CMS released a proposal in August 2016 to implement three new bundled payment demonstration programs that place financial accountability on hospitals for 90-day episodes involving the following three diagnoses:

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

Comments on the proposal will be accepted through October 3, 2016. The 5-year demonstrations would take effect in July 2017. Below a summary of the main components of the program as well as a summary of another incentive payment discussed in the rule for cardiac rehabilitation services.

**Background & Goals**

- Goal for the three proposed episode payment models (EPMs) is to improve the quality of care provided to beneficiaries while reducing episode spending
- These episodes were chosen based on the hospital’s significant opportunity to redesign care and improve quality of care furnished
  - Also significant variation in spending among these high-expenditure, common episodes
- The SHFFT episode builds upon the Comprehensive Care for Joint Replacement (CJR) program, completing the transition to episode payment for the surgical treatment and recovery of hip fracture
- CMS expects EPMs to result in Medicare savings of $170 million over 5 performance years

**Beneficiaries Included**

- Beneficiaries must meet certain criteria on admission to be included in the program and may not opt out
  - Enrolled in Medicare, not eligible for Medicare based on end-stage renal disease, not in a managed care plan, have Medicare as primary payer, not aligned in a Next Generation ACO or any BPCI Model or under care of a physician whose practice participates in the BPCI Model 2
- CMS expects this patient population would be substantially different from the population in CJR episodes, due to the clinical nature of the cardiac and SHFFT episodes
- Beneficiaries within these episodes commonly have chronic conditions, need both planned and unplanned care throughout the episode
- About half the average historical spending on AMI was for the initial hospitalization
  - Majority of post-discharge spending was due to hospital readmissions
  - Relatively less spending on skilled nursing facility (SNF) services, Part B services and hospital outpatient services
- For CABG model historical episodes, about three-quarters of spending was for the initial hospitalization
  - Remaining spending relatively evenly divided between Part B professional services and hospital readmissions
Lesser percentage on SNF services

- For historical CABG episodes (CYs 2012-2014) the annual number of potentially eligible beneficiary discharges for the CABG model nationally was approximately 48,000
- For historical SHFFT episodes (CYs 2012-2014) annual potentially eligible beneficiary discharges was approximately 109,000

Defining the Episode

- All three episodes would begin with an inpatient admission to an anchor hospital
  - Full proposed rule lists applicable MS-DRG codes for each episode
- Episodes end 90 days after the date of discharge from the anchor hospital
- Include the inpatient stay and all related care covered under Medicare Parts A and B, including service such as:
  - Home health agency (HHA), Hospice, Physician care, Inpatient hospital, Inpatient psychiatric facility (IPF), Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), Hospital outpatient, Independent outpatient therapy, Clinical laboratory, Durable medical equipment, Part B drugs
- When multiple hospitalizations occur, CMS has proposed a method to attribute the financial responsibility to just one hospital
  - Recognizing patients often wish to return home to their local area for post-acute care
- Will exclude unrelated hospital readmissions for MS-DRGs for oncology, trauma medical admissions, surgery for chronic conditions unrelated to a condition likely to have been affected by care furnished during the EPM episode, and surgery for acute conditions unrelated to a condition resulting from or likely to have been affected by care during the EPM episode
- Exclude from Part B services acute disease diagnoses unrelated to a condition resulting from or likely to have been affected by care during the EPM episode
  - Also certain chronic disease diagnoses, as specified by CMS on a diagnosis-by-diagnosis basis, depending on whether the condition was likely to have been affected by care during the episode or whether substantial services were likely to be provided for the chronic condition during the episode
  - Exclusion lists would be published by CMS and updated by sub-regulatory guidance annually

Financial Risk & Incentives

- Financial risk rests with the acute care hospital where beneficiary has initial hospitalization for one of the procedures/diagnoses
  - Total spending in the episode will be reconciled at the conclusion of the episode against a target price calculated by CMS
  - Providers and hospitals will be paid as usual under Medicare FFS
- Hospitals can earn reconciliation payments by appropriately reducing expenditures and meeting certain quality measures
- First performance year will begin July 1, 2017
Beginning with episodes ending in second quarter of performance year two (2018) hospital will be required to pay back Medicare if spending exceeds target price or may receive a bonus payment for spending less than the episode payment.

Proposing to limit how much a hospital can gain or lose based on its actual episode payments relative to quality-adjusted target prices.

Hospital may choose to contract with other providers for gainsharing:
- Allow other hospitals and ACOs to enter these contracts—CJR does not allow this.
- No restrictions on gain/risk sharing contracts except as already prohibited by law (i.e., anti-kickback laws).

**Quality Measures**

- In addition to episode spending, hospitals’ quality performance also assessed at reconciliation.
- Each hospital would receive a composite quality score and a corresponding quality category:
  - Those that achieve a quality category of "acceptable" or higher would be eligible for a reconciliation payment.
- Will use established measures used in other CMS quality-reporting programs:
  - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).
  - Hospital CAHPS Survey.
  - Successful Voluntary Reporting of Patient-Reported Outcomes.
  - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization.
  - AMI Excess Days: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction.
  - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery.

- Points for quality performance and improvement (as applicable) will be awarded for each episode measure and then summed to develop a composite quality score that will determine the hospital's quality category for the episode.

**Geographic Areas Included**

- To be included in the AMI and CABG models, a hospital must have an address located in selected geographic areas called Metropolitan Statistical Areas (MSAs):
  - The physical location associated with the CMS Certification Number (CCN).

- CMS will randomly select 98 MSAs through random selection from 294 eligible MSAs:
  - The proposed rule listed the 294 eligible MSAs, which included 14 MSAs in PA:
    - 10900 Allentown-Bethlehem-Easton, PA-NJ
    - 11020 Altoona, PA
    - 14100 Bloomsburg-Berwick, PA
    - 16540 Chambersburg-Waynesboro, PA
    - 21500 Erie, PA
    - 25420 Harrisburg-Carlisle, PA
    - 35620 New York-Newark-Jersey City, NY-NJ-PA
37980 Philadelphia-Camden-Wilmington, PA-NJ-DE-MD
38300 Pittsburgh, PA
39740 Reading, PA
42540 Scranton-Wilkes-Barre-Hazleton, PA
48700 Williamsport, PA
49620 York-Hanover, PA
49660 Youngstown-Warren-Boardman, OH-PA

- Some or all of these areas could be selected in the final rule
- Hospitals with fewer than 75 AMI episodes annually were excluded from consideration in the random sample
- The SHFFT model is being tested in the same hospitals participating in the CJR model
  - Allows all surgical treatment options for Medicare beneficiaries with hip fracture (hip arthroplasty and fixation) to be included in episode payment models
  - CMS believes the infrastructure already in place at CJR hospitals will allow for easy implementation of SHFFT episodes

**Interaction with Other Value-Based Programs**

- One track of EPM participants will be required to use Certified Electronic Health Record Technology (CEHRT), which would allow the EPM to qualify as an advanced alternative payment model (APM) under the new MACRA requirements for physicians
  - Under MACRA, physicians must participate in either an APM or a merit-based incentive payment system (MIPS)
  - The CEHRT requirement will allow physicians to satisfy this responsibility by participating in one of the proposed EPMs
- CMS will allow for a separate track of EPMs where participant hospitals will not be required to use CEHRT
  - Will be identical except this track will not help physicians meet their APM requirements under MACRA
- CMS is proposing to make this same change in the CJR model—creating 2 tracks, one of which will use CEHRT and therefore qualify as an APM for physicians
  - Will look to do the same for BPCI models, but not until CY 2018
- The EPMs will exclude from participation any hospitals participating in BPCI Models 2 and 4 for the hip and femur procedures except major joint or for all three of the BPCI cardiac episodes (AMI, PCI, and CABG)
- Propose to exclude beneficiaries included in certain Innovation Center ACO models, the Next Generation ACO Model and Comprehensive ESRD Care
- Other CMS programs such as the Medicare Shared Savings Program and other ACO or total cost of care initiatives will remain eligible for inclusion in the EPMs

**Beneficiary Right to Choose**

- As with the CJR model, beneficiaries will retain the right to obtain health services from any individual or organization qualified to participate in the Medicare program
- Eligible beneficiaries would not have the option to opt out of inclusion in the applicable model
- Hospitals must supply beneficiaries with written information regarding the design and implications of these models as well as the beneficiaries' rights under Medicare
Including their right to use their providers of choice

**Waiver of Certain Medicare Requirements**

- As with the CJR model, CMS is proposing to waive certain federal requirements to allow EPM participants more flexibility in program design and innovation:
  - Telehealth originating site and geographic site requirement, to allow in-home telehealth visits
  - Model-specific limits to the number of post-discharge nursing visits in the home
  - Model-specific decisions about offering the SNF 3-day stay waiver
  - For intensive cardiac rehabilitation services to allow a Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant, in addition to a physician, to perform specific physician functions

**Fourth Proposed Demonstration: Cardiac Rehabilitation (CR) Incentive Payments**

- Along with the EPMs, CMS is proposing a cardiac rehabilitation (CR) incentive payment model to encourage care coordination and greater utilization of medically necessary CR and intensive cardiac rehabilitation (ICR)
- Designed to reward increased referral of AMI and CABG model beneficiaries to CR/ICR programs
- Payments would be available to hospital participants in 45 geographic areas that were not selected for the EPMs discussed above, as well as 45 geographic areas that were selected for the EPMs
  - MSAs will be randomly selected
- Hospitals may use incentive payment to coordinate CR and support beneficiary adherence to the CR treatment plan
- Payment may be used for 90 days post-hospital discharge regardless of whether beneficiary is part of an EPM
- Standard Medicare payments will continue to providers involved in this model with incentive payment made at conclusion of 90 days:
  - Initial payment would be $25 per CR service for each of the first 11 services paid for by Medicare during the care period for a heart attack or bypass surgery.
  - After 11 services are paid for by Medicare for a beneficiary, the payment would increase to $175 per service paid for by Medicare during the care period
- CMS will count the number of CR/ICR services for the relevant time periods under the Outpatient Prospective Payment System (OPPS)
- CR incentive payments may be shared with other individuals and entities only under circumstances which comply with all existing laws and regulations

**CMS Seeks Comment on Post-Acute Care Providers’ Adoption of Health IT**

- In the proposed rule, CMS also discusses the limitations in the availability of health IT that can be used for care management across settings
- They note that this poses a significant barrier to the readiness of non-hospital providers and suppliers to assume financial responsibility for episodes in potential future models
• Recognize that partnerships with post-acute care providers (such as home health and hospice) could be a crucial driver of episode spending and quality, given that many beneficiaries in the CJR model receive post-acute care services after discharge from the hospital.

• Would like to explore ways to reduce these barriers including:
  o Incentives to encourage post-acute care providers to make necessary investments in health IT infrastructure
  o Payment mechanisms that could leverage savings achieved under episode payment models to contribute to these investments
  o Any other strategies to enhance the adoption, implementation, and upgrading of certified health IT

• CMS seeks comments on these ideas as well as the following questions:
  o What are key challenges associated with the inclusion of post-acute care providers as the financially responsible entity or as collaborators with other financially responsible entities in episode payment models today?
  o What would be a sufficient financial incentive or bonus to enhance the adoption, implementation, and upgrading of certified health IT in post-acute care settings?
  o How else can episode payment models encourage the use of certified health IT and information sharing among providers and suppliers caring for episode payment model beneficiaries to improve care coordination and patient outcomes?
  o Within the existing CJR model, are there additional opportunities to encourage investment in adoption, implementation, and upgrading of certified health IT among post-acute care providers to support improvements in care coordination and patient outcomes?
  o What CJR model refinements could enable direct investments to support these improvements, particularly among post-acute care providers who are unaffiliated with CJR model participant hospitals but who provide services to CJR model beneficiaries, including post-acute care providers who may enter into financial arrangements with CJR model participant hospitals as CJR collaborators?