Advancing Care Coordination through Episode Payment Models (EPMs):
Summary of the Proposed Rule
Overview

- Three new mandatory Episode Payment Models (EPMs)
- Cardiac Rehabilitation (CR) Incentive Payment Model
- Refinements to CJR & BPCI Demonstrations
Episode Payment Models
Overview: Three New EPMs

- CMS proposes three new EPMs
  - Acute myocardial infarction (AMI)
  - Coronary artery bypass graft (CABG)
  - Surgical hip/femur fracture treatment excluding lower extremity joint replacement (SHFFT)

- Cardiac (AMI & CABG) EPMs will be mandatory in 98 randomly selected metropolitan statistical areas (MSAs) – MSAs to be announced later

- SHFFT EPM will be an expansion of CJR and added in the same 67 MSAs

- Proposed start – July 1, 2017

- Five-year model – ending December 31, 2021
Metropolitan Statistical Areas (MSAs) Affected by Model

- MSAs may or may not overlap with MSAs currently testing the Comprehensive Care for Joint Replacement (CJR) demonstration
- Complete list of affected markets will be included in the final rule.
Episode Definition

- Episode is initiated upon admission to short-term acute care hospital (anchor hospitalization) and ends 90 days post-discharge.

<table>
<thead>
<tr>
<th>AMI</th>
<th>CABG</th>
<th>SHFFT</th>
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<tbody>
<tr>
<td>• Acute myocardial infarction</td>
<td>• Coronary artery bypass graft admissions for coronary revascularization irrespective of AMI diagnosis (MS-DRGs 231-236)</td>
<td>• Surgical hip/femur fracture treatment procedures excluding lower extremity joint replacement (MS-DRGs 480-482)</td>
</tr>
<tr>
<td>• AMI admissions treated with medical management (MS-DRGs 280-282)</td>
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<td></td>
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<tr>
<td>• AMI admissions treated with PCI (MS-DRGs 246-251 w/ AMI ICD-CM dx code)</td>
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</tbody>
</table>
Episode Payment Calculation & Risk-Bearing

- Retrospective payment model – after episode ends, the episode payment will be calculated based on Medicare claims data and reconciled against the established EPM quality-adjusted target price.

**PY1 – Q1 PY 2**
Jul 17 – Mar 18
- Upside gains
  Capped at 5%
- Downside loss
  No repayment

**Q2-4 PY 2**
Apr 18 – Dec 18
- Upside gains
  Capped at 5%
- Downside loss
  Capped at 5%

**PY 3**
Jan 19 – Dec 19
- Upside gains
  Capped at 10%
- Downside loss
  Capped at 10%

**PY 4-5**
Jan 20 – Dec 21
- Upside gains
  Capped at 20%
- Downside loss
  Capped at 20%

*Downside risk begins*
Target Price: Benchmarking

- Target prices will be established based on a blend of regional- and hospital-specific historical spending, with increasing proportion of regional history over time.
- CMS proposes to use 9 US Census region definitions.
Quality Component

- Composite quality score to assign EPM participants to four quality categories

**AMI**
- **MORT-30-AMI**: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization (NQF #0230)
- **AMI Excess Days**: Excess Days in Acute Care after Hospitalization for AMI
- **HCAPHS Survey (NQF #0166)**
- **Voluntary Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality eMeasure (NQF #2473) data submission**

**CABG**
- **MORT-30-CABG**: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Hospitalization (NQF #2558)
- **HCAPHS Survey (NQF #0166)**

**SHFFT**
- **Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA (NQF #1550)**
- **Successful Voluntary Reporting of Patient-Reported Outcomes and Limited Risk Variables data submission**
- **HCAPHS Survey (NQF #0166)**

*Same as CJR*
## Measure Performance Weights

<table>
<thead>
<tr>
<th>Model</th>
<th>Quality Measure</th>
<th>Weight in Composite Quality Score</th>
<th>Quality Domain/Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CABG Model</strong></td>
<td>MORT-30-AMI (NQF #0230)</td>
<td>50%</td>
<td><strong>Outcome/80%</strong></td>
</tr>
<tr>
<td></td>
<td>AMI Excess Days</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hybrid AMI Mortality (NQF #2473) Voluntary Data</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HCAHPS Survey (NQF #0166)</td>
<td>20%</td>
<td><strong>Patient Experience/20%</strong></td>
</tr>
<tr>
<td><strong>AMI Model</strong></td>
<td>MORT-30-CABG (NQF #2558)</td>
<td>75%</td>
<td><strong>Outcome/75%</strong></td>
</tr>
<tr>
<td></td>
<td>HCAHPS Survey (NQF #0166)</td>
<td>25%</td>
<td><strong>Patient Experience/25%</strong></td>
</tr>
<tr>
<td><strong>SHFFT Model</strong></td>
<td>THA/TKA Complications (NQF #1550)</td>
<td>50%</td>
<td><strong>Outcome/50%</strong></td>
</tr>
<tr>
<td></td>
<td>THA/TKA Voluntary PRO and Limited Risk Variable Submission</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HCAHPS Survey (NQF 0166)</td>
<td>40%</td>
<td><strong>Patient Experience/50%</strong></td>
</tr>
</tbody>
</table>

**Outcome** represents 80%, **Patient Experience** represents 20%.
## EPM Composite Quality Score

<table>
<thead>
<tr>
<th>Quality Composite Score Range</th>
<th>Quality Category</th>
<th>Eligible for Reconciliation Payment</th>
<th>Effective Discount % for Reconciliation Payment</th>
<th>Effective Discount % for Repayment Amount</th>
</tr>
</thead>
</table>
| >13.2                        | Excellent            | Yes                                 | 1.5%                                          | PY1: N/A*  
PY2-3: 0.5%  
PY4-5: 1.5% |
| >6 and <13.2                 | Good                 | Yes                                 | 2%                                            | PY1: N/A  
PY2-3: 1%  
PY4-5: 2% |
| >4 and <6                    | Acceptable           | Yes                                 | 3%                                            | PY1: N/A  
PY2-3: 2%  
PY4-5: 3% |
| <4                           | Below Acceptable     | No                                  | 3%                                            | PY1: N/A  
PY2-3: 2%  
PY4-5: 3% |
Sharing in Risk and Reward

- EPM hospitals may share reconciliation payments and repayment risk with collaborators

- Gainsharing Eligibility
  - Must meet the criteria set by participating hospital
  - Physicians, NPPs, and PGPs must furnish a billable service in an episode

**EPM Collaborators:**
- SNF
- HHA
- IRF
- LTCH
- PGP
- Physician/NPP
- Outpatient therapy providers
- ACOs
- Hospitals
- CAHs
Limits on Gainsharing and Risk Sharing

**Gainsharing Payments**
- Participant hospitals may share reconciliation payments and internal cost savings
- Individual physicians/practitioners gainsharing payments are capped at 50% of their PFS for episode services
- PGPs may receive gainsharing payments up to 50% of their PFS payments for episode services

**Alignment Payments**
- Participant hospitals may share repayment responsibilities
- Hospital must retain responsibility for retaining 50% of the repayment amount
- A single collaborator that is not an ACO may not pay more than 25% of their repayment amount
  - ACO collaborators may pay up to 50% of the repayment amount
Payment Policy Waivers

- **Home Visits**
  - Waives supervision requirement so clinical staff may provide home visits under general supervision
  - AMI – up to 13 home visits in the 90 days
  - CABG – up to 9 home visits in the 90 days
  - SHFFT – up to 9 home visits in the 90 days
  - Waive global period restrictions to allow for home visits

- **Telehealth**
  - Waives the geographic and originating site requirements for telehealth services
  - Telehealth services may be provided in an EPM beneficiary’s home or residence

- **SNF 3-Day Stay**
  - **AMI only**
    - Not applicable for CABG or SHFFT
  - Allows coverage of a SNF stay following discharge from an anchor EPM hospital stay of fewer than 3 days
  - SNF must have at least 3 star rating for 7/12 preceding months

**Dates**
- Home Visits: July 1, 2017
- Telehealth: July 1, 2017
- SNF 3-Day Stay: April 1, 2018
Patterns of Care: Contrast to LEJR Episode in CJR

- LEJR in CJR is predominantly elective, has rare hospital readmissions & commonly substantial post-acute care provider utilization -> none of which are characteristics in AMI or CABG

- AMI, CABG & SHFFT EPMs all encompass chronic conditions that require both planned and unplanned care

- AMI model as important next step for testing EPMs for clinical conditions with variety of different approaches to treatment and management
  - Single clinical condition with substantially different clinical care pathways: medical management and PCI
Opportunities for Savings

Understanding historical spending patterns for the three high-expenditure, common episodes selected with their significant variation in mind

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<td>•~50% of spending on anchor hospitalization&lt;br&gt;• Majority of post-discharge spending is for readmissions&lt;br&gt;• Lesser spending on SNF, Part B professional services &amp; hospital outpatient services</td>
<td>•~75% of spending on anchor hospitalization&lt;br&gt;• Post-discharge spending is evenly distributed among Part B professional services &amp; hospital readmissions&lt;br&gt;• Most patients discharged to SNF</td>
<td>• Substantial readmissions&lt;br&gt;• High use of PAC services</td>
</tr>
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Cardiac Rehabilitation Incentive Payment Model
Overview: CR Incentive Model

- Direct financial incentives for hospitals treating AMI or CABG beneficiaries to encourage care coordination and greater utilization of medically necessary CR/ICR services in the 90 days post-discharge
- 45 MSAs from the AMI and CABG EPM group
- 45 MSAs from outside the AMI/CABG group
- CR/ICR viewed as underutilized way of improving long-term patient outcomes
  - Focus: increased utilization of CR/ICR services along where payment is NOT tied to quality or efficiency
Refinements to the CJR and BPCI Demonstrations
Overview: CJR Updates

- Creation of two separate tracks – Track 1 and Track 2 – where Track 1 would create a pathway to qualification as an Advanced APM under MACRA
  - Track 1 requirement that practitioner use certified EHR technology (CEHRT)
  - Opens possibility for similar pathway and expansion of BPCI
- Technical changes for quality scoring effect on reconciliation payments
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