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Inside Medicare's episode payment models

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The Centers for Medicare and Medicaid Services (CMS) released final rules on January 3, 2017 and May 19, 2017.

The three major areas of focus include:

- The creation of three new Medicare Parts A and B episode payment models (EPMs) under section 1115A of the Social Security Act
- The creation of a new cardiac rehabilitation incentive payment model
- Modifications to the existing Comprehensive Care for Joint Replacement (CJR) model

In addition to these major areas of focus, CMS also addresses the potential future of Medicare bundled payment models, indicating its intention to continue a voluntary bundled payment model after the conclusion of Bundled Payments for Care Improvement (BPCI) initiative, designed to help providers meet the criteria to take advantage of an Advanced Alternative Payment Model (APM), and inviting input on potential future condition-specific episode payment models.

This document outlines the major provisions of these final rules and suggests possible implications for affected providers. (All information in this document is drawn from 42 CFR Parts 510 and 512, CMS-5519-F and CMS-5519-F3.[1])

Milliman is not engaged in the practice of law and this report should not be construed as providing legal interpretation. We recommend that you consult a legal expert in fraud and abuse law if you are considering entering gainsharing arrangements of any kind.

Episode payment models for cardiac and orthopedic conditions

The final rules describe three new EPMs that include episodes of care surrounding certain clinical conditions. These episodes are shown in the table in Figure 1 along with the Medicare Severity Diagnosis-Related Groups (MS-DRGs) that will constitute an anchor admission for the episodes.

1 See 42 CFR Parts 510 and 512, CMS-5519-F and CMS-5519-F3: https://www.gpo.gov/fdsys/pkg/FR-2017-01-03/pdf/2016-30746.pdf and https://www.gpo.gov/fdsys/pkg/FR-2017-05-19/pdf/2017-10340.pdf.

FIGURE 1: EPISODES OF CARE

	MS-DRGs	DESCRIPTION	DISCHARGES INCLUDED
ACUTE MYOCARDIAL INFARCTION (AMI) EPISODE *168,000 Medicare discharges nationally per year*	MS-DRGs 280-282	Acute myocardial infarction	All discharges
	MS-DRGs 246-251	Percutaneous coronary intervention (PCI)	Only when accompanied by an AMI diagnosis code in any position on the inpatient claim
CORONARY ARTERY BYPASS GRAFT (CABG) EPISODE *48,000 Medicare discharges nationally per year*	MS-DRGs 231-236	Coronary artery bypass graft	All discharges
SURGICAL HIP/FEMUR FRACTURE TREATMENT EXCLUDING LOWER EXTREMITY JOINT REPLACEMENT (SHFFT) EPISODE *109,000 Medicare discharges nationally per year*	MS-DRGs 480-482	Hip and femur procedures	All discharges

Under the final rule CMS released on January 3, 2017, each EPM would have run from July 1, 2017–December 31, 2021–with the first performance year including episodes that ended by December 31, 2017, and the subsequent four performance years including episodes that ended by December 31 of 2018–2021. However, in the final rule released on May 19, 2017, CMS delayed the start of the EPMs until January 1, 2018, effectively canceling the first performance year. According to the most recent final rule, each EPM will run from January 1, 2018–December 31, 2021 (performance years 2–5).

EPM CONSTRUCTION

Affected providers

The AMI/CABG episodes will be implemented in 98 randomly selected metropolitan statistical areas (MSAs), including Boston-Cambridge-Newton, MA-NH; Chicago-Naperville-Elgin, IL-IN-WI; Dallas-Fort Worth-Arlington, TX; Indianapolis-Carmel-Anderson, IN; and Nashville-Davidson-Murfreesboro-Franklin, TN.[2] The SHFFT episodes will be implemented in the 67 MSAs that were already selected to participate in the ongoing CJR model, which began on April 1, 2016. The three EPMs will be mandatory for all Inpatient Prospective Payment System (IPPS) hospitals that are located in the selected regions, with the exception of hospitals that are already testing these same episodes under the existing BPCI Model 2.

The exemption for hospitals that are already participating in BPCI will be at the episode level, so hospitals that were exempt from CJR (because they are included in the BPCI Model 2 Major Joint Replacement of the Lower Extremity episode) may be included in SHFFT, and those that are exempt from AMI may still be subject to CABG. Furthermore, the AMI/CABG regions were selected without regard to participation in CJR/SHFFT, and there are 17 MSAs that have been selected for all four of these models, including Indianapolis-Carmel-Anderson, IN; Nashville-Davidson-Murfreesboro-Franklin, TN; and Oklahoma City, OK.

Services included

Episodes in all three EPMs will begin with an anchor inpatient hospitalization for one of the selected MS-DRGs. The episodes will last for 90 days after hospital discharge and will include all related services during that time period. In a way that is similar to the BPCI and CJR programs, CMS has defined related services broadly, excluding from the episodes only hemophilia clotting factors, certain unrelated readmissions (defined by their MS-DRGs), and certain Part B services in the post-discharge period (defined by their principal diagnosis codes). These lists of unrelated services will be based on those that have been used for BPCI since its inception, with some modifications to create a unified exclusions list for both AMI and CABG episodes.

To be included in the EPMs, beneficiaries must not be in a BPCI episode and must meet certain other inclusion criteria. The inclusion criteria align with other CMS models. In addition, CMS finalized a new policy for the EPMs that will exclude beneficiaries prospectively aligned to a Next Generation Accountable Care Organization (NGACO), to a Track 3 Shared Savings Program (SSP) ACO or to an ESRD Seamless Care Organization (ESCO) that has accepted downside risk in the Comprehensive ESRD Care (CEC) Model. The exclusion will apply both to the three newly proposed EPMs and to CJR (effective July 1, 2017 for CJR).

Financial methodology and risk

All three EPMs will be retrospective episode payment models, meaning that all claims will be processed and paid as normally and, after the end of the performance period, CMS will retroactively compare actual expenditures with the quality-adjusted target price. Reconciliation will occur for the first time two months after the end of the performance year with payment or recoupment occurring in the second quarter of that year. There will also be a recalculation of the reconciliation the following year to account for any additional claims processed. This calculation, termed the subsequent reconciliation, will occur approximately 14 months after the end of the prior performance year to account for final claims run-out and any canceled EPM episodes.

Hospitals in the EPMs will be able to earn reconciliation payments beginning with episodes in calendar year 2018 (the "second performance year," per the language of the final rule).[3] Risk for repayment to CMS will begin with the third performance year (episodes ending from January 1, 2019–December 31, 2019. Participants who wish to take on downside risk earlier can choose to begin downside risk on January 1, 2018. There will be stop-loss limits applied to set a maximum potential gain or loss under these models. The stop-loss limit will increase over time to allow for larger gains as well as larger losses.

In addition to financial liability for the actual episode expenditures, EPM hospitals will be liable for certain increases in expenditures in the 30 days following the end of the episode. CMS will calculate the average 30-day post-episode spending for each hospital and compare it with the regional average 30-day post-episode spending for the region. If the EPM hospital average spending is more than three standard deviations above the regional average, the EPM hospital will be required to repay CMS.

Target price setting methodology

Target prices for the EPMs will be constructed in a similar fashion to the target prices used for CJR. The prices will take into account the following key components:

- **Historical baseline pricing:** CMS will set target prices for the EPMs using historical expenditures, measured during a three-year historical baseline period. The three-year historical

2 A comprehensive list of included MSAs for AMI, CABG, SHFFT, CJR, and CR Inventive Payment MSAs is at **https://data.cms.gov/dataset/Episode-Payment-Models-Metropolitan-Statistical-Ar/28af-bkkh**.

3 There will be no reconciliation for the first performance year because the start of the EPMs has been delayed until the second performance year.

period used will change in performance years 3 and 5. Update factors will be used to account for changes in the Medicare fee schedules between the three-year historical period and the performance period.

- **Incorporation of regional data:** Historical hospital experience will be weighted together with historical experience at the regional (census division) level. Regional data will account for one-third of prices the second performance year, two-thirds of prices the third performance year, and the entirety of prices in the fourth and fifth performance years. For hospitals that do not have sufficient hospital-specific historical experience, a 100% regional weight will be used throughout the life of the EPMs.
- **Clinical factors for risk adjustment:** CMS will set separate target prices for different types of episodes based on the MS-DRG of the anchor admission. Pricing adjustments will be made to account for certain high-cost AMIs that have CABG readmissions later in the episode. CMS will also price the anchor portion and the post-acute portion of CABG episodes separately to account for variability in post-acute care related to clinical factors (including whether or not the CABG admission had any complications or comorbidities and whether an AMI diagnosis code was included on the anchor claim).
- **High payment ceiling:** Extraordinarily high-cost episodes will be capped at a high payment ceiling, both in calculating historical pricing and in determining performance period expenditures, limiting the financial liabilities for these expensive cases. The high payment ceiling will be set at two standard deviations above the mean calculated episode price at the regional level.
- **Discount based on quality metrics:** A discount will be applied to the target prices in order to provide savings to the Medicare Trust Funds. Effective reconciliation payment discounts will range from 1.5% to 3% based on quality performance. Each of the EPMs will have its own set of quality metrics for purposes of calculating a composite performance score and assigning the discount.
- **Phasing in of downside risk:** By default, hospitals will have no repayment responsibility in the second performance year, but hospitals can choose to take on downside risk. For hospitals electing downside risk in the second performance year and for all hospitals in the third and fourth performance years, the effective discount for repayments to CMS will be 0.5% to 2.0%—one percentage point less than the effective reconciliation payment discount rates listed above.[4] In the fifth performance year, the effective repayment discounts will be the same as the reconciliation payment effective discounts.

4 Participants will only be required to repay CMS if spending increases or is reduced by less than the effective repayment discount rate. If spending is reduced by more than the effective repayment discount rate but by less than the effective reconciliation payment discount rate, the participant neither receives a reconciliation payment from CMS nor makes a repayment to CMS..

WAIVERS AVAILABLE TO EPM HOSPITALS

Gainsharing waivers

Under the EPMs, hospitals will be able to enter into financial arrangements with third parties to share payment reconciliation amounts or internal cost savings. These provider arrangements will be subject to myriad restrictions by CMS, which will be similar to those enforced in the ongoing CJR model with some minor technical differences. The primary new feature introduced in the EPM gainsharing framework is the ability to enter into financial arrangements with ACOs or other hospitals to share losses or gains. This was not formerly allowed under CJR. However, the CJR program will be adjusting to align with this.

Beneficiary engagement incentives

Hospitals will be allowed to provide engagement incentives to EPM beneficiaries in the form of items or services that are reasonably connected to medical care provided during the EPM episode. These incentives will not be tied to use of a particular provider or supplier, and their costs cannot be shifted to another federal program. Technology exceeding $1,000 in retail value for any one beneficiary will be disallowed.

Any technology incentive exceeding $100 in retail value must remain the property of the EPM hospital, which would collect it at the completion of the beneficiary's EPM episode.

Medicare payment policy waivers

CMS will offer several Medicare payment policy waivers to EPM hospitals. These will apply to care of beneficiaries who are in the episodes at the time the waivers are used, even if episodes are later canceled. They will include the following:

- **Telehealth waiver:** CMS will waive the telehealth geographic site and originating site requirements so that beneficiaries may receive telehealth services in their homes.
- **Post-discharge home visit waiver:** CMS will waive the direct supervision requirement for post-discharge home visits so that EPM beneficiaries who are not homebound can receive services in their homes by nurses without a physician present. For CJR episodes, CMS currently allows nine of these visits within the episode. They will allow up to nine visits for CABG and SHFFT episodes and up to 13 visits for AMI episodes.
- **Three-day stay waiver:** Normally, Medicare fee-for-service (FFS) beneficiaries must have a three-day hospital stay to qualify for skilled nursing facility (SNF) services. CMS will allow beneficiaries in the AMI episode to be discharged into a covered SNF stay at a SNF with a 3-star or better rating, even if they are not in the hospital for three full days. This waiver will be applicable for AMI episodes starting on or after October 4, 2018 (ending after January 1, 2019) and will not be available earlier to hospitals who elect downside risk for the second performance year. This waiver will not be available to CABG or SHFFT beneficiaries because of their acuity.

MACRA CONSIDERATIONS

There will be two tracks for each EPM, with Track 1 qualifying as an APM for purposes of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The primary difference between the two tracks is that Track 1 requires use of certified electronic health record technology (CEHRT) to align it with the criteria required in the definition of Advanced APMs in the Quality Payment Program (QPP) final rule.[5] For those EPM hospitals that do not wish to attest to CEHRT use, the hospital will be in Track 2 and will not qualify as an Advanced APM.

In order to operationalize the EPM as an Advanced APM under MACRA, it will be necessary for the EPM hospital to list the clinicians associated with the EPM hospital and, therefore, members of the EPM APM entity that could potentially become qualified participants of an Advanced APM.

Changes to the Comprehensive Care for Joint Replacement model

The final rules include several changes to the CJR model, most of which are to align CJR with the EPMs. These key CJR model changes include the following:

- **Exclusion of beneficiaries in prospectively aligned models:** CMS will cancel (or never initiate) CJR episodes for beneficiaries who are prospectively aligned to a NGACO, to a Track 3 SSP ACO or to an ESCO in the CEC model. This change will take effect July 1, 2017.
- **Quality:** CMS will limit the hospitals included in quality metric scoring comparisons to only subsection (d) hospitals instead of all hospitals nationally. Quality improvement points will be allocated when a hospital has at least a two-decile improvement instead of the current three deciles.
- **Gainsharing:** CMS will align the CJR gainsharing policies with those of the new EPMs, including the ability to enter into arrangements with other hospitals and ACOs as well as other documentation and reporting requirements.
- **Medicare payment policy waivers:** CMS has clarified that if, after the use of the three-day stay waiver, it is found that the CJR beneficiary did not qualify for the waiver, then CMS will not pay the SNF for the stay. In this case, the SNF cannot charge the beneficiary for any non-covered services and the hospital will be responsible for these costs unless it provided a discharge planning notification that fully informed the beneficiary of his or her financial liability.
- **MACRA-related adjustments:** CMS will create a CJR Track 1, which will be an Advanced APM. Track 1 will require CEHRT attestation as well as the provision of a clinician financial arrangement list in order to determine eligible clinicians who are a part of the Advanced APM.

5 81 FR 77008-77831.

Cardiac rehabilitation incentive payment model

CMS finalized a new incentive payment model to encourage providers to use cardiac rehabilitation/intensive cardiac rehabilitation (CR/ICR) services more often. These services are currently covered by Medicare FFS, but they may be underutilized. The performance years of this model will align with the EPMs.

MODEL CONSTRUCTION

Affected providers

The CR/ICR incentive payment model will be implemented in 90 MSAs nationally. Of these MSAs, 45 were selected to participate in the CABG and AMI EPMs described above (this portion of the model is referred to as EPM-CR), including Boston-Cambridge-Newton, MA-NH and Dallas-Fort Worth-Arlington, TX. An additional 45 MSAs were selected from the set of MSAs that were eligible but not selected for EPM (this portion of the model is referred to as FFS-CR), including Phoenix-Mesa-Scottsdale, AZ and San Francisco-Oakland-Hayward, CA. CMS selected these MSAs randomly with stratification on the following variables:

- Percentage of patients starting CR/ICR services
- Percentage of patients completing CR/ICR services (experiencing 25 or more services)
- Number of providers currently providing CR/ICR services

Services included

Services that qualify as CR/ICR will be identified based on their Healthcare Common Procedure Coding System (HCPCS) codes. When these services are billed within any EPM episode or within what would be an EPM episode if a given FFS-CR hospital were participating in EPM, they will be eligible for an incentive payment.

Payment methodology

In addition to regular payment, an additional incentive payment will be made every time a CR/ICR service is billed. This incentive payment will be equal to $25 for each of the first 11 CR/ICR sessions for a given beneficiary and $175 for each session after the 11th session for that beneficiary. There will not be a cap to the number of sessions eligible for this incentive payment beyond the regular coverage restrictions on the use of CR/ICR services. These payments will come from the Medicare Part B Trust Fund and will be distributed to the hospital at the end of each performance year.

Waivers available

A Medicare payment policy waiver will be provided to allow a nonphysician practitioner to be the "supervisory physician" for CR/ICR services. This means a nurse practitioner, physician assistant, or clinical nurse specialist would perform the functions of the supervisory physician, which include prescribing exercise,

and establishing, reviewing, and signing a treatment plan. Medicare coverage requirements for CR/ICR services require a medical director (who would still need to be a physician under the proposed rule) in addition to the supervisory physician.

Unlike EPM payments, CR/ICR incentive payments cannot be shared with other organizations outside of arrangements that are allowed under current law. CR/ICR hospitals will be allowed to provide transportation as a beneficiary engagement incentive.

Implications of the final rules

These rules signal CMS's strong support for episode-based APMs. The mandatory nature of the models will ensure that a significant number of providers at all levels would be touched by EPMs. Furthermore, the adjustments to CJR and the construction of the EPMs to allow them to qualify as Advanced APMs under MACRA (in combination with the ability to take advantage of gainsharing arrangements) provides a strong incentive for physicians to align with the hospitals affected by these models. There is currently a proposed rule to modify the EPMs, CJR, and the CR/ICR incentive payment model under review at the Office of Information and Regulatory Affairs in the Office of Management and Budget. We look forward to learning more about that rule in coming months.

Because these models will be mandatory, we can expect a wide variety of preparedness among model participants. Analyzing past performance on these clinical episodes will be key to understanding and taking advantage of potential savings opportunities and mitigating downside risk. Milliman has the knowledge and experience to assist interested providers in understanding the potential implications of EPMs based on historical claims data and preparing for these coming changes.

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