

FACT SHEET: THE ADVANCING CARE COORDINATION THROUGH EPISODE PAYMENT MODELS FINAL RULE

February 1, 2017

INTRODUCTION

On December 20, 2016, the Centers for Medicare and Medicaid Services (CMS) released the [Advancing Care Coordination through Episode Payment Models Final Rule](#). The purpose of the rule is to move further toward quality-based care over fee-for-service models by establishing episodic payment models (EPMs) that reward hospitals for delivering better health care to patients at lower cost.

The final rule introduces 3 payment models for clinicians who provide care to patients receiving treatment for heart attacks, heart surgery to bypass blocked coronary arteries, or cardiac rehabilitation following a heart attack or heart surgery. The rule also introduces 1 payment model for clinicians providing care to patients who receive surgery after a hip fracture, other than a hip replacement. CMS also updates the Comprehensive Care for Joint Replacement Model (CJR), which was initiated in April 2016. Finally, the rule encourages small practices to participate in an Accountable Care Organization (ACO) by limiting the downside risk in the Medicare Shared Savings Program.

These new payment models mean that clinicians will have additional opportunities to qualify for a 5% incentive payment through an Advanced Alternative Payment Model (APM), an option within the Quality Payment Program that was established under the Medicare Access and CHIP Reauthorization Act. Participants in the cardiac and orthopedic payment models have the potential to earn incentive payments in performance year 2019, or as early as 2018 if they collaborate with participant hospitals that choose the Advanced APM path. CJR participants may potentially earn the incentive payment in performance year 2017 (this year).

During the comment period for the proposed rule, APTA sought clarification as to whether certain groups of nonphysician health care professionals, such as physical therapists, could be EPM collaborators. In the final rule, CMS addressed our comments and stated, “Therefore, we are

adding to the list of entities that are eligible to be EPM collaborators a nonphysician practitioner group practice, defined as an entity that is enrolled in Medicare as a group practice, includes at least one owner or employee who is a nonphysician practitioner, does not include a physician owner or employee, and has a valid and active TIN [tax identification number].” CMS specifically added physical therapists in private practice as well as physical therapists engaged in outpatient settings to the list of EPM collaborators.

CARDIAC AND ORTHOPEDIC CARE COORDINATION MODELS

The 4 models are as follows:

- Acute Myocardial Infarction (AMI) Model
- Coronary Artery Bypass Graft (CABG) Model
- Surgical Hip and Femur Fracture Treatment (SHFFT) Model
- Cardiac Rehabilitation (CR) Incentive Payment Model

The first performance period for these new models will begin on July 1, 2017, and end December 31, 2021.

In addition, under the final rule the CJR model now qualifies as an Advanced APM under the Quality Payment Program; and CJR policies involving financial arrangements, beneficiary engagement incentives, compliance enforcement, appeals process, and beneficiary notifications now align with those of EPMs.

MODEL DESIGN FOR AMI, CABG, SHFFT, AND CJR

Under the episode payment models (CABG, AMI, SHFFT) and CJR, the hospital is accountable for the quality and cost of an episode of care. This means that there is an increased incentive to coordinate care among hospitals, physicians, and postacute care providers. For each performance year of the models, CMS will establish Medicare episode quality-adjusted target prices for each participant hospital; the target includes payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who are treated and discharged for included Medicare Severity-Diagnosis Related Groups (MS-DRGs). Almost all Part A and Part B services provided in the 90 days after hospital discharge are included in the episode price.

All providers and suppliers will continue to be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year. Following the end of a model performance year, actual spending for all episodes (total expenditures for related

services under Medicare Parts A and B) will be aggregated and compared with the target price for the participant hospital. Depending on the participant hospital's quality and financial performance, it will either receive an additional payment from Medicare or will need to repay Medicare for part of the difference from the target price.

For AMI, CABG, and SHFFT, participants will earn a composite quality score (CQS), which is based on the quality of care previously provided and will compare an organization's quality performance with that of other hospitals. Hospitals with relatively high-quality performance will be eligible for additional financial incentives within the models. After completing a model performance year, participant hospitals that spend less than the target price and achieve an acceptable or better CQS will be eligible to earn a reconciliation payment from Medicare for the difference between the target price and their actual spending, up to a specified cap.

Acute Myocardial Infarction Model

An AMI episode is defined as the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the Inpatient Prospective Payment System (IPPS) that eventually results in a discharge paid under any of the following MS-DRGs:

- MS-DRG 280 (Acute myocardial infarction, discharged alive with MCC)
- MS-DRG 281 (Acute myocardial infarction, discharged alive with CC)
- MS-DRG 282 (Acute myocardial infarction, discharged alive without CC/MCC)

The episode of care continues for 90 days following hospital discharge, and almost all Part A and Part B services provided in those 90 days are included in the episode price. For each performance year, CMS will set Medicare episode prices for each participant hospital to include payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who are treated and discharged for AMI eligible DRGs at that hospital. Prices will also be set based on census region, and the target prices used will be a blend of provider-specific and regional pricing.

Coronary Artery Bypass Graft Model

Acute care hospitals in certain selected geographic areas will participate in retrospective bundled payments for items and services that are related to CABG treatment and recovery, beginning with a hospitalization for CABG treatment and extending for 90 days following hospital discharge.

A CABG episode is defined as the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the IPPS that eventually results in a discharge paid under any of the following MS-DRGs:

- MS-DRG 231 (Coronary bypass with percutaneous transluminal coronary angioplasty (PTCA) with MCC)
- MS-DRG 232 (Coronary bypass with PTCA without MCC)
- MS-DRG 233 (Coronary bypass with cardiac catheterization with MCC)
- MS-DRG 234 (Coronary bypass with cardiac catheterization without MCC)
- MS-DRG 235 (Coronary bypass without cardiac catheterization with MCC)
- MS-DRG 236 (Coronary bypass without cardiac catheterization without MCC)

The episode of care continues for 90 days following hospital discharge. The following categories of items and services are included in the episodes: physician services, inpatient hospital services (including hospital readmissions), inpatient psychiatric facility services, long-term care hospital services, inpatient rehabilitation facility services, skilled nursing facility services, home health agency services, hospital outpatient services, outpatient therapy services, clinical laboratory services, durable medical equipment, Part B drugs, hospice, and some per-beneficiary-per-month care management payments under models tested under section 1115A of the Social Security Act. Unrelated services are excluded from the episode.

Surgical Hip and Femur Fracture Treatment Model

A SHFFT episode is defined as the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the IPPS that eventually results in a discharge paid under any of the following MS-DRGs:

- MS-DRG 480 (Hip and femur procedures except major joint with major complication or comorbidity - CC)
- MS-DRG 481 (Hip and femur procedures except major joint with complication or comorbidity - MCC)
- MS-DRG 482 (Hip and femur procedures except major joint without CC or MCC)

CARDIAC REHABILITATION INCENTIVE PAYMENT MODEL

The CR Incentive Payment Model allows acute care hospitals in selected geographic areas to participate in retrospective incentive payments for beneficiaries who receive cardiac rehabilitation/intensive cardiac rehabilitation (CR/ICR) services for the first 90 days following care for acute myocardial infarction or a coronary artery bypass graft.

A 2-part cardiac rehabilitation incentive payment is to be paid retrospectively to participating hospitals based on the total cardiac rehabilitation services to Medicare beneficiaries:

1. The initial payment is \$25 per cardiac rehabilitation service for each of the first 11 services paid for by Medicare during the care period for an AMI or CABG care episode.
2. After Medicare pays for 11 services, the payment increases to \$175 per service during the care period for an AMI or CABG care episode.

Based on Medicare coverage, the number of cardiac rehabilitation program sessions is limited to 2 1-hour sessions per day, up to 36 sessions within a period of up to 36 weeks. There is an option for an additional 36 sessions over an extended period of time if approved by the Medicare Administrative Contractor. Intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions, up to 6 sessions per day within a period of up to 18 weeks.

PARTICIPANTS

The AMI and CABG models will be implemented in 98 geographic areas, defined by metropolitan statistical areas (MSAs), which are counties associated with a core urban area that has a population of at least 50,000. To participate, MSAs must have had at least 75 cases eligible for the AMI model, among other criteria.

The SHFFT model will be implemented in the 67 MSAs where CJR currently is under way. To participate in the CJR model, MSAs had to have at least 400 eligible CJR cases. Participant hospitals are all acute care hospitals paid under the IPPS that are not already participating in models 2, 3, or 4 of the Center for Medicare and Medicaid Innovation's Bundled Payment for Care Improvement initiative for AMI, CABG, or SHFFT episodes.

Approximately 1,120 hospitals will participate in the AMI and CABG models, 860 hospitals in the SHFFT model, and 1,320 hospitals in the CR incentive payment model.

The list of affected MSAs can be found here:

<https://innovation.cms.gov/initiatives/epm>

WAIVERS OF MEDICARE PROGRAM REQUIREMENTS

The final rule provides several waivers of Medicare program requirements, including a waiver to allow an EPM beneficiary who does not qualify for home health services to receive visits in his or

her place of residence any time during the EPM episode following discharge from an anchor hospitalization. Visits are limited to 13 for the AMI model, 9 for the CAPG model, and 9 for the SHFFT model. The rule also allows practitioners to bill for services provided by licensed clinical staff, such as nurses, who are considered “auxiliary personnel” as defined in 410.26(a)(1), when provided under the general, rather than direct, supervision of the physician or nonphysician practitioner.

Services furnished under the waiver will be billed under the physician fee schedule by the physician or nonphysician practitioner or by the entity, including a hospital, to which the supervising physician or nonphysician practitioner has reassigned his or her benefits. CMS is also waiving current Medicare billing rules to allow a physician who performed a procedure during the anchor hospitalization of the EPM episode to bill separately for these postdischarge home visits when he or she is providing the general supervision of the home visit.

ADDITIONAL ASPECTS OF THE RULE

Under the final rule, beneficiaries will retain their freedom to choose services and providers, and providers will be expected to continue to meet current Medicare standards.

The rule also makes some additional minor changes to the CJR model. These changes include refinements for use of the skilled nursing facility waiver, exclusion of beneficiaries participating in selected ACOs, and revising target pricing methodology to include reconciliation and repayment amounts for performance years 3, 4, and 5.

NEW ACO MODEL OPPORTUNITY

The rule introduces the new Medicare ACO Track 1+ Model, which will become effective in 2018 to encourage more clinicians to join Advanced APMs. The new model limits the downside risk compared with current Track 2 or Track 3 models of the Medicare Shared Savings Program, and hopes to encourage more rapid progression to performance-based risk.

The model has a fixed 30% loss-sharing rate and a maximum level of downside risk that would vary based on the ACO’s composition, with potentially lower levels of risk available to qualifying ACOs that include physicians or small rural hospitals. In 2018, the maximum loss limit will be either 8% of ACO participant Medicare fee-for-service revenue or 4% of the ACO’s updated benchmark, depending on the composition of the ACO. For 2019 and 2020, eligible ACOs could

opt for a higher percentage of revenue, consistent with changes to the Advanced APM nominal risk requirement.

The Track 1+ Model 2018 application cycle will align with the annual application cycle for the Medicare Shared Savings Program. Although the dates have not been formalized, those wishing to apply should plan to submit the required Notice of Intent to Apply in May 2017.

