Overview of the CMS Episode Payment Model Final Rule

On January 3, the Centers for Medicare & Medicaid Services (CMS) released a final rule creating three new episode payment models (EPMs) through CMS' innovation waiver authority. The final rule creates a new mandatory bundled payment model for heart attack and cardiac bypass surgery services and expands the existing Comprehensive Care for Joint Replacement (CJR) Model to include additional surgical services for hip and femur fractures. The cardiac bundled payment model is mandatory for hospitals in 98 geographic areas. CMS also creates a cardiac rehabilitation incentive payment model to increase cardiac rehabilitation utilization in 90 geographic areas.

UPDATE: On February 15, CMS issued a delay of certain portions of this regulation in accordance with the memorandum issued by the Assistant to the President and Chief of Staff, entitled "Regulatory Freeze Pending Review." As a result, provisions of the rule that were scheduled to become effective on February 18, 2017 were delayed to March 21, 2017. However, provisions of the rule scheduled to become effective on July 1, 2017 were not delayed as a result of this rulemaking, including the implementation of the new cardiac episode payment models for Acute Myocardial Infarction (AMI) and Coronary Artery Bypass Surgery Graft (CABG) as well as the expansion of the CJR model. As a result of a subsequent Interim Final Rule issued March 20, the effective date of this rule is now May 20 and episode start dates have been delayed from July 1 to October 1, 2017. NOTE: The Agency is currently seeking feedback on the need for a further delay or additional modifications to this rule.

The new and expanded bundled payment models are accompanied by modified policies regarding overlap of certain ACO and EPM activities. CMS finalized an overlap policy that will exclude from EPMs those beneficiaries who are assigned to Track 3 Medicare Shared Savings Program (MSSP) and Next Generation ACOs for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), surgical hip/femur fracture treatment (SHFFT), and CJR episodes. The new policy also allows ACOs to be eligible for gainsharing as EPM collaborators. Although these policy changes are a small step in the right direction, NAACOS continues to have concerns regarding the overlap of ACO and bundled payment initiatives. NAACOS has repeatedly advocated for CMS to create a policy to exclude all ACO patients from episode and bundled payment models. The limited exclusion policy finalized by CMS will undermine ACO activities in the affected regions and therefore negatively affect ACOs' ability to succeed. NAACOS continues to advocate for more reasonable policies related to bundled payment initiatives that allow for ACOs' continued success. These EPMs, finalized in the last days of the Obama administration, will likely be subject to scrutiny from the incoming administration and may be modified prior to their implementation. We encourage NAACOS members to contact their legislators urging more sensible policies that eliminate competing interests for these programs.

Below is a summary of key provisions of the final rule for ACOs. For more information on the final rule, access the CMS website.

Episode Payment Models

Cardiac Episode Payment Model

Program participants: The cardiac EPM includes participant hospitals located in 98 randomly selected Metropolitan Statistical Areas (MSAs) throughout the country. Acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and located in the selected MSAs will be required to participate and are automatically included in the model, except for acute care hospitals in Maryland as well as hospitals in the Vermont All-Payer ACO Model. There is no application process for the model, and hospitals outside the selected MSAs are unable to participate.

Services and procedures: The cardiac EPM focuses on Acute Myocardial Infarction (AMI) and Coronary Artery Bypass Graft (CABG) episodes. Specifically, the episode of an AMI would begin with admission of a Medicare beneficiary to an IPPS hospital for the following MS-DRGs, where the specific MS-DRG is the anchor MS-DRG for the episode:

- AMI MS-DRGs
    - 280 (Acute myocardial infarction, discharged alive with major complication or comorbidity [MCC]);
    - 81 (Acute myocardial infarction, discharged alive with complication or comorbidity [CC]); and
    - 282 (Acute myocardial infarction, discharged alive without CC/MCC)
- Percutaneous Coronary Intervention MS-DRGs, when the claim includes an AMI ICD-10 diagnosis code in the principal or secondary position on the IPPS claim as specified in Table 3 (page 140 of proposed rule)
    - 246 (Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ vessels/stents); ++ 247 (Percutaneous cardiovascular procedures with drug-eluting stent without MCC);
    - 248 (Percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ vessels/stents);
    - 249 (Percutaneous cardiovascular procedures with non-drug-eluting stent without MCC);
    - 250 (Percutaneous cardiovascular procedures without coronary artery stent with MCC); and
    - 251 (Percutaneous cardiovascular procedures without coronary artery stent without MCC)

A CABG model episode begins with the admission of a Medicare beneficiary to an IPPS hospital for a CABG that is paid under the following CABG MS-DRGs and the specific MS-DRG is the anchor MS-DRG for the episode:

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

An episode of care begins when a Medicare fee-for-service beneficiary is admitted to a participant hospital and lasts through 90 days post-discharge. The bundle includes all related items and services paid under Medicare Part A and Part B with the exception of certain excluded services defined by CMS. In the final rule, CMS noted hospital and emergency department transfers could require special scenarios for EPM episodes and therefore revised the proposed transfer policy. For AMI episodes, the episode will be canceled at the original transferring hospital and a new one established upon admission to the hospital accepting the transfer if the discharging DRG for that hospital falls under applicable cardiac episode payment model MS-DRGs and the hospital accepting the transfer is a participant in the cardiac episode payment model.

Timeframe: The cardiac EPM will begin on October 1, 2017, and the first program year will be October 1 through December 31, 2017. Beginning in 2018, the cardiac EPM will evaluate participant hospitals based on a full calendar year performance period. The program will run for five years, concluding at the end of 2021.

Financial impact: Participant hospitals will be evaluated based on their cost and quality during a cardiac episode of care (admission through 90 days post-discharge). During the performance years, providers and suppliers would be paid for episode services under the existing Medicare payment systems, such as the IPPS or Medicare physician fee schedule. In the first two years of the program, participant hospitals will be

eligible for bonuses based on their performance but held harmless from penalties. Beginning in 2019, hospitals may be responsible for paying Medicare a portion of the episode spending based on their performance and whether they exceed CMS-created spending targets. Hospitals can voluntarily take on risk in performance year two for hospitals wishing to offer collaborating suppliers participation in an Advanced Alternative Payment Model (APM) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Both bonuses and penalties will be capped and payment adjustments will be made retroactively following the close of the performance year. CMS established additional financial protection for rural hospitals, sole community hospitals (SCHs), Medicare Dependent Hospitals (MDHs), Rural Referral Centers (RRCs), and low-volume hospitals including reduced stop-loss limits.

Cost evaluation: Participant hospitals will be evaluated based on the hospital's actual spending for the episode (total expenditures for related services under Medicare Parts A and B) and compared to the Medicare target episode price for a particular hospital. The episode target price will be established based on expenditure data from previous years and will begin as a blend of each participant hospital's specific expenditure data and regional episode expenditure data. Over time, this will shift, and target prices will be based solely on regional data by program years four and five. CMS will adjust prices to reflect the most resource-intensive cardiac care provided during the hospitalization. Target prices will also be adjusted based on whether the patient was treated with surgery or medical management. Hospitals receive quality-adjusted target prices based on a 1.5 to 3 percent discount rate relative to historical spending with the lowest discount percentage for hospitals providing the highest-quality care.

Quality evaluation: CMS will tie each hospital's level of bonus or penalty to a composite quality score based on the following quality measures:

- Heart Attacks: Hospital 30-Day, All-Cause Risk Standardized Mortality Rate Following AMI Hospitalization, Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, Voluntary Hybrid Hospital 30-Day, All-Cause Risk Standardized Mortality
- Bypass Surgery: Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following CABG Surgery, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

CMS also added a voluntary CABG quality measure: Patient-reported outcomes and limited risk variable data following elective primary Total Hip Arthroplasty/Total Knee Arthroplasty.

Beneficiary impact: Medicare beneficiaries included in the cardiac EPM will continue to have full discretion to choose their providers and suppliers.

Cardiac Rehab Incentive Payment Model

Background: CMS established a new payment model to test the effects of payments that encourage the use of cardiac rehab services. This cardiac rehabilitation incentive payment model will provide an incentive payment to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery. The payment will be based on beneficiary utilization of cardiac rehabilitation and intensive cardiac rehabilitation services in the 90-day care period following hospital discharge. These payments can be used by hospitals to coordinate cardiac rehabilitation services and will be available to hospital participants in 90 geographic areas (half of which will overlap with the cardiac episode payment model geographic areas to test effectiveness of this model).

Timeframe: This payment model will begin on October 1, 2017 and run for five years, concluding at the end of 2021.

Financial impact: CMS finalized a two-part cardiac rehabilitation incentive payment that would be paid retrospectively, based on the total cardiac rehabilitation use of beneficiaries attributable to participant hospitals. CMS will continue to make standard Medicare payments for cardiac rehabilitation services to all

providers of these services throughout the model. The initial retrospectively paid rehabilitation incentive payment will be $25 per cardiac rehabilitation service for each of the first 11 services paid for by Medicare during the care period for AMI or CABG episodes. After 11 services are paid for by Medicare, the payment will increase to $175 per service paid for by Medicare during the care period. The number of cardiac rehabilitation program sessions will be limited to a maximum set by CMS. CMS defines cardiac rehabilitation services as programs that include physician-prescribed exercise, tailored modification of cardiac risk factors, a psychosocial assessment, an outcomes assessment, and an individualized treatment plan. Services must be provided in a physician's office or an outpatient setting, and physicians must be available to assist patients during treatment. CMS also includes non-physician practitioners in the definition for providers and suppliers of cardiac rehabilitation services.

Comprehensive Care for Joint Replacement Model Expansion

Background: In April, 2016 CMS launched the CJR model which focuses on lower extremity joint replacement, targeting hip and knee replacement surgeries as identified by MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities). An episode of care begins when a Medicare fee-for-service beneficiary is admitted to a participant hospital and lasts through 90 days post-discharge. The bundle includes all related items and services paid under Medicare Part A and Part B with the exception of certain services identified by CMS. Providers and suppliers are paid for episode services under the existing Medicare payment systems and participant hospitals are evaluated based on the hospital's actual spending for the episode (total expenditures for related services under Medicare Parts A and B) and compared to the Medicare target episode price for a particular hospital. The episode target price is established based on expenditure data from previous years and is a blend of each participant hospital's specific expenditure data and regional episode expenditure data. CMS identified 67 MSAs for this program. Hospitals located in these geographic areas are automatically included in this model and required to participate. CMS estimates approximately 800 hospitals are currently participating in this program. Please reference our CJR Overview resource and the CMMI CJR website for more detailed information on this EPM.

Expansion: In this rule, CMS finalized an expansion of the CJR model to include additional surgical treatments for hip and femur fractures beyond hip replacement. As is currently done in the CJR program, the newly expanded Surgical Hip/Femur Fracture Treatment (SHFFT) model anchor hospitalization would be defined by admission for a surgical procedure, which is defined by the MS-DRGs for that procedure as listed below. A SHFFT model episode would begin with the admission of a Medicare beneficiary to an IPPS hospital for surgical treatment of hip or femur fracture (other than joint replacement) that is paid under the following SHFFT MS-DRGs and where the specific MS-DRG is called the anchor MS-DRG for the episode:

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

As is currently done in the CJR model, the bundle will include all related items and services paid under Medicare Part A and Part B with the exception of certain exclusions determined by CMS.

Program participants: CMS will use the existing 67 MSAs selected for the current CJR model.

Quality evaluation: CMS will use the same measures used in the existing CJR model. This includes Hospital-Level Risk Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty, HCAHPS Survey, Voluntary Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome and Limited Risk Variable.

Bundled Payments for Care Improvement Expansion

Building on the existing BPCI initiative, the Innovation Center notes it intends to implement a new voluntary bundled payment model for 2018 where the model or models would be designed to meet the criteria to be an Advanced APM under the Quality Payment Program (QPP) created by MACRA. CMS does not provide further details regarding this voluntary program(s), therefore we expect to see further rulemaking in the future addressing this new initiative.

Additional Key Policies

ACO Overlap with EPMs

There are a number of instances where the finalized EPM episodes will overlap with each other or with existing programs, including the MSSP, Next Generation ACO model, CJR and BPCI. Providers will be permitted to participate in these programs simultaneously. CMS addresses overlap issues related to when a Medicare beneficiary receives care that could simultaneously be counted under more than one of these models. In previous rulemaking, the agency addressed overlap issues related to ACOs and BPCI as well as CJR, and in this rule CMS accounts for instances where an EPM and ACO model overlap or when EPM episodes would overlap with each other or with CJR or BPCI episodes.

Unfortunately, CMS finalized a policy that will exclude only beneficiaries aligned to MSSP Track 3 and Next Generation ACOs from EPMs. CMS will also exclude beneficiaries from EPMs who are aligned to End Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) in the Comprehensive ESRD Care initiative in tracks with downside risk for financial losses. This overlap policy is limited to AMI, CABG, SHFFT and CJR payment models. Shared savings payments to ACOs and losses repaid by ACOs to CMS have the potential to overlap with EPM reconciliation payments. As with CJR, CMS will attribute savings achieved during an EPM episode to the EPM participant, and it will include EPM reconciliation payments for ACO-assigned beneficiaries as ACO expenditures. NAACOS continues to oppose this approach. For EPMs CMS will make an adjustment to the reconciliation amount to account for any of the applicable discount for an episode resulting in Medicare savings that is paid back through shared savings under the MSSP or any other ACO model, but only when an EPM hospital also participates in the ACO and the beneficiary in the EPM episode is also assigned to that ACO. In these cases, CMS will reclaim from the EPM participant any discount percentage paid out as shared savings for ACOs when the hospital is an ACO participant and the beneficiary is aligned with that ACO. The agency explains that this adjustment is necessary to ensure that the applicable discount under the EPM is not reduced because a portion of that discount is paid out in shared savings to the ACO and thus, indirectly, back to the hospital. Recoupment takes place 14 months following the end of each performance period.

NAACOS has advocated for a blanket exclusion from EPMs for all ACO assigned patients. However, CMS justifies a more limited exclusion policy by stating that a blanket exclusion would dilute the volume of EPMs and thereby limit the agency's testing of these models. CMS also cites operational concerns with excluding ACO patients, who are not prospectively assigned. CMS therefore finalized this limited exclusion policy and states their intention to study the effects of the policy to improve their understanding of the appropriate entity to hold accountable for the costs within the episode. CMS states that the agency may revisit this policy in future rulemaking.

CMS estimates a small fraction of total beneficiaries assigned to ACOs qualifying for this finalized exclusion policy will have relevant anchor hospitalizations that would initiate an EPM. Specifically, the agency notes that from 2013 through 2015 only about 2.4 percent of beneficiaries aligned to Pioneer ACO Model participants had an anchor hospitalization that would have initiated an AMI, CABG or SHFFT model.

Finally, noting operational concerns raised by stakeholders, the agency states it is in the process of developing a web portal where EPM participants can, at the point of care, look up and identify beneficiaries prospectively assigned to ACOs who will be excluded from EPMs. The rule notes this system is currently in testing and is expected to be operational when EPMs are implemented. CMS will provide more specific information on the development of this system in the future and provides little detail on the functionality of such a system in this rule.

Other Overlap Policies

In general, CMS will also give precedence to BPCI over EPM models, meaning that BPCI episodes would cancel or prevent the initiation of an AMI, CABG or SHFFT episode. The agency finalized a different and more complex approach for overlap of CJR and EPM episodes and overlap of multiple EPM episodes. Finally, the agency will give precedence to the ongoing CJR/EPM episode over subsequent episodes initiated during the post-hospital discharge period, except where the second admission is explicitly excluded from the initial bundle, in which case concurrent participation in both episodes would be permitted.

ACO Gainsharing in EPMs

CMS allows most ACOs to participate in both CJR and EPM models as "collaborators," which enables ACOs to participate in gainsharing arrangements under these models. This marks a shift in policy that will benefit ACOs, as the agency had previously proposed to exclude ACOs from the definition of CJR collaborators. Next Generation and Track 3 ACOs are excluded, as CMS excludes beneficiaries who are prospectively assigned to a Shared Savings Program ACO from CJR episodes. Collaborators are entities that CJR and EPM participants engage to make contributions to the participant's episode performance on spending or quality. The participant and collaborator share the reconciliation payments they may receive from CMS, the internal cost savings that the CJR or EPM obtains, and the financial responsibility for any repayments that are made to CMS. Aside from Next Generation and Track 3 ACOs, ACOs qualify to be both CJR collaborators and EPM collaborators.

Gainsharing payments, which are payments from an EPM or CJR participant to a collaborator, may be comprised only of EPM/CJR reconciliation payments, the EPM/CJR participant's internal cost savings, or some combination thereof. "Alignment payments," which flow from EPM/CJR collaborators back to EPM/CJR participants, may consist only of a portion of the amount owed by an EPM/CJR participant to CMS, called the "repayment amount."

In order to be eligible to receive a gainsharing payment or be required to make an alignment payment, an ACO must have contributed to EPM activities and been clinically involved in the care of EPM beneficiaries during the performance year for which the CJR participant-hospital accrued internal cost savings or earned the reconciliation payment that either comprises the gainsharing payment or was assessed a repayment amount. This means the ACO must have had an ACO provider/supplier that directly furnished an item or service rendered to an EPM beneficiary during an EPM episode in the appropriate performance year.

Sharing arrangements, pursuant to which gainsharing and alignment payments are made, must be in writing, signed by the parties, and entered into before care is furnished under the relevant sharing arrangement. Additionally, participation in a sharing arrangement must be entirely voluntary, and no penalty may be applied for nonparticipation. Sharing arrangements must require collaborators to comply with program integrity requirements, including beneficiary notification requirements, access to records, record retention, and participation in any enforcement activities performed by CMS or its designees. The terms of a sharing arrangement cannot impair beneficiary access.

While an EPM/CJR participant may receive alignment payments from EPM/CJR collaborators, the amount of those payments cannot exceed 50 percent of the EPM/CJR participant's total repayment amount, and no individual EPM/CJR collaborator's alignment payments can account for more than 25 percent of the EPM/CJR participant's repayment amount. This is to ensure that EPM/CJR participants maintain an appropriate amount of responsibility for services they provide. However, recognizing the size and spending power of some ACOs, CMS allows alignment payments from ACOs to account for up to 50 percent of an EPM participant's repayment amount.

Fraud and Abuse Implications

Sharing arrangements under the EPM and CJR cannot be based on criteria including the volume or value of referrals, as the whole purpose of these sharing arrangements is to create financial alignment surrounding the shared goals of quality and efficiency in episodes of care. With this in mind, the criteria used to select EPM/CJR collaborators must include quality of care. When EPM/CJR participants enter into sharing arrangements with EPM/CJR collaborators such as ACOs, their compliance programs must include "oversight of sharing arrangements and compliance with the applicable requirements" of the EPM/CJR, which provides a "program integrity safeguard."

The calculation of gainsharing payments is subject to two requirements to protect against fraud and abuse. First, the methodology used to calculate gainsharing payments must be "transparent, measurable, and verifiable in accordance with generally accepted accounting principles (GAAP) and Government Auditing Standards (The Yellow Book)." Second, the methodology used to calculate savings must reflect the actual internal cost savings the EPM/CJR participant realizes through documentation of EPM/CJR activities and must exclude any other savings the entity might realize. Additionally, gainsharing payments shall not be made to collaborators subject to actions for noncompliance with the fraud and abuse laws.

Pathway for EPMs to Qualify as Advanced Alternative Payment Models

CMS finalized a new pathway for physicians who participate in bundled payment models to qualify for Advanced Alternative Payment Models (APM) bonuses under the QPP created by MACRA. CMS established two tracks for EPMs and CJR for the purposes of Advanced APM qualification.

Track 1 will include EPM and CJR participants who will qualify as Advanced APMs under MACRA by meeting Certified EHR Technology (CEHRT) and financial risk requirements and Track 2 which will not qualify. EPM participants that choose to attest to CEHRT use and submit a clinician financial arrangements list beginning in performance year three will be designated as a Track 1 EPM participant. Those who elect voluntary downside risk in performance year two, attest to CEHRT use, and submit a clinician financial arrangements list will be designated a Track 1 EPM participant beginning in performance year two. Those that choose not to attest to CEHRT use will be designated a Track 2 EPM participant. EPM participants will attest to CEHRT use in a form and manner specified by CMS.

Clinician financial arrangement lists will identify Eligible Clinicians (ECs) to make Qualifying APM participant (QP) determinations for the QPP. ECs can include EPM or CJR collaborators, collaboration agents, or downstream collaboration agents (physician group practice members who are part of an ACO that is an EPM or CJR collaborator). If an EC participates in multiple Advanced APM Entities during a QP Performance Period and is not determined to be a QP based on participation in any of those Advanced APM Entities, then CMS will assess the EC individually using combined information for services associated with that individual's National Provider Identifier (NPI) and furnished through all the EC's Advanced APM Entities during the QP Performance Period. This includes all Advanced APM Entities for which the EC is represented on either a Participation List or Affiliated Practitioner List that CMS uses for QP determinations. CMS will make adjustments to ensure that patients and payments for services that may be counted in the QP

calculations for multiple Advanced APM Entities (for example, payments for services furnished to a beneficiary attributed to an ACO that are also part of an episode in an episode payment model) are not double-counted for the individual.

ECs on an Affiliated Practitioner List will be assessed individually, unlike eligible clinicians on a Participation List who are assessed as a group. Thus, CMS could make a determination across the two models if an EC was not determined to be a QP based on participation in any one of the Track 1 EPMs. CMS will only count beneficiaries attributed to an Advanced APM Entity toward a clinician's QP Threshold Score and will not count those beneficiaries who would have been attributed to an Advanced APM Entity if it were not for the fact that a different model overlapped.

To learn more about MACRA, please refer NAACOS's resource, *The ACO Guide to MACRA*.