

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



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Agenda

- Part 1: Context
- Part 2: Proposed Rule
- Part 3: Episode Payment Models
- Part 4 Cardiac Rehabilitation Model
- Part 5: Refinements to Comprehensive Care for Joint Replacement (CJR) Model
- Part 6: Conclusion & Summary

Part 1



Context

Context

- **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

Additional Context

- Informed by prior models and demonstrations, as well as the existing Bundled Payments for Care Improvement (BPCI) initiative and Comprehensive Care for Joint Replacement (CJR) models
- Hundreds of providers have participated or are participating in the BPCI initiative, including thousands of physicians participating in cardiac and orthopedic bundles
- Over 700 hospitals began testing the CJR model in 2016
- The proposed new models would test the impact of bundled payments on a larger scale

Part 2



***Proposed
Rule***

Proposed Rule

- The CMS Innovation Center published a proposed rule on August 2nd, 2016
 - Public comment period closes October 3rd, 2016
- The rule proposes:
 - Three new episode payment models (EPMs)
 - A cardiac rehabilitation (CR) incentive payment model
 - Refinements to the (CJR) model

What are these newly proposed models?

- The new EPMs would **test bundled payments for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) and surgical hip and femur fracture treatment (SHFFT)** across a broad cross-section of hospitals.
- The new CR Incentive Payment model would **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.
- These payment models would be **implemented through rulemaking, and the performance periods would begin on July 1, 2017 and continue through December 31, 2021 (5 performance years).**

Part 3



Episode Payment Models

Episode Payment Models (EPMs)

- Through **bundling payments** and targeting care efficiencies surrounding **AMI, CABG, and SHFFT episodes**, the models would provide the opportunity to achieve high quality care, improve health for beneficiaries, and reduce Medicare spending.
- The models would allow CMS to gain additional valuable experience with episode payments for hospitals, and their collaborating post-acute care and other providers, with variety in utilization patterns and patient populations.

EPMs as Advanced Alternative Payment Models

- The rule contains a track that would allow **EPM participants to be in an Advanced Alternative Payment Model (APM)**. Under an Advanced APM, eligible clinicians (which for the EPMs would be those with financial arrangements under the EPMs) would be considered for a qualifying APM participant (QP) determination and therefore potentially be excluded from a payment adjustment under the MIPS program, based on the criteria proposed in the Quality Payment Program proposed rule.
- EPM participants that meet proposed requirements for use of Certified Electronic Health Record Technology (CEHRT) and financial risk would be in **Track 1 (an Advanced APM track)** and EPM participants that do not meet these requirements would be in **Track 2 (a non-Advanced APM track)**.
- **Most EPM participants could be in a Track 1 Advanced APM beginning in April, 2018.**
 - Sole community hospitals, Medicare Dependent Hospitals, rural hospitals, and Rural Referral Centers would not meet the proposed Advanced APM financial risk criteria until 2019.

EPM Participants

- AMI & CABG EPMs: Hospitals in 98 selected metropolitan statistical areas (MSAs), with limited exceptions. The MSAs would be randomly selected from 294 eligible MSAs and presented in the final rule.
- SHFFT EPM: Hospitals in MSAs selected for the CJR model, with limited exceptions.

EPM Episode Definition: Included Beneficiaries

- Care of Medicare beneficiaries would be included 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)
 - **Not** covered under a **United Mine Workers of America** health plan
 - **Not** aligned to an Accountable Care Organization (ACO) in the **Next Generation ACO model** or an **ACO in a track of the Comprehensive ESRD Care Initiative incorporating downside risk for financial losses**
 - **Not under the care of an attending or operating physician**, as designated on the inpatient hospital claim, who is a member of a **physician group practice that initiates BPCI Model 2 episodes at the EPM participant** for the MS-DRG that would be the anchor MS-DRG under the EPM
 - **Not** already in **any BPCI model episode**

EPM Episode Definition: Episode Initiation

Episodes would be initiated by hospitalizations of eligible Medicare 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

EPM Episode Definition: Services

- **Included services**

- Physicians' services
- Inpatient hospitalization (including readmissions)
- Inpatient Psychiatric Facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Independent outpatient therapy
- Clinical laboratory
- Durable medical equipment (DME)
- Part B drugs
- Hospice

- **Excluded services**

- Acute disease diagnoses unrelated to a condition resulting from or likely to have been affected care during the EPM episode
- Certain chronic disease diagnoses, depending on whether the condition was likely to have been affected by care during the EPM episode or whether substantial services were likely to be provided for the chronic condition during the EPM episode

EPM Episode Definition: Duration

- EPM episodes include:
 - **Hospitalization and 90 days post-discharge**
 - **All Part A and Part B services**, with the exception of certain excluded services that are clinically unrelated to the episode

EPM Relationship to Other CMS Models and Programs

- Comprehensive Care for Joint Replacement (CJR)
 - Due to clinical similarities, the SHFFT model would be implemented in the same regions as the CJR model, allowing providers to leverage strategies in place for CJR.
- Bundled Payments for Care Improvement
 - BPCI episodes would take precedence in cases where a BPCI episode would otherwise occur concurrently with an EPM episode.
- Accountable Care Organizations
 - ACOs would be eligible to become EPM collaborators and participate in the care redesign process and share upside and downside risk with EPM participants. Beneficiaries in Innovation Center prospectively aligned ACO models with two-sided risk such as the Next Generation ACO model would be excluded from the EPMs.

EPM Payment and Pricing: Risk Structure

- **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 would be compared to the episode quality-adjusted target prices (which reflect a discount on the EPM-episode benchmark price based on quality performance and improvement).
 - If aggregate quality-adjusted target prices are greater than actual episode spending and hospital episode quality performance is acceptable or better, a hospital may receive a reconciliation payment.
 - If aggregate quality-adjusted target prices are less than actual episode spending, hospitals would be responsible for making a payment to Medicare if downside risk applies to the performance year.
- Responsibility for repaying Medicare begins for episodes in the 2nd quarter of performance year 2, with **no downside responsibility in performance year 1 and 1st quarter of performance year 2.**

EPM Payment and Pricing: Setting Quality-Adjusted Target Prices

- Quality-adjusted target prices
 - CMS intends to establish **for each EPM participant** prior to start of applicable performance period
 - Based on **3 years of historical data** to set EPM-episode benchmark price
 - **Pricing adjustments** for hospital-to-hospital transfer scenarios and CABG readmissions in the AMI model and based on the presence or absence of AMI in the CABG model
 - Quality-adjusted target prices includes **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
 - Years 1&2: 2/3 hospital-specific, 1/3 regional
 - Year 3: 1/3 hospital-specific, 2/3 regional
 - **Years 4&5: 100% regional pricing**

EPM Payment and Pricing: Quality Measures

AMI Quality Measures:

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

CABG Quality Measures:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558) (MORT-30-CABG)
- HCAHPS Survey (NQF #0166)

SHFFT Quality Measures (same as CJR):

- Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550) (Hip/Knee Complications)
- HCAHPS Survey (NQF #0166)
- Voluntary Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Patient-Reported Outcome (PRO) and Limited Risk Variable data submission (Patient-reported outcomes and limited risk variable data following elective primary THA/TKA)

EPM Payment and Pricing: Linking Quality to Payment

- **Quality performance** and **improvement** points would be assigned to each EPM participant based on their performance and improvement on the **required quality measures** and their **submission of voluntary data**, if applicable to the model.
- These points would be summed for each EPM participant to determine the participant's **composite quality score** for the model.
- That composite quality score then determines whether the participant is eligible for a reconciliation payment (if savings are achieved beyond the quality-adjusted target price) and what effective discount percentage is applied to the EPM-episode benchmark price for reconciliation payment.
 - Participants with **unacceptable quality are not eligible for reconciliation payments** and have an **effective discount percentage of 3 percent**.
 - Those with **acceptable, good, or excellent quality are eligible for reconciliation payment** and have an **effective discount percentage of 3 percent, 2 percent, or 1.5 percent**, respectively.
- EPM participants with a higher level of quality performance would generally experience a lower effective discount percentage at reconciliation, resulting in greater financial opportunity for the EPM participant.

EPM Payment and Pricing: Risk Limits and Adjustments

- We would apply a **cap at 2 standard deviations above the regional mean (high payment episode ceiling)** when calculating actual EPM-episode payments and when calculating historical EPM-episode payments used to set EPM-episode benchmark and quality-adjusted target prices. Actual payments to providers and suppliers under Medicare FFS for episode services would not be capped.
- Reconciliation payments would be capped at **5%** of quality adjusted target prices for performance years 1 and 2, **10%** for performance year 3, and **20%** for performance years 4 and 5 (**stop-gain**).
- Hospital responsibility to repay Medicare would be phased-in and capped (**stop-loss**):
 - Performance Year 1 and 1st Quarter of Performance Year 2: **No responsibility** to repay Medicare.
 - 2nd – 4th Quarters of Performance Year 2: Medicare repayments would be **capped at 5%** of quality adjusted target prices.
 - Performance Year 3: Medicare repayments would be **capped at 10%** of quality-adjusted target prices.
 - Performance Years 4 & 5: Medicare repayments would be **capped at 20%** of quality-adjusted target prices
- **Additional protection** for rural hospitals, sole community hospitals (SCH), Medicare dependent hospitals (MDH), and rural referral centers (RRC) with stop-loss of 3% for the 2nd-4th quarters of performance year 2 and 5% for performance years 3-5.

EPM Overlap with ACOs and Other Models

- Hospitals in MSAs selected to participate in EPMs **may also participate in an ACO or other model.**
- The financial reconciliations under EPMs and other CMS models and programs would, to the extent feasible, account for all Medicare Trust Fund payments for beneficiaries in those models and programs and generally ensure that Medicare saves the 1.5-3 percent discount amount on EPM episodes.

EPM Financial Arrangements: Sharing Gains and Losses

- 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.**
- **Collaborators** may include the following entities and provider and supplier types:
 - Physicians and nonphysician practitioners
 - Home health agencies
 - Skilled nursing facilities
 - Long term care hospitals
 - Physician group practices
 - Inpatient rehabilitation facilities
 - Providers of outpatient therapy services
 - Hospitals
 - Critical access hospitals
 - Accountable care organizations (ACO) that participate in the Medicare Shared Savings Program

EPM Financial Arrangements: Gainsharing Payments

- EPM participants may **share gains** with collaborators:
 - Reconciliation payments in the form of a performance-based payment.
 - Internal cost savings realized through care redesign activities associated with services furnished to beneficiaries during an EPM episode.
- Collaborators **would be required** to engage with the hospital in its care redesign strategies and, for collaborators other than ACOs and physician group practices (PGPs), to furnish services to EPM beneficiaries during EPM episodes in order to be eligible for such payments.
- Payments must be substantially based on **quality of care** and the **provision of EPM activities**.

EPM Financial Arrangements: Distribution and Downstream Distribution Payments

- Collaborators may **share gainsharing payments** as distribution payments to collaboration agents (physician group practice members, ACO participants, or ACO providers/suppliers).
- Collaboration agents that are physician group practices that are also ACO participants may **share distribution payments** as downstream distribution payments to downstream collaboration agents who are physician group practice members.
- Payments must be substantially based on **quality of care** and the **provision of EPM activities**

EPM Financial Arrangements: Alignment Payments

- EPM participants **may share various percentages of downside risk** with collaborators.
 - Where that is the case, CMS would continue to **assess repayments solely from the EPM participant.**
 - The **EPM participant would be responsible for recouping from its collaborators alignment payments** according to the agreements between those entities.
- CMS proposes to **limit the EPM participant's sharing of downside risk to 50% of the total repayment amount** to CMS.
 - The EPM participant would be required to retain 50% of the downside risk.
 - The EPM participant could not share more than 25% of its repayment responsibility with any one collaborator, except for an ACO where this limit would be 50%.

EPM Beneficiary Incentives

- Consistent with applicable law, **EPM participants may offer certain items or services to beneficiaries** during an EPM episode.
- The items or services must be, among other things:
 - 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
 - Reasonably connected to medical care provided to an EPM beneficiary during an EPM episode
 - A preventive care item or service or an item or service that advances a clinical goal for a beneficiary in an EPM episode by engaging the beneficiary in better managing his or her own health
 - Not tied to the receipt of items or services outside the EPM episode.
 - Not tied to the receipt of items or services from a particular provider or supplier.
 - Not 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.

EPM Financial Arrangements: 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 the law.
 - Waivers, if any, would be promulgated separately by OIG and CMS.

AMI Model Program Rule Waivers: Skilled Nursing Facility

- The **AMI model** would **waive the SNF 3-day rule** for coverage of a SNF stay following the anchor hospitalization beginning in performance year 2.
- Beneficiaries discharged pursuant to the waiver **must be admitted to SNFs rated 3-stars or higher** on the CMS Nursing Home Compare website.
- Beneficiaries **must NOT be discharged prematurely** to SNFs, and they must be able to exercise their freedom of choice without patient steering.

EPM Program Rule Waivers: Home Visits

- **The EPMs would waive the “incident to” rule for physician services.**
- **Allows the licensed clinical staff of a physician to furnish a home visit in the beneficiary’s home.**
- **Permitted only for beneficiaries who do not qualify for Medicare coverage of home health services.**
- **Waiver allows a maximum of 13 visits during an AMI model episode and 9 visits during a CABG or SHFFT model episode, billed under the Physician Fee Schedule using a HCPCS code created specifically for the models.**

EPM Program Rule Waivers: Telehealth

- **Waives the geographic site requirement** and the originating site requirement for telehealth services to permit telehealth visits to originate in **the beneficiary's home or place of residence.**
- Telehealth visits under the waiver **cannot be a substitute for in-person home health services** paid under the home health prospective payment system.
- Requires all **telehealth services to be furnished in accordance with all other Medicare coverage and payment criteria.**
- The facility fee paid by Medicare to an originating site for a telehealth service is waived if the service was originated in the beneficiary's home.

AMI and CABG Model Program Rule Waivers: Definition of Qualified Physician for Three Functions Related to Cardiac Rehabilitation

- 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 is proposing to provide a waiver to the definition of a qualified physician to include a nonphysician 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.
- This waiver is available for a provider or supplier of CR and ICR services furnished to an eligible beneficiary during a proposed AMI or CABG model episode.

EPM Data Sharing: Specifications

- CMS would share data EPM participants for hospitals to:
 - Evaluate their practice patterns
 - Redesign care delivery pathways
 - Improve care coordination
- In response to an EPM participant's request and in accordance with our regulations and applicable privacy laws, **CMS would share beneficiary Part A and B claims for the duration of the episode** in:
 1. Summary format,
 2. Raw claims line feeds, or
 3. Both summary and raw claims
- **Data would be available** for the hospital's **baseline period** and on a **quarterly basis** during a hospital's performance period.

EPM Beneficiary Protections: Access to Care

- Beneficiaries' **access to care would not be impacted** by the EPMs.
 - These payment models propose to change the payment methodology for hospitals in select geographic areas.
 - Beneficiary **copayments would 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>.

EPM Beneficiary Protections: Beneficiary Notification

- Beneficiary notification about the EPMs would **ensure transparency**.
 - **Providers and suppliers involved in risk sharing through financial arrangements** with an EPM participant would be required to **notify beneficiaries of the payment model**.
 - If there are no risk sharing arrangements, **EPM participants** must notify beneficiaries of payment implications.
- Beneficiary notification requirements would focus the attention of all parties on the requirement to provide all medically necessary services.

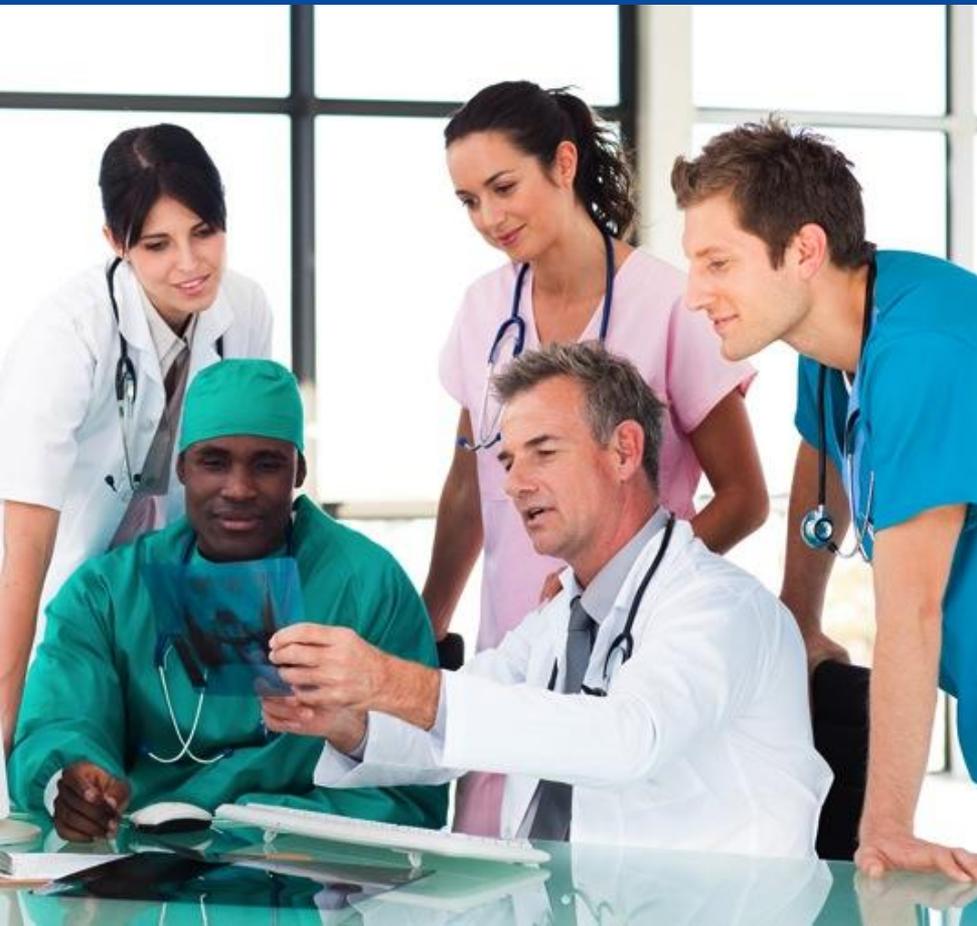
EPM Beneficiary Protections: Monitoring

- **CMS monitoring would assess compliance** with the EPM requirements for beneficiary protections.
- EPM participants are familiar with both bundled payment and risk-sharing and are unlikely to compromise patient care.
- Nonetheless, **CMS would 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. In extremely serious circumstances, expulsion from the model and/or other sanctions including suspension of payments or revocation from the EPM if indicated.

Part 4



Cardiac Rehabilitation Incentive Payment Model

Cardiac Rehabilitation Incentive Payment Model

- In addition to the AMI, CABG, and SHFFT models, the CMS Innovation Center is proposing a **cardiac rehabilitation (CR) incentive payment model**.
- Cardiac rehabilitation is **capable of achieving significant improvements in patient outcomes**, but is currently underutilized.
- Beneficiaries who begin CR services are likely to follow through with a substantial number of follow-up sessions, which are predictive of improved clinical outcomes.
- Under existing Medicare coverage, the number of CR program sessions are 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 (ICR) program sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

Cardiac Rehabilitation

Incentive Payment Model Participants

- Participants would be IPPS **hospitals** in **45 MSAs selected from the 98 AMI & CABG model MSAs, and 45 fee-for-service (FFS) MSAs** from the MSAs eligible for the AMI & CABG models that were not selected for those models.
 - MSAs would be categorized based on their historical CR utilization pattern.
 - EPM-CR and FFS-CR MSAs would be selected from each historic utilization group.
 - The number to be selected from each group would be in proportion to the number of EPM MSAs in the group.
- Model performance years would be the same as those of the EPMs.

Cardiac Rehabilitation Incentive Payment Model Payment Methodology

- **Retrospective CR incentive payments** to participant hospitals would be made based on CR utilization for CR model beneficiaries in each performance year in order to increase referrals to CR and CR utilization by increasing CR care coordination and reducing barriers such as lack of transportation.
- CR model beneficiaries would be those who are in AMI or CABG model episodes for EPM-CR participants and those who would have been in AMI or CABG models episodes if the FFS-CR participants were EPM participants.
- The CR incentive payment would be made for medically necessary CR/ICR services provided during the 90 days post-hospital discharge from AMI or CABG hospitalization, where the model beneficiary's overall care is paid under either an EPM or the Medicare FFS program.
- Incentive payment structure to the CR model participant for each model beneficiary:
 - **\$25 for first 11 CR/ICR services** during the episode/care period
 - **\$175 for each additional CR/ICR service** during the episode/care period

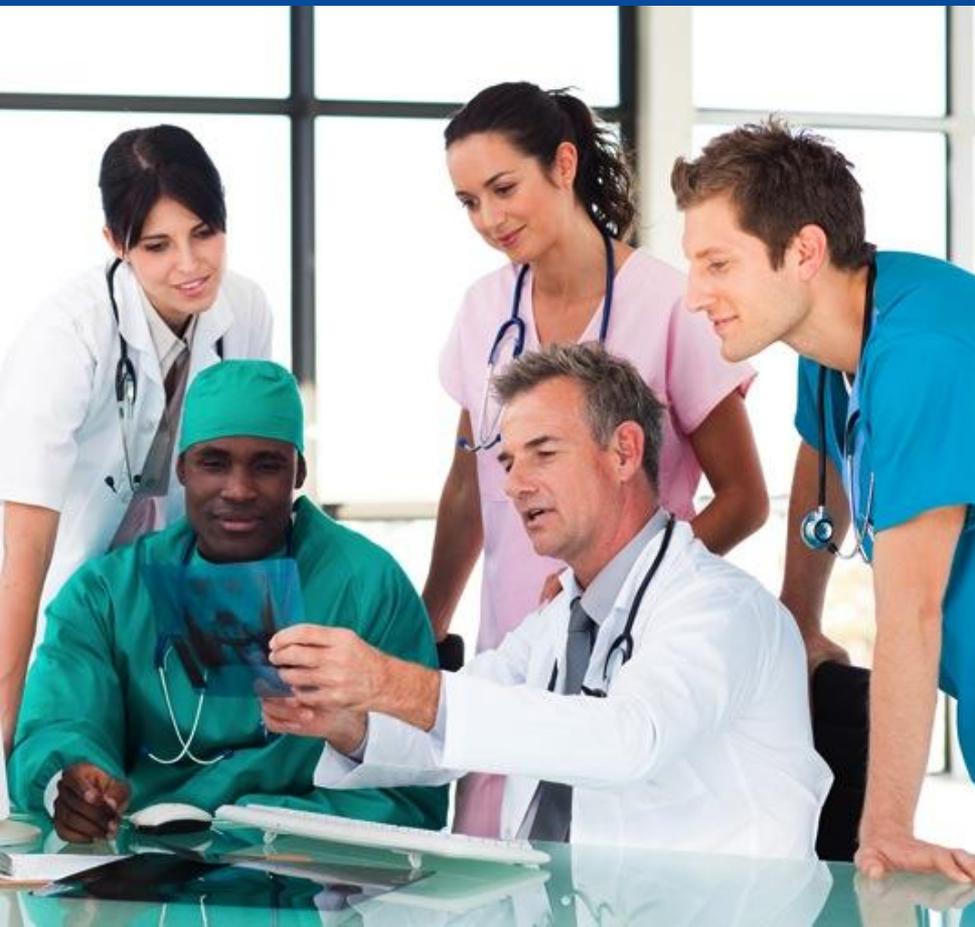
Cardiac Rehabilitation Incentive Payment Report

- Annually following the end of the CR performance year and in the same timeframe when EPM participants are issued a reconciliation report, each CR model participant would receive a **cardiac rehabilitation incentive payment report** that includes:
 - The number of AMI and CABG model episodes or AMI and CABG care periods attributed to the CR participant in which Medicare paid for 11 or fewer CR/ICR services for a beneficiary during the CR performance year, if any.
 - The number of AMI and CABG model episodes or AMI and CABG care periods attributed to the CR participant in which Medicare paid for 12 or more CR/ICR services for a beneficiary during the CR performance year, if any.
 - The total number of CR/ICR services Medicare paid for during AMI and CABG model episodes or AMI and CABG care periods.
 - The amount of the CR incentive payment attributable to the AMI and CABG model episodes or AMI and CABG care periods.
 - The total amount of the CR incentive payment.

Cardiac Rehabilitation Incentive Payment Model Key Proposals for FFS-CR Participants

- We would **share data** with participants in the CR incentive payment model under the same terms, conditions, and authority as is proposed for the EPMs.
 - We would make a more limited set of data available under the CR incentive payment model for FFS-CR participants than is proposed for the EPMs. These data would include CR/ICR services that occurred during the AMI or CABG care period.
- We would allow FFS-CR participants to provide **transportation to CR/ICR services as a beneficiary engagement incentive** for CR model beneficiaries during AMI and CABG care periods to allow these participants similar use of beneficiary engagement incentives to achieve the CR incentive payment model goals as would be available to EPM-CR participants for that purpose.
- We would provide a **waiver** to allow, in addition to a physician, **a nonphysician practitioner to perform the functions of supervisory physician; prescribing exercise; and establishing, reviewing, and signing an individualized treatment plan for providers or suppliers of CR/ICR services** furnished to a CR model beneficiary during an AMI or CABG care period. This proposed waiver for FFS-CR beneficiaries is similar to the proposed physician definition waiver for EPM beneficiaries during the proposed AMI and CABG model episodes.

Part 5



Refinements to Comprehensive Care for Joint Replacement (CJR) Model

Refinements to CJR

- **Proposals to align CJR with proposed terminology and policies for the EPMs, including:**
 - Meet the proposed criteria in the Quality Payment Program proposed rule to be an Advanced APM 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.

Part 6



Conclusion

Evaluation of the EPMs, CR Incentive Payment Model and CJR: Focus Areas

- Evaluation would assess the impact of the EPMs, CR incentive payment model, and CJR on the aims of **improved care quality and efficiency as well as reduced health care costs.**
- Focus areas include:
 - Payment impact
 - Utilization impact
 - Outcomes/quality
 - Referral patterns and market impact
 - Unintended consequences
 - Potential for extrapolation of results

Summary

Proposed Rule includes:

- New episode payment models for AMI, CABG, and SHFFT care
- New cardiac rehabilitation incentive payment model
- Modifications to existing CJR model

When and Where Do I Submit Comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during this call as formal comments on the rule.
 - Reference the proposed rule for information on submitting these comments by the close of the 60-day comment period on October 3rd 2016. When commenting, refer to file code CMS-5519-P.
- Instructions for submitting comments can be found in the proposed rule;
 - *Note-FAX transmissions will not be accepted.
- You must officially submit your comments via:
 - Regulations.gov (electronically)
 - Regular mail
 - Express or overnight mail
 - Hand/courier
- For additional information on the EPMs, please visit innovation.cms.gov/initiatives/epm
- For additional information on the CR incentive payment model, please visit innovation.cms.gov/initiatives/cardiac-rehabilitation.