	No	No	Yes
Bloomington, IN	Yes	No	Yes
Boise City, ID	Yes	No	No
Boston-Cambridge-Newton, MA-NH	Yes	No	Yes
Boulder, CO	No	Yes	No
Brunswick, GA	No	No	Yes
Buffalo-Cheektowaga-Niagara Falls, NY	No	Yes	No
Canton-Massillon, OH	Yes	No	Yes
Cape Coral-Fort Myers, FL	Yes	No	Yes
Cape Girardeau, MO-IL	Yes	Yes	No

EPM MSAs (Cont.)

MSA Title	Cardiac EPM Region	CJR/SHFFT Region	Cardiac Rehab Incentive Region
Carson City, NV	No	Yes	Yes
Cedar Rapids, IA	Yes	No	No
Champaign-Urbana, IL	No	No	Yes
Charleston-North Charleston, SC	Yes	No	Yes
Charlotte-Concord-Gastonia, NC-SC	No	Yes	No
Chattanooga, TN-GA	Yes	No	Yes
Cheyenne, WY	No	No	Yes
Chicago-Naperville-Elgin, IL-IN-WI	Yes	No	No
Chico, CA	Yes	No	No
Cincinnati, OH-KY-IN	No	Yes	No
Cleveland-Elyria, OH	No	No	Yes
Coeur d'Alene, ID	Yes	No	No
Columbia, MO	Yes	Yes	No
Columbia, SC	Yes	No	No
Columbus, GA-AL	Yes	No	Yes
Columbus, IN	No	No	Yes
Corpus Christi, TX	No	Yes	Yes
Crestview-Fort Walton Beach-Destin, FL	Yes	No	No
Dallas-Fort Worth-Arlington, TX	Yes	No	Yes
Daphne-Fairhope-Foley, AL	Yes	No	Yes
Davenport-Moline-Rock Island, IA-IL	No	No	Yes
Decatur, IL	No	Yes	No
Denver-Aurora-Lakewood, CO	Yes	Yes	No
Des Moines-West Des Moines, IA	Yes	No	No
Dothan, AL	No	Yes	No
Dover, DE	Yes	No	No
Duluth, MN-WI	No	No	Yes
Durham-Chapel Hill, NC	Yes	Yes	Yes

EPM MSAs (Cont.)

MSA Title	Cardiac EPM Region	CJR/SHFFT Region	Cardiac Rehab Incentive Region
Elizabethtown-Fort Knox, KY	Yes	No	Yes
Erie, PA	Yes	No	No
Eugene, OR	Yes	No	Yes
Evansville, IN-KY	No	No	Yes
Fayetteville-Springdale-Rogers, AR-MO	No	No	Yes
Flint, MI	No	Yes	No
Florence, SC	No	Yes	Yes
Florence-Muscle Shoals, AL	Yes	No	Yes
Fort Collins, CO	Yes	No	No
Fort Wayne, IN	Yes	No	No
Gainesville, FL	No	Yes	No
Gainesville, GA	Yes	Yes	No
Grand Junction, CO	Yes	No	Yes
Greensboro-High Point, NC	No	No	Yes
Greenville, NC	No	Yes	No
Greenville-Anderson-Mauldin, SC	Yes	No	No
Gulfport-Biloxi-Pascagoula, MS	No	No	Yes
Harrisburg-Carlisle, PA	No	Yes	Yes
Hattiesburg, MS	No	No	Yes
Hilton Head Island-Bluffton-Beaufort, SC	Yes	No	Yes
Hot Springs, AR	No	Yes	No
Huntington-Ashland, WV-KY-OH	Yes	No	Yes
Idaho Falls, ID	Yes	No	Yes
Indianapolis-Carmel-Anderson, IN	Yes	Yes	No
Iowa City, IA	Yes	No	No
Jefferson City, MO	Yes	No	No
Jonesboro, AR	Yes	No	Yes
Joplin, MO	Yes	No	Yes

EPM MSAs (Cont.)

MSA Title	Cardiac EPM Region	CJR/SHFFT Region	Cardiac Rehab Incentive Region
Kalamazoo-Portage, MI	Yes	No	No
Kansas City, MO-KS	Yes	Yes	No
Kennewick-Richland, WA	Yes	No	No
Killeen-Temple, TX	No	Yes	No
Knoxville, TN	No	No	Yes
La Crosse-Onalaska, WI-MN	Yes	No	No
Lake Havasu City-Kingman, AZ	Yes	No	No
Lakeland-Winter Haven, FL	Yes	No	No
Lansing-East Lansing, MI	Yes	No	No
Lexington-Fayette, KY	Yes	No	No
Lima, OH	Yes	No	Yes
Lincoln, NE	No	Yes	Yes
Little Rock-North Little Rock-Conway, AR	Yes	No	Yes
Los Angeles-Long Beach-Anaheim, CA	No	Yes	No
Lubbock, TX	No	Yes	No
Madison, WI	Yes	Yes	Yes
Manchester-Nashua, NH	Yes	No	No
Medford, OR	Yes	No	No
Memphis, TN-MS-AR	Yes	Yes	No
Miami-Fort Lauderdale-West Palm Beach, FL	No	Yes	No
Milwaukee-Waukesha-West Allis, WI	Yes	Yes	Yes
Missoula, MT	Yes	No	Yes
Modesto, CA	No	Yes	No
Monroe, LA	No	Yes	Yes
Montgomery, AL	No	Yes	No
Morgantown, WV	No	No	Yes
Muncie, IN	No	No	Yes
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	Yes	No	No

EPM MSAs (Cont.)

MSA Title	Cardiac EPM Region	CJR/SHFFT Region	Cardiac Rehab Incentive Region
Naples-Immokalee-Marco Island, FL	No	Yes	Yes
Nashville-Davidson--Murfreesboro--Franklin, TN	Yes	Yes	No
New Bern, NC	Yes	No	Yes
New Haven-Milford, CT	No	Yes	No
New Orleans-Metairie, LA	No	Yes	No
New York-Newark-Jersey City, NY-NJ-PA	No	Yes	No
Niles-Benton Harbor, MI	Yes	No	Yes
Norwich-New London, CT	No	Yes	No
Ogden-Clearfield, UT	No	Yes	No
Oklahoma City, OK	Yes	Yes	No
Omaha-Council Bluffs, NE-IA	Yes	No	Yes
Orlando-Kissimmee-Sanford, FL	No	Yes	No
Palm Bay-Melbourne-Titusville, FL	No	No	Yes
Pensacola-Ferry Pass-Brent, FL	No	Yes	Yes
Phoenix-Mesa-Scottsdale, AZ	No	No	Yes
Pittsburgh, PA	No	Yes	No
Portland-Vancouver-Hillsboro, OR-WA	No	Yes	No
Port St. Lucie, FL	No	Yes	Yes
Prescott, AZ	Yes	No	Yes
Provo-Orem, UT	No	Yes	No
Pueblo, CO	Yes	No	Yes
Punta Gorda, FL	No	No	Yes
Raleigh, NC	Yes	No	No
Rapid City, SD	Yes	No	No
Reading, PA	Yes	Yes	Yes
Reno, NV	Yes	No	No
Richmond, VA	Yes	No	No
Riverside-San Bernardino-Ontario, CA	No	No	Yes

EPM MSAs (Cont.)

MSA Title	Cardiac EPM Region	CJR/SHFFT Region	Cardiac Rehab Incentive Region
Roanoke, VA	Yes	No	Yes
Rochester, MN	No	No	Yes
Rockford, IL	No	No	Yes
Rome, GA	No	No	Yes
Saginaw, MI	No	Yes	No
St. George, UT	Yes	No	Yes
St. Joseph, MO-KS	Yes	No	Yes
St. Louis, MO-IL	No	Yes	Yes
Salem, OR	Yes	No	Yes
Salinas, CA	Yes	No	No
San Francisco-Oakland-Hayward, CA	No	Yes	Yes
Santa Fe, NM	No	No	Yes
Santa Maria-Santa Barbara, CA	No	No	Yes
Savannah, GA	Yes	No	No
Scranton--Wilkes-Barre--Hazleton, PA	No	No	Yes
Seattle-Tacoma-Bellevue, WA	No	Yes	Yes
Sebastian-Vero Beach, FL	No	Yes	No
Sebring, FL	No	No	Yes
Sherman-Denison, TX	Yes	No	No
South Bend-Mishawaka, IN-MI	No	Yes	No
Spokane-Spokane Valley, WA	Yes	No	No
Springfield, IL	Yes	No	Yes
Springfield, MO	No	No	Yes
Staunton-Waynesboro, VA	No	Yes	No
Tampa-St. Petersburg-Clearwater, FL	No	Yes	No
Toledo, OH	No	Yes	Yes
Topeka, KS	No	Yes	No
Tucson, AZ	Yes	No	Yes

EPM MSAs (Cont.)

MSA Title	Cardiac EPM Region	CJR/SHFFT Region	Cardiac Rehab Incentive Region
Tulsa, OK	Yes	No	Yes
Tuscaloosa, AL	Yes	Yes	Yes
Tyler, TX	No	Yes	No
Utica-Rome, NY	Yes	No	No
Waco, TX	No	No	Yes
Waterloo-Cedar Falls, IA	Yes	No	Yes
Wenatchee, WA	Yes	No	No
Wichita, KS	Yes	Yes	Yes
Wilmington, NC	Yes	No	No
Winston-Salem, NC	Yes	No	No
Youngstown-Warren-Boardman, OH-PA	Yes	No	No
Yuma, AZ	Yes	No	No