Cardiac Rehabilitation Incentive Payment Model

On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) announced regulations regarding the Cardiac Rehabilitation (CR) Incentive Payment Model in the Advancing Care Coordination through Episode Payment Models final rule. The final rule finalizes three Episode Payment Models (EPMs) and a Cardiac Rehabilitation Incentive Payment Model and includes some modifications to the Comprehensive Care for Joint Replacement (CJR) Model.

This final rule implements a new Medicare payment model under the authority of Section 1115A of the Social Security Act, called the Cardiac Rehabilitation Incentive Payment Model, in which acute care hospitals in certain selected geographic areas receive retrospective incentive payments for beneficiary utilization of cardiac rehabilitation/intensive cardiac rehabilitation (CR/ICR) services during the 90 days following discharge from a hospitalization treatment of an acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) surgery. Considering the evidence demonstrating that CR/ICR services improve long term patient outcome, the room for improvement in CR/ICR service utilization for beneficiaries eligible for this benefit, and the need for ongoing, chronic treatment for underlying coronary artery disease among beneficiaries that have had an AMI or a CABG, there is a need for improved long term care management and care coordination for beneficiaries and incentivizing the use of CR/ICR services is an important component of meeting this need. The model is designed to reduce barriers to high value care by testing a financial incentive for hospitals that encourages the management of beneficiaries that have had an AMI or a CABG in ways that may contribute to long term improvements in quality and reductions in Medicare spending.

The first performance period will begin on July 1, 2017. The CR Incentive Payment Model will continue for 5 performance years, ending on or about December 31, 2021.

Overall Model Design

The CR Incentive Payment Model tests the effects on quality of care and Medicare expenditures of providing explicit financial incentives to hospitals (termed CR participants) for beneficiaries hospitalized for treatment of AMI or CABG to encourage care coordination and greater utilization of medically necessary CR/ICR services for 90 days post hospital discharge where the beneficiary's overall care is paid under either the AMI or CABG model or the Medicare fee-for-service (FFS) program. The period of post-discharge AMI or CABG care for which the CR incentive payment available is defined by the discharge of an eligible Medicare fee-for-service beneficiary from a hospital paid under the Inpatient Prospective Payment System (IPPS) under

specific Medicare Severity-Disease Related Groups (MS-DRGs). There are important advantages to testing the CR incentive payment in conjunction with the AMI and CABG models. First, we wish to understand whether and how the effects of a financial incentive for the use of CR/ICR services differ depending upon whether a beneficiary's care is covered under an EPM or the Medicare FFS program. Second, we wish to be able to examine each intervention's separate effects on the quality and efficiency of the care beneficiaries receive. We believe that coordinating the design, implementation, and evaluation of the EPMs and the CR incentive payment model is the best way to ensure that we accomplish both of these goals.

The care period for which the CR incentive payment will be made to the CR participant based on the CR/ICR service utilization of model beneficiaries continues for 90 days following discharge. All providers and suppliers will continue to be paid under the usual payment system rules and procedures of the Medicare program for services furnished to model beneficiaries throughout the care period , including CR?ICR services. Following the end of a model performance year, depending on the Medicare beneficiary utilization of CR/ICR services, the CR participant may receive an additional payment (the CR incentive payment) from Medicare.

Major Policy Changes from the Proposed Rule to the Final Rule

We are generally finalizing the model as proposed, with one significant several policy change from the proposed rule to the final rule. The change is bulleted below.

Beneficiary Engagement incentives: In the proposed rule, we had proposed to allow hospitals participating in the Model to provide transportation to CR/ICR services as an in-kind beneficiary engagement incentive for beneficiaries during AMI care periods and CABG care periods to achieve the CR incentive payment model goal of increasing CR/ICR service utilization. Several commenters requested that CMS allow hospitals that are FFS participants in the model to provide a broader set of beneficiary engagement incentives, similar to those available to those CR participants who are also AMI and CABG model participant hospitals. In response, we have finalized policies for beneficiary engagement incentives to be provided by FFS participants in the model under circumstances that are similar to the in-kind beneficiary engaged incentives finalized for the AMI and CABG models and that advance the clinical goals for a beneficiary in the CR Incentive Payment Model. Participant hospitals may choose to provide in-kind patient engagement incentives to beneficiaries in an AMI care period or CABG care period under the CR incentive payment model, subject to certain conditions. This includes, for example, that the incentive must be provided directly by the participant to the beneficiary during relevant care period and that the item or service provided must be reasonably connected to medical care provided. Beneficiary engagement incentives involving technology are subject to certain additional conditions.

General Model Overview

Participants

The CR Incentive Payment Model will be implemented in 90 geographic areas, 45 of which were also selected for the two cardiac care EPMs, defined by metropolitan statistical areas (MSAs). MSAs are counties associated with a core urban area that has a population of at least 50,000. Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection. These CR participant hospitals are termed EPM-CR participants. Additionally, 45 geographic areas that were not selected for the cardiac care EPMs (but were candidates for the cardiac care EPM selection) were selected to participate in this model. The model will be tested the same five-year period as the EPMs. The 90 MSAs selected can be found on our website: https://innovation.cms.gov/initiatives/epm.

Care period upon which the CR incentive payment is based

CR/ICR services that count toward the calculation of the retrospective CR incentive payment that a CR participant may receive are those that are furnished in the 90 days post-discharge from the hospitalization for AMI treatment or CABG that results in the beneficiary being included in the CR Incentive Payment Model. For EPM-CR participants, included beneficiaries are those in AMI or CABG episodes. For FFS-CR participants, included beneficiaries are those who would otherwise be eligible to be in an AMI or CABG hospital if the FFS-CR participant was an AMI or CABG model participant. These latter beneficiaries are not in an AMI or CABG episode where their overall care is paid under an EPM, but they are in an AMI care period or CABG care period under the CR Incentive Payment Model where overall care is paid under the FFS program.

AMI episode or AMI care period

An AMI episode or AMI care period is defined by 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 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). In addition to AMI MS-DRGs, an MS-DRG for percutaneous catheter insertion (PCI) which includes an AMI ICD-10-CM diagnosis code in the principal or secondary position on the IPPS claim will initiate an AMI episode or AMI care period. The following PCI MS-DRGs are eligible to initiate an AMI episode or AMI care period, so long as the criterion for AMI diagnosis code as specified previously is met: MS-DRG 246 (Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ vessels/stents), MS-DRG 247 (Percutaneous cardiovascular procedures with drug-eluting stent without MCC), MS-DRG 248 (Percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ vessels/stents), MS-DRG 249 (Percutaneous cardiovascular procedures with non-drug-eluting stent without MCC), MS-DRG 250 Percutaneous cardiovascular procedures without coronary artery stent with MCC), and MS-DRG 251 (Percutaneous cardiovascular procedures without coronary artery stent without MCC).

CABG episode or CABG care period

A CABG episode or CABG care period is defined by 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 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), or MS-DRG 236 (Coronary bypass without cardiac catheterization without MCC).

CR incentive payment

The CR Incentive Payment Model is a retrospective incentive payment model where CR participants may receive a CR incentive payment based on the CR/ICR service utilization of their beneficiaries in AMI or CABG episodes or AMI or CABG care periods. All providers and suppliers furnishing CR/ICR services to beneficiaries throughout the year will be paid for those CR/ICR services under the existing Medicare payment systems, specifically the hospital Outpatient Prospective Payment System (OPPS) or Physician Fee Schedule (PFS).

Following completion of a CR Incentive Payment Model performance year, CR participant hospitals will receive a CR incentive payments from Medicare based the utilization of CR/ICR services of model beneficiaries. The HCPCS codes for CR/ICR services are:

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

CMS will calculate a CR amount for each beneficiary include in the CR incentive payment model based as the sum of $25 for each of the first 11 CR/ICR services paid by Medicare under the OPPS or that report place of service code 11 (office) on the PFS claim during the AMI or CABG episode or AMI care period or CABG care period and $175 for each CR/ICR service paid by Medicare under the OPPS or that report place of service code 11 beyond the first 11 CR/ICR services. The CR participant's CR incentive payment for a CR performance year will be

determined based on the sum of the CR amounts across all of its beneficiaries for that CR performance year.

Based on Medicare coverage for CR/ICR services which is unchanged under the CR incentive payment model, the number of cardiac rehabilitation program sessions is limited to a maximum of two one-hour sessions per day for up to 36 sessions over up to 36 weeks, with the option for an additional 36 sessions over an extended period of time if approved by the Medicare Administrative Contractor. Intensive cardiac rehabilitation program sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

For CR participants to receive timely and meaningful feedback on their performance with respect to CR incentive payments, CMS will annually issue to CR participants a report containing data on CR/ICR service utilization in AMI or CABG episodes or AMI care periods or CABG care periods, and the amount of the CR incentive payment attributed to those episodes or care periods.

Additional flexibilities for participant hospitals

CMS provides additional tools to improve the effectiveness of CR/ICR service coordination by participant hospitals in selected MSAs. These tools include: 1) providing hospitals upon request and in accordance with applicable privacy and security laws and established privacy and security protection inpatient claims for potential admissions for CABG, AMI, and PCI (with an AMI ICD-10-CM diagnosis code in the principal or any secondary diagnosis code position) MS-DRGs and carrier and outpatient claims containing CR/ICR service that occurred in the 90-day period after discharge; ; 2) waiving certain Medicare requirements to encourage flexibility in the delivery of CR/ICR services; and 3) facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.

To provide greater program flexibility that might increase the availability of CR and ICR services to beneficiaries, we provided a waiver to the definition of a physician to allow, in addition to a physician, a nonphysician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) to perform the functions of supervisory physician, prescribing exercise, and establishing, reviewing and signing an individualized treatment plan in furnishing CR/ICR services to beneficiaries of FFS-CR participants. This waiver for FFS-CR participants is similar to the physician definition waiver for EPM-CR participants that is available under the AMI and CABG models. In addition, participant hospitals may provide beneficiaries with certain in-kind engagement incentives to advance the clinical goals of their care, under certain conditions.

No waivers of any fraud and abuse authorities are being issued in this final rule. Any fraud and abuse waivers issued in connection with the FFS-CR beneficiary engagement incentives model will be available at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html and on OIG's Web site.

Beneficiary benefits and protections

Beneficiaries retain their freedom of choice to choose services and providers. Physicians and hospitals are expected to continue to meet current standards required by the Medicare program. All existing safeguards to protect beneficiaries and patients remain in place. If a beneficiary believes that his or her care is adversely affected, he or she should call 1-800- MEDICARE or contact his or her state's Quality Improvement Organization by going to http://www.qioprogram.org/contact-zones.

Innovation Center

The CR Incentive Payment Model has been designed by the Center for Medicare and Medicaid Innovation (Innovation Center), which was established by Section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center to test innovative payment and service delivery models to reduce program expenditures and preserve or enhance the quality of care for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. The Innovation Center's mission is to take locally-driven approaches – approaches from doctors and other health care partners providing care to patients every day – and give them platform to scale through a collaborative and highly transparent process.

The Advancing Care Coordination through Episode Payment Models final rule can be viewed at https://www.federalregister.gov/public-inspection/current starting December 20, 2016.

For **more information** about the CR Incentive Payment Model, go to https://innovation.cms.gov/initiatives/cr-model

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