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Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR): Final Rule Overview

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Today's Agenda

- Request for hospital point of contact (POC) information
  - Please send the following information to epmsupport@cms.hhs.gov
    - Hospital CCN in Subject Line
    - Names of two primary points of contact for EPM communication
    - Titles, telephone numbers, and email addresses for POCs
    - Hospital Physical Mailing Address

- Highlight major policy changes in final rule compared to proposed rule

- Overview of Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) final rule

- Slides will be available on our website https://innovation.cms.gov/initiatives/epm/ as soon as possible.

Proposed Rule to Final Rule

- The proposed rule was published on August 2, 2016, with the comment period ending October 3, 2016. After reviewing nearly 175 highly detailed comment submissions from the public on the proposed rule, and considering commenters' thoughtful perspectives, several major changes were made from the proposed rule.

- On December 20, 2016, the final rule entitled: Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) went on display at the Federal Register. As directed by the White House memorandum of January 20, 2017 entitled "Regulatory Freeze Pending Review", CMS is delaying **the effective date** of the provisions of the final rule, which were to become effective on February 18, **until March 21**. The delay notice was published in the Federal Register on February 15, 2017. No other changes to the rule beyond the effective date delay are anticipated at this time.

- The full text of the rule is available now online and in PDF format at the following website:
  - https://www.federalregister.gov/documents/2017/01/03/2016-30746/medicare-program-advancing-care-coordination-through-episode-payment-models-epms-cardiac.

EPM Final Rule Summary

The Advancing Care Coordination Final rule implements three new Medicare Parts A and B episode payment models, in which acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) and surgical hip and femur fracture treatment (SHFFT). The rule also implements a Cardiac Rehabilitation (CR) Incentive Payment model and makes modifications to the existing Comprehensive Care for Joint Replacement (CJR) model under section 1115A of the Social Security Act.

- The new CR Incentive Payment model will test incentive payments to increase utilization of CR services for AMI and CABG patients, both alongside the AMI and CABG EPMs as well as in conjunction with traditional fee for service (FFS) Medicare payments.

- The CJR model changes will clarify, modify and update certain provisions around target pricing, composite quality, and beneficiary incentives and exclusions. Additionally the final rule creates an option for CJR participant hospitals to be in an Advanced APM that would, in turn, allow eligible clinicians to be considered for a QP determination.

Major Policy Changes from the Proposed Rule

In response to comments received on the proposed rule, CMS made the following changes to the final rule policies:

- **Pricing and Payment**

➢ Downside risk will begin for all on October 1, 2018 instead of on April 1, 2018 which was the proposed date; The models now allow voluntary opt in to downside risk Jan 1, 2018 (to meet advanced APM requirements).

➢ A low-volume provider definition was created in response to comment and hospitals in this category will have the same lower stop-loss limits provided to rural hospitals in the model.

- **Quality**

➢ Proposed quality measures were finalized with a modification to the proposed CABG measures to include data submission for the STS composite CABG measure as a voluntary measure worth 2 additional points toward the composite CABG quality score.

Major Policy Changes from the Proposed Rule

- **Transfers:**

➢ We did not finalize the proposal for chained anchor hospitalization therefore the terms 'chained anchor stay' and 'Price-DRG' are not applicable for the final models. We now cancel AMI episodes that begin on inpatient admission to the initial treating hospital when any inpatient-to-inpatient transfer occurs.

➢ A new AMI or CABG episode begins at the transfer hospital if that transfer hospital is an AMI or CABG participant and the MS-DRG (and diagnosis) assigned at the transfer hospital meets the criteria for initiating an AMI or CABG episode.

➢ Begin episode and assign risk and clinical episode to final discharging hospital after any transfer (either from the emergency department or inpatient hospitalization at the initial treating hospital).

What Are the EPMs Designed To Do for Patients and the Health System?

Better Care

- Better care for patients through more coordinated, higher quality care during and after select episodes or care periods

Smarter Spending

- Smarter spending of health care dollars by holding hospitals accountable for total episode spending, not just inpatient costs, and incentivizing use of high value services during care periods

Healthier People and Communities

- Healthier people and communities by improving coordination in health care and by connecting care across hospitals, physicians, and other health care providers

EPM Participants

- AMI & CABG EPMs: Hospitals in 98 selected metropolitan statistical areas (MSAs), with limited exceptions. The MSAs were randomly selected from 293 eligible MSAs and presented in the final rule.

- SHFFT EPM: Hospitals in MSAs selected for the CJR model, with limited exceptions.

- Participant hospitals in these selected MSAs are all acute care hospitals paid under the IPPS that are not currently participating in Models 1, 2 or 4 of the Bundled Payments for Care Improvement (BPCI) Initiative.

- Current estimate is that **over 2,000 hospitals will participate in the EPMs and CR Incentive Payment Model**. Participant lists are available at the EPM website. https://innovation.cms.gov/initiatives/epm/

Advanced APM Tracks

In order to maximize the opportunities for eligible clinicians to participate in Advanced APMs, CMS finalized two tracks for each of the EPMs. Participants may switch between tracks during the 5 years the models run.

- Track 1 – Advanced APM Track
  - Participant hospitals must meet and attest to the CEHRT use requirement, as specified in section 1833(z)(3)(D)(i)(I) of the Act
  - Participants must submit a clinician financial arrangements list to CMS no more than quarterly
  - Participation of eligible clinicians collaborating with Track 1 hospitals will count toward Advanced APM participation for purposes of the Quality Payment Program

- Track 2 – Non Advanced APM Track
  - EPM participants that do not choose to meet and attest to the CEHRT use requirement will be in Track 2

What is an EPM Episode of Care?

- EPM episodes initiate with hospitalizations of eligible Medicare fee-for-service beneficiaries discharged with specified MS-DRGs:
  - **AMI** (AMI MS-DRGs: 280-282 & PCI MS-DRGs: 246-251 with AMI ICD-CM diagnosis code)
    - IPPS admissions for AMI treated medically or with revascularization via percutaneous coronary intervention (PCI)
  - **CABG** (MS-DRGs: 231-236)
    - IPPS admissions for surgical coronary revascularization irrespective of AMI diagnosis
  - **SHFFT** (MS-DRGs: 480-482)
    - IPPS admissions for hip/femur fracture fixation, other than joint replacement

- Episodes include:
  - Hospitalization and 90 days post-discharge
  - The day of discharge is counted as the first day of the 90-day post-discharge period.
  - All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode

EPM Eligible Beneficiaries

- Medicare beneficiaries are eligible for EPM episodes if Medicare is the primary payer and the beneficiary is:
  - Enrolled in Medicare Part A and Part B throughout the duration of the episode;
  - Not eligible for Medicare on the basis of End Stage Renal Disease;
  - Not enrolled in a managed care plan (e.g., Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations); and
  - Not covered under a United Mine Workers of America health plan.
- If at any time during the episode the Medicare beneficiary no longer meets all of these criteria aforementioned, the episode is canceled.

Included and Excluded EPM Episode Services

Included Services

- Physicians' services
- Inpatient hospitalization
- Inpatient hospital readmission
- Inpatient Psychiatric Facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Outpatient therapy
- Clinical laboratory
- Durable medical equipment (DME)
- Part B drugs and biologicals
- Hospice
- PBPM payments under models tested under section 1115A of the Social Security Act

Excluded Services

- Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications.
- Chronic conditions that are generally not affected by the episode.
- The list of excluded MS-DRGs and ICD-CM diagnosis codes, including both ICD-9-CM and ICD-10-CM, is posted on the CMS website.
- Potential modifications to the MS-DRGs and/or ICD-10-CM exclusion lists will be posted to the CMS website in mid-March. Public input will be considered and the final 2017 exclusion lists reflecting any changes from this code review will be posted to the CMS website by mid-May.

Payment and Pricing: Risk Sharing

- **Retrospective, two-sided risk** model with **hospitals bearing financial responsibility**
  - Providers and suppliers continue to be paid via Medicare FFS
  - After a performance year, actual episode spending will be compared to the episode target prices
    - If aggregate target prices are greater than actual episode spending, hospitals may receive a reconciliation payment
    - If aggregate target prices are less than actual episode spending, hospitals will be responsible for making a payment to Medicare
- Responsibility for repaying Medicare can begin in Performance Year 2, **for participants who elect voluntary early downside risk.** Otherwise, phased-in **downside risk begins in Performance Year 3 for all participants (i.e., for episodes that begin as of October 4, 2018)**.

Payment and Pricing: Target Prices

- **CMS will establish target prices for each participant hospital**
  - Specific to MS-DRGs for each of the models
  - Risk stratification (e.g., CABG readmission in AMI episode)
- Based on **3 years of historical data**
- Quality-adjusted target prices include **an effective discount factor** (based on quality performance and improvement) to serve as Medicare's savings
- Based on **blend of hospital-specific and regional episode data** (US Census Division), transitioning to regional pricing
  - Performance Years 1 and 2: 2/3 hospital-specific, 1/3 regional
  - Performance Year 3: 1/3 hospital-specific, 2/3 regional
  - Performance Years 4 and 5: 100% regional pricing

Payment and Pricing: Link to Quality through Pay-for-Performance

- Hospitals are assigned a composite quality score each year based on their *performance and improvement* in model-specific quality measures and data submission.
- Voluntary data submission is weighted at 10% of composite quality scores for each of the models.
- More information on quality is available at the EPM website: https://innovation.cms.gov/initiatives/epm

Payment and Pricing: Link to quality through pay-for-performance

Downside Risk for All Participants– DR effective for episodes ending on or after 1/1/2019 (anchor discharges occurring on or after 10/4/2018)

	PY1	PY2	PY3	PY4	PY5
Stop-loss threshold	n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2	n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2	5%	10%	20%
Stop loss threshold for certain hospitals*	n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2	n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2	3%	5%	5%
Discount percentage (range) for Repayment, Depending on Quality Category	n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2	n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2	0.5%-2.0%	0.5%-2.0%	1.5%-3.0%

***Including rural and sole-community hospitals, rural referral centers, Medicare Dependent Hospitals and hospitals determined to be EPM volume protection hospitals within an EPM.**

Payment and Pricing: Link to quality through pay-for-performance (continued)

Voluntary Downside Risk – DR effective for episodes ending on or after 1/1/2018 (anchor discharges occurring on or after 10/4/2017)

	PY1	PY2	PY3	PY4	PY5
Stop-loss threshold	n/a as no downside risk in PY1	5%	5%	10%	20%
Stop loss threshold for certain hospitals*	n/a as no downside risk in PY1	3%	3%	5%	5%
Discount percentage (range) for Repayment, Depending on Quality Category	n/a as no downside risk in PY1	0.5%-2.0%	0.5%-2.0%	0.5%-2.0%	1.5%-3.0%

***Including rural and sole-community hospitals, rural referral centers, Medicare Dependent Hospitals and hospitals determined to be EPM volume protection hospitals within an EPM.**

Payment and Pricing: Rural

- **Additional protection** for rural, sole community (SCH), Medicare dependent (MDH), rural referral center (RRC), and certain low-volume hospitals with **stop-loss of 3% for Performance Year 2 (if voluntary downside risk elected), 3% for Performance Year 3 and 5% for Years 3 through 5**.

- These protections strike an appropriate balance between protecting hospitals that often serve as the only access of care for Medicare beneficiaries and having these hospitals meaningfully participate in the model.

Overlap with BPCI

- Hospital **participation in BPCI vs. EPMs** in selected MSAs
  - Hospitals in BPCI Models 1, 2, or 4 for episodes that would otherwise qualify as EPMs (e.g., SHFFT, AMI, CABG) **may remain in BPCI and are not required to participate in the EPM model for those episodes covered under BPCI**.
  - BPCI participants that terminate from a BPCI model for the equivalent EPM episode and are located in an MSA that has been selected for that EPM are required to participate in the EPM model.
  - Hospitals not already in BPCI **may not elect** to participate in BPCI in lieu of participation in the EPM model.
  - A hospital participating in BPCI for one type of episode (e.g., CABG) will still be required to participate in unrelated EPMs (e.g., AMI or SHFFT) if it is located in a selected MSA and a beneficiary would otherwise qualify for an EPM episode that is not covered under BPCI.
- Instances where BPCI participation takes precedence over EPM when hospital is not participating in BPCI:
  - BPCI Model 2 or 3 PGP practicing at an EPM hospital when the EPM hospital is not a BPCI participant.
  - BPCI Model 3 episode initiates when a patient is discharged from an EPM hospital to a BPCI Model 3 PAC provider.

Overlap with ACOs

- Hospitals selected to participate in the EPM model may also participate in an ACO or other models.

- Beneficiaries prospectively aligned to ACOs with downside risk (e.g., NextGen ACOs, MSSP Track 3 ACOs, or the Comprehensive ESRD Care Initiative) are excluded from EPMs. The ACO will be accountable for those beneficiaries' total cost of care.

- Beneficiaries aligned with all other ACOs will be eligible to participate in EPMs. Savings achieved during an EPM episode shall be attributed to the EPM participant and EPM reconciliation payments for ACO-aligned beneficiaries shall be considered ACO expenditures.

Overlap with Other Models

- Per beneficiary per month (PBPM) payments for new and enhanced services shall be included in EPM reconciliation calculations if CMS determines, on a model by model basis, that the services paid for by the PBPM payments are:
  - (1) not excluded from an EPM model's episode definition;
  - (2) rendered during the episode; and
  - (3) paid for from the Medicare Part A or Part B Trust Funds.

Financial Arrangements: Gainsharing

- Consistent with applicable law and regulations, EPM participants may have certain financial arrangements to share gains and losses with collaborators to support their efforts to improve quality and reduce costs.
- EPM Collaborator means an ACO or one of the following Medicare-enrolled individuals or entities that enters into a sharing arrangement:

Skilled Nursing Facility (SNF)
Home Health Agency (HHA)
Long-term care hospital (LTCH)
Inpatient rehabilitation facility (IRF)
Physician
Non-physician practitioner
Therapist in private practice
Comprehensive outpatient rehabilitation facility (CORF)
Provider of outpatient therapy services
Physician Group Practice (PGP)
Hospital
Critical Access Hospital (CAH)
Non-physician Practitioner Group Practice (NPPGP)
Therapy Group Practice (TGP)

Financial Arrangements: Gainsharing Payments

- EPM participants may **share** with EPM collaborators:
  - Gainsharing payments in the form of reconciliation payments, or internal cost savings, or both.
- **EPM collaborators** (other than an ACO, PGP, NPPGP, or TGP) must have directly furnished a billable item or service to an EPM beneficiary during an EPM episode that occurred in the same performance year for which the EPM participant accrued the internal cost savings or earned the reconciliation payment that comprises the gainsharing payment or was assessed a repayment amount.
- To be eligible to receive a gainsharing payment, or to be required to make an alignment payment, an **EPM collaborator that is an ACO, PGP, NPPGP, or TGP** must meet specific criteria such as:
  - Contributing to **EPM activities** and being clinically involved in the care of EPM beneficiaries.

Financial Arrangement: Alignment Payments

- The EPM participant must not receive any amounts under a sharing arrangement from an EPM collaborator that are not alignment payments.
- For a performance year, the aggregate amount of all alignment payments received by the EPM participant must not exceed 50% of the EPM participant's repayment amount.
- The aggregate amount of all alignment payments from an EPM collaborator to the EPM participant may not be greater than—
  - With respect to an EPM collaborator other than an ACO, 25% of the EPM participant's repayment amount; or
  - With respect to an EPM collaborator that is an ACO, 50% of the EPM participant's repayment amount.

Financial Arrangements: Distribution Payments

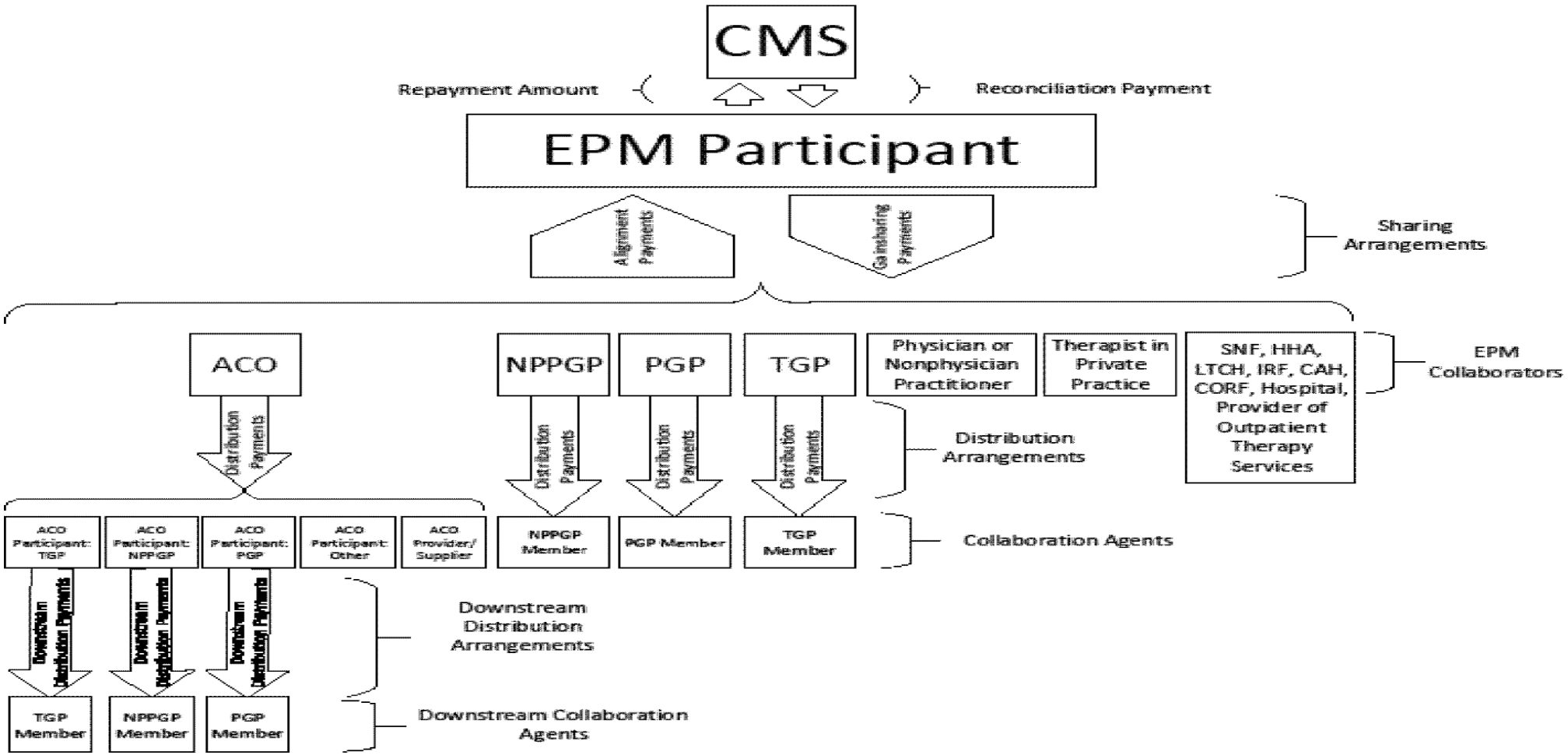
- Distribution arrangement means a financial arrangement between an EPM collaborator that is an ACO, PGP, NPPGP, or TGP and a collaboration agent for the sole purpose of distributing some or all of a gainsharing payment received by the ACO, PGP, NPPGP, or TGP.
- The EPM collaborator may not enter into a distribution arrangement with any individual or entity that has a sharing arrangement with the same EPM participant.
- Distribution payments must be substantially based on quality of care and the provision EPM activities.
- For PGPs, distribution payments must be determined either in a manner that complies with § 411.352(g) of this chapter or must be substantially based on quality of care and the provision EPM activities.

Financial Arrangements: Downstream Distribution Arrangements

- Downstream distribution arrangement means a financial arrangement between a collaboration agent that is both a PGP, NPPGP, or TGP and an ACO participant and a downstream collaboration agent for the sole purpose of distributing some or all of a distribution payment received by the PGP, NPPGP, or TGP.
- The total amount of all downstream distribution payments made to downstream collaboration agents must not exceed the amount of the distribution payment received by the PGP, NPPGP, or TGP from the ACO.
- For PGPs, downstream distribution payments must be determined either in a manner that complies with § 411.352(g) of this chapter or must be substantially based on quality of care and the provision EPM activities.
- Downstream Distribution Payments must be substantially based on **quality of care** and the **provision of EPM activities**

Financial Arrangements: Overall Chart

Figure 3: FINAL EPM FINANCIAL ARRANGEMENTS



Financial Arrangements: Beneficiary Incentives

- **EPM participants may choose to provide in-kind patient engagement incentives to beneficiaries in an EPM episode, subject to the following conditions:**
  - The incentive must be provided directly by the EPM participant or by an agent of the EPM participant under the EPM participant's direction and control to the EPM beneficiary during an EPM episode.
  - The item or service provided must be reasonably connected to medical care provided to an EPM beneficiary during an EPM episode.
  - The item or service must be a preventive care item or service or an item or service that advances a clinical goal, as listed in § 512.525 (c), for a beneficiary in an EPM episode by engaging the beneficiary in better managing his or her own health.

Financial Arrangements: Beneficiary Incentives

- The item or service must not be tied to the receipt of items or services outside the EPM episode.
- The item or service must not be tied to the receipt of items or services from a particular provider or supplier.
- The availability of the items or services must not be advertised or promoted except that a beneficiary may be made aware of the availability of the items or services at the time the beneficiary could reasonably benefit from them.
- The cost of the items or services must not be shifted to another federal health care program, as defined at section 1128B(f) of the Act.

Financial Arrangements and Beneficiary Incentives Waivers

- Some financial arrangements **may implicate the federal fraud and abuse laws**.
- The Secretary **may consider whether waivers of certain fraud and abuse laws are necessary** to test the EPMs.
  - No waivers needed for arrangements that comply with existing federal law.
  - Waivers, if any, would be promulgated separately by OIG and CMS.

Program Rule Waivers: Telehealth

- Only for services that may be furnished via telehealth under existing requirements and are included in an EPM episode in accordance with § 512.210, CMS waives:
- **The geographic site requirement of** section 1834(m)(4)(C)(i)(I) through (III) of the Act for episodes being tested in an EPM (**Except for the geographic site requirements for a face-to-face encounter for home health certification**)
- The originating site requirements under section 1834(m)(4)(C)(ii)(I) through (VIII) of the Act for episodes being tested in an EPM to permit a telehealth visit to originate in the beneficiary's home or place of residence (**Except for the originating site requirements for a face-to-face encounter for home health certification**)
- CMS waives the payment requirements so that the facility fee normally paid by Medicare to an originating site for a telehealth service is not paid if the service is originated in the beneficiary's home or place of residence.
- CMS waives the payment requirements to allow the distant site payment for telehealth home visit HCPCS codes unique to this model to more accurately reflect the resources involved in furnishing these services in the home by basing payment upon the comparable office visit relative value units for work and malpractice under the Physician Fee Schedule.

Program Rule Waivers: Skilled Nursing Facility 3-Day Stay

- **The SNF 3-day stay rule is waived for the AMI model only**.
- CMS waives the SNF 3-day rule for coverage of a qualified SNF stay for a beneficiary who is an EPM beneficiary on the date of discharge from the anchor hospitalization on or after October 4, 2018.
- Beneficiaries discharged pursuant to the waiver **must be transferred to SNFs rated 3-stars or higher for at least 7 of the previous 12 months** is charged pursuant to the waiver as reported on the CMS Nursing Home Compare website. A list of qualifying SNFs will be posted to the EPM website prior to each calendar quarter to which it applies.
- All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

Program Rule Waivers: Skilled Nursing Facility 3-Day Stay

- If the EPM hospital discharges a beneficiary to a SNF **that is not a qualified SNF** under § 512.450 (b) of this section and provides the beneficiary with a discharge planning notice to the beneficiary at the time of discharge to a SNF then the SNF coverage requirements apply and the beneficiary may be financially liable for uncovered SNF services.

- The EPM hospital will be financially liable for the SNF stay and the SNF must not bill the beneficiary for the costs of the uncovered SNF services furnished during the SNF stay if, **subsequent to an EPM hospital applying the SNF 3-day rule waiver under this section**, CMS determines the EPM hospital discharges a beneficiary to:
  - To a SNF that is not a qualified SNF under paragraph (b) of this section and the EPM hospital does not provide the beneficiary with a discharge planning notice, as described at § 512.450(b)(3);
  - That is in an EPM where the SNF 3-day rule waiver is not applicable under paragraph (a) of this section; or
  - Prior to October 4, 2018, where the SNF 3-day rule waiver is not applicable under paragraph (b) of this section.

Program Rule Waivers: Home Visits

- CMS waives the requirement that services and supplies furnished incident to a physician's service must be furnished under the direct supervision of the physician (or other practitioner) to permit home visits as specified in this section.

- The waiver of the direct supervision requirement in applies only certain circumstances such as:
  - A beneficiary who has been discharged from an anchor hospitalization.
  - The home visit is furnished at the beneficiary's home or place of residence.
  - The beneficiary does not qualify for home health services under sections 1835(a) and 1814(a) of the Act at the time of any such home visit.
  - The visit is furnished by clinical staff under the general supervision of a physician or non-physician practitioner.

- The number of visits that are furnished to the beneficiary during are:
  - AMI episode = up to 13 post-discharge home visits;
  - CABG episode = up to 9 post-discharge home visits; and
  - SHFFT episode = up to 9 post-discharge home visits.

Data Sharing: Specifications

- CMS will **share data with EPM participant hospitals** so they will be able to:
  - Evaluate their practice patterns.
  - Redesign care delivery pathways.
  - Improve care coordination.

- In response to a hospital's request in each applicable model, and in accordance with our regulations and related privacy laws, **CMS will share beneficiary Part A and B claims for the duration of the episode** in
  - Summary format,
  - Raw claims line feeds, or
  - Both summary and raw claims.

We anticipate data sharing with participant hospitals will begin in the late spring. **Data will be available** for the hospital's **baseline period** and no less often than on a **quarterly basis with the goal of as often as on a monthly basis if practicable** during a hospital's performance period.

Data Sharing: Specifications

- CMS will also share **aggregate regional claims data with EPM participant hospitals** because regional prices are incorporated when establishing target prices. These files will provide aggregate **expenditure data available for all claims associated with AMI, CABG, and SHFFT episodes for the U.S. Census Division** in which the EPM participant hospital is located.
- In addition, we are exploring making **aggregate summary data** organized by **anchor MS-DRG, provider type, and region for care** for episodes that would **meet the criteria for inclusion in the regional component** of EPM **publicly available** for non-EPM participants.

Data Sharing: Privacy

- Data sharing in EPM **fully complies with laws and regulations** pertaining to privacy.

- The HIPAA Privacy Rule **restricts our ability to share beneficiary-identifiable data with EPM collaborators** and non-EPM participants because the selected participant hospitals are specifically held financially responsible the EPM episodes.

- However, we will require a **Data Request and Attestation form** for each model that will have a mechanism in place for **business associates**, as defined under HIPAA, **to receive data directly from CMS on an EPM participant's behalf**. This gives participant **hospitals the ability to re-disclose EPM data to their collaborators** provided they are in compliance with HIPAA.

Beneficiary Protections: Access to Care

- Beneficiaries' **access to care should not be impacted** by the EPMs.
  - This is a payment model that changes the payment methodology for hospitals in select geographic areas.
  - Beneficiary **deductibles and copayments will not change**.
  - Beneficiaries may still **select any provider of choice with no new restrictions**.
  - Beneficiaries may still **receive any Medicare covered services with no new restrictions**.

- If a beneficiary believes that his or her care is adversely affected, he or she should call 1-800-MEDICARE or contact their state's Quality Improvement Organization by going to: http://www.qioprogram.org/contact-zones. The Alternative Payment Models Beneficiary Ombudsman will also be monitoring the Models and fielding inquiries from beneficiaries if needed.

Beneficiary Protections: Beneficiary Notification

- Beneficiary notification about the EPMs will **support transparency.**
- Beneficiary notification requirements focus the attention of all parties on the requirement to provide all medically necessary services.
- As part of discharge planning and referral, EPM participants must provide a complete list of HHAs, SNFs, IRFs, or LTCHs that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient.
- EPM participants must notify beneficiaries of payment implications.

Beneficiary Protections: Beneficiary Notification by an EPM Participant

- EPM participant notification
  - Required to notify beneficiaries of EPMs upon admission
  - If the admission is scheduled, the EPM participant must provide notice as soon as the admission is scheduled
  - In the event notification is not practicable in the preceding circumstances, notice must be provided as soon as reasonable practicable, but no later than discharge
  - What is included in the notice?
    - Explanation of the EPMs and possible affect for beneficiary care
    - Statement that beneficiary retains freedom of choice to choose providers and services
    - Explanation of how patients can access care records and claims data
    - Statement that all existing Medicare beneficiary protections continue to be available to the beneficiary
    - A list of the providers, suppliers, and ACOs with whom the EPM participant has a sharing arrangement

Beneficiary Protections: Beneficiary Notification by An EPM Collaborator

Party	Who has risk sharing relationship with EPM participant	Who provides item or service to EPM beneficiary	Notice Requirements	Timing
EPM collaborator	SNF, HHA, LTCH, IRF, Physician, Nonphysician practitioner, Therapist in private practice, CORF, Provider of outpatient therapy services, Hospital, r CAH	SNF, HHA, LTCH, IRF, Physician, Non-physician practitioner, Therapist in private practice, CORF, Provider of outpatient therapy services, Hospital, CAH	1. Structure of EPM 2. Existence of individual or entity's sharing arrangement	No later than first time EPM beneficiary receives item or service Exception: Notice must be provided as soon as reasonable practicable
EPM collaborator that is a NPPGP, PGP, TPG	NGGPG, PGO, or TGP	Member of NPPGP, PGP or TGP	1. Structure of EPM 2. Existence of entity's sharing arrangement	No later than first time EPM beneficiary receives item or service Exception: Notice must be provided as soon as reasonable practicable
EPM collaborator that is an ACO	ACO	ACO participant or ACO provider/supplier	1. Structure of EPM 2. Existence of entity's sharing arrangement	No later than first time EPM beneficiary receives item or service Exception: Notice must be provided as soon as reasonable practicable

Beneficiary Protections: Monitoring

- CMS **monitoring assesses compliance** with the model requirements for beneficiary protections.

- EPM participants are familiar with both bundled payment and risk-sharing and are unlikely to compromise patient care.

- Nonetheless, **CMS will monitor for potential risks** such as:
  - Attempts to increase profit by delaying care
  - Attempts to decrease costs by avoiding medically indicated care
  - Attempts to avoid high cost beneficiaries
  - Evidence of compromised quality or outcomes

EPM Compliance with Requirements of Participation

- EPM participants, and any entity or individual furnishing a service to a beneficiary during an EPM episode, must comply with all of the **requirements of participation for the model**.

- **CMS may do one or more of the following** if an EPM participant fails to comply with any of the requirements of the EPMs:
  1. Issue a warning letter to the EPM participant.
  2. Require the EPM participant to develop a corrective action plan.
  3. Reduce or remove an EPM participant's positive net payment reconciliation amount (NPRA) calculation.
  4. Reduce or remove an EPM participant's CR incentive payment.
  5. Require an EPM participant to terminate a sharing arrangement with an EPM collaborator and prohibit further engagement by the EPM participant in sharing arrangements with the EPM collaborator.
  6. In extremely serious circumstances, expulsion from the model and/or other sanctions including suspension of payments or revocation from the EPM if indicated.

Evaluation: Focus Areas

- The EPM model will include evaluations of Cardiac and SHFFT episodes that focus on assessing changes in care quality and efficiency including reduced health care costs.
- The evaluation for the Cardiac Rehab Incentive Payment Model will assess changes in utilization, retention, and duration of cardiac rehabilitation sessions.
- Focus areas of evaluation include:
  - Payment and utilization impact
  - Outcomes/quality
  - Referral patterns and market impact
  - Experiences of providers and patients
  - Unintended consequences
  - Potential for extrapolation of results

Cardiac Rehabilitation Incentive Payment Model

- In addition to the AMI, CABG, and SHFFT models, the CMS Innovation Center finalized a **cardiac rehabilitation (CR) incentive payment model**.
- Participants will be IPPS **hospitals** in **45 MSAs selected from the 98 AMI and CABG model MSAs, and 45 fee-for-service (FFS) MSAs** from the MSAs eligible for the AMI and CABG models that were not selected for those models.
- Incentive payment structure to the CR model participant **retrospectively** for each model beneficiary:
  - **$25 for each of the first 11 CR/ICR services** during the episode/care period
  - **$175 for each additional CR/ICR service** during the episode/care period

Cardiac Rehabilitation: Beneficiary Incentives

- In the proposed rule, we had proposed to allow participating hospitals to provide transportation to CR/ICR services as an in-kind beneficiary engagement incentive for beneficiaries to achieve the CR incentive payment model goal of increasing CR/ICR service utilization.
- CMS has finalized policies for beneficiary engagement incentives similar to the in-kind beneficiary engagement incentives finalized for the AMI and CABG models.
- 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.

Program Rule Waiver: Definition of a Qualified Physician

- Services provided under cardiac rehabilitation (CR)/intensive cardiac rehabilitation (ICR) programs may be furnished to eligible beneficiaries during a proposed AMI or CABG model episode.
- CR and ICR services must be furnished under the supervision of a qualified physician.
- CMS finalized a waiver to the definition of a qualified physician to include a non-physician practitioner (defined for the purposes of this waiver as a physician assistant, nurse practitioner, or clinical nurse specialist) to perform the specific functions of supervisory physician—prescribing exercise; and establishing, reviewing, and signing an individualized treatment plan.

Changes to CJR

- Finalized policies to **align CJR with terminology and policies for the EPMs**, including:
  - Meeting the criteria in the Quality Payment Program rule to offer an Advanced APM track beginning in 2017.
  - Exclusion of a small number of beneficiaries aligned to certain ACOs from CJR.
  - Inclusion of reconciliation and repayment amounts when updating data for quality-adjusted target prices.
  - Modifying standard to determine quality improvement on quality measures.
  - Additional types of CJR collaborators.

Additional Sources of Information

- The EPM final rule can be viewed at https://www.federalregister.gov
- For **more information** about the EPMs, go to https://innovation.cms.gov/initiatives/epm
- Email inquiries to epmrule@cms.hhs.gov