Issue Brief

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CMS Finalizes New Medicare Episode Payment Models "to Reward Better Care at Lower Cost"

The Centers for Medicare & Medicaid Services has issued a final rule that will add new payment models that are intended "to continue the Administration's progress to shift Medicare payments from rewarding quantity to rewarding quality by creating strong incentives for hospitals to deliver better care to patients at a lower cost."

A copy of the 1,606-page rule is at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-30746.pdf. The rule is scheduled for publication in the *Federal Register* on January 3, 2017.

CMS says that the "purpose of this final rule, which is titled "Advancing Care Coordination through Episode Payment Models" is to implement the creation and testing of three new episode payment models and a Cardiac Rehabilitation incentive payment model under the authority of the Center for Medicare and Medicaid Innovation (the Innovation Center), as well as to implement several modifications to the Comprehensive Care for Joint Replacement model." CMS says that the rule will:

1. **Improve cardiac care:**
   "Three new payment models will support clinicians in providing care to patients who receive treatment for heart attacks, heart surgery to bypass blocked coronary arteries, or cardiac rehabilitation following a heart attack or heart surgery."

2. **Improve orthopedic care:**
   "One new payment model will support clinicians in providing care to patients who receive surgery after a hip fracture, other than hip replacement. In addition, CMS is finalizing updates to the Comprehensive Care for Joint Replacement Model, which began in April 2016."

3. **Provides an Accountable Care Organization opportunity for small practices:**
   "The new Medicare ACO Track 1+ Model will have more limited downside risk than in Tracks 2 or 3 of the Medicare Shared Savings Program in order to encourage more practices, especially small practices, to advance to performance-based risk."

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COMMENT

While the rule is intended to continue Medicare's movement toward bundled payments, questions regarding such movement are already being raised as the new Trump administration takes form. Some in Washington believe that the new administration is more interested in redirecting Medicare and

Medicaid to have less rather than more government influence. No doubt, a completely different set of priorities will arise and many rules, including this one, may be changed or rescinded.

In part, the new Administration and the Republican Congressional majority have stated that repeal of the Affordable Care Act will take center stage.

This is another long, detailed and complex rule. However, it is well written and organized. Each section presents a good summation of the proposed issues, CMS' responses to comments, and "final decision" sections.

CMS expects the EPMs to result in savings to Medicare of $159 million during the five performance years of the models. It is interesting in that CMS says that only 175 comments were received.

EPISODE PAYMENT MODELS

The EPM models will be referred to as:

- The Acute Myocardial Infarction model – Using AMI MS–DRGs (280-282) and those Percutaneous Coronary Intervention MS-DRGs (246-251) representing IPPS admissions for AMIs that are treated with PCIs:
- The Coronary Artery Bypass Graft model – Using CABG MS-DRGs (231-236)
- The Surgical Hip and Femur Fracture Treatment model – Using SHFFT MS-DRGs (480-482)
- The Cardiac Rehabilitation Incentive Payment model

Acute care hospitals in certain selected geographic areas will be required to participate in retrospective episode-based payments for items and services that are related to AMI, CABG, and SHFFT treatment and recovery, beginning with a hospitalization and extending for 90 days following the hospital discharge. Again, hospitals in the selected areas will be required to participate.

The first performance period (the effective date) will begin July 1, 2017. The duration of the models is until December 31, 2021.

The final rule also makes adjustments to the Comprehensive Care for Joint Replacement model, allowing the model to qualify as an Advanced APM under the Quality Payment Program as well as aligning the model's policies with the episode payment models around financial arrangements and beneficiary engagement incentives, compliance enforcement, appeals processes, and beneficiary notifications.

MODEL DESIGN

Under the episode payment models (CABG, AMI, SHFFT and CJR), the hospital will be financially accountable for the quality and cost of an episode of care.

For each performance year, CMS will establish Medicare episode quality-adjusted target prices for each participant hospital that includes payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who are treated and discharged for included Medicare Severity-Diagnosis Related Groups. Almost all Part A and Part B services provided in the 90-days post-discharge are included in the episode price. Quality-adjusted target prices for each year will initially be set based on a blend of provider-specific

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pricing and pricing in the relevant nine CMS census regions while increasing the proportion of regional pricing over time.

All providers and suppliers will continue to be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the year. Following the end of a model performance year, actual spending for all episodes (total expenditures for related services under Medicare Parts A and B) will be aggregated and compared to the aggregate quality-adjusted target price for the participant hospital. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending exceeding the aggregate target price.

For the AMI, CABG and SHFFT Models, participants will earn a composite quality score which is based on quality of care previously provided. Participants' CQS will be largely based on an organization's quality performance in comparison to that of other hospitals and, as CMS notes, "will allow hospitals with relatively high quality performance an increased opportunity for financial incentives within the models."

CMS is finalizing its policy for no repayment responsibility (downside risk) for all of the new episode payment models in performance years one and two, with optional downside risk in performance year two and a reduced discount percentage for repayment responsibility in performance years three and four, in order to phase in financial responsibility for spending during the model episodes throughout the model performance years. (Note that this timeline for downside risk applies to the AMI, CABG and SHFFT models only; the timeline for downside risk in the CJR Model has not changed.)

Hospitals will be eligible to earn up to 5 percent of their target price in performance years one, two and three: 10 percent in performance year four; and 20 percent in performance year five for the AMI, CABG and SHFFT models. Hospitals with model episode spending that exceeds the target price will be financially responsible for the difference to Medicare up to a specified repayment limit. CMS is also finalizing parallel stop-loss and stop-gain limits, which CMS says is intended to both protect hospitals from excess financial risk offset while limiting gains proportional to the potential downside risk.

Under the CR Incentive Payment Model, all providers and suppliers will continue to be paid under the usual Medicare payment system rules and procedures. Following the end of a model performance year, depending on beneficiaries' utilization of CR/Intensive CR services, participant hospitals may receive an additional incentive payment from Medicare.

PARTICIPANTS

CMS is finalizing its proposal, without modification, to implement the SHFFT EPM in those MSAs where the CJR model is being implemented. Further, CMS is finalizing its proposal to implement the cardiac EPMs in randomly selected MSAs from among all those in the country.

CMS is finalizing its proposal, without modification, to implement the CABG and the AMI EPMs in the same areas.

The SHFFT Model will be implemented in the 67 MSAs where the CJR Model is currently underway The AMI and CABG

continued

Models will be implemented in 98 MSA geographic areas. The cardiac rehabilitation incentive program is to be implemented in 90 MSA geographic areas. Hospitals in Maryland and Vermont are excluded.

MSA	MSA Title	Comprehensive Care for Joint Replacement Model	Surgical Hip and Femur Fracture Treatment	Acute Myocardial Infarction	Coronary Artery Bypass Graft	Cardiac Rehabilitation Incentive Payment Model
10180	Abilene, TX	N	N	Y	Y	Y
10420	Akron, OH	Y	Y	Y	Y	N
10740	Albuquerque, NM	Y	Y	N	N	N
10780	Alexandria, LA	N	N	Y	Y	Y
10900	Allentown-Bethlehem-Easton, PA-NJ	N	N	Y	Y	Y
11260	Anchorage, AK	N	N	Y	Y	N
11540	Appleton, WI	N	N	N	N	Y
11700	Asheville, NC	Y	Y	N	N	N
12020	Athens-Clarke County, GA	Y	Y	N	N	N
12100	Atlantic City-Hammonton, NJ	N	N	Y	Y	N
12220	Auburn-Opelika, AL	N	N	Y	Y	Y
12420	Austin-Round Rock, TX	Y	Y	Y	Y	N
12700	Barnstable Town, MA	N	N	N	N	Y
13020	Bay City, MI	N	N	N	N	Y
13140	Beaumont-Port Arthur, TX	Y	Y	N	N	N
13380	Bellingham, WA	N	N	Y	Y	Y
13460	Bend-Redmond, OR	N	N	Y	Y	N
13900	Bismarck, ND	Y	Y	N	N	N
14010	Bloomington, IL	N	N	N	N	Y
14020	Bloomington, IN	N	N	Y	Y	Y
14260	Boise City, ID	N	N	Y	Y	N
14460	Boston-Cambridge-Newton, MA-NH	N	N	Y	Y	Y
14500	Boulder, CO	Y	Y	N	N	N
15260	Brunswick, GA	N	N	N	N	Y
15380	Buffalo-Cheektowaga-Niagara Falls, NY	Y	Y	N	N	N
15940	Canton-Massillon, OH	N	N	Y	Y	Y
15980	Cape Coral-Fort Myers, FL	N	N	Y	Y	Y
16020	Cape Girardeau, MO-IL	Y	Y	Y	Y	N
16180	Carson City, NV	Y	Y	N	N	Y
16300	Cedar Rapids, IA	N	N	Y	Y	N
16580	Champaign-Urbana, IL	N	N	N	N	Y
16700	Charleston-North Charleston, SC	N	N	Y	Y	Y

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MSA	MSA Title	Comprehensive Care for Joint Replacement Model	Surgical Hip and Femur Fracture Treatment	Acute Myocardial Infarction	Coronary Artery Bypass Graft	Cardiac Rehabilitation Incentive Payment Model
16740	Charlotte-Concord-Gastonia, NC-SC	Y	Y	N	N	N
16860	Chattanooga, TN-GA	N	N	Y	Y	Y
16940	Cheyenne, WY	N	N	N	N	Y
16980	Chicago-Naperville-Elgin, IL-IN-WI	N	N	Y	Y	N
17020	Chico, CA	N	N	Y	Y	N
17140	Cincinnati, OH-KY-IN	Y	Y	N	N	N
17460	Cleveland-Elyria, OH	N	N	N	N	Y
17660	Coeur d'Alene, ID	N	N	Y	Y	N
17860	Columbia, MO	Y	Y	Y	Y	N
17900	Columbia, SC	N	N	Y	Y	N
17980	Columbus, GA-AL	N	N	Y	Y	Y
18020	Columbus, IN	N	N	N	N	Y
18580	Corpus Christi, TX	Y	Y	N	N	Y
18880	Crestview-Fort Walton Beach-Destin, FL	N	N	Y	Y	N
19100	Dallas-Fort Worth-Arlington, TX	N	N	Y	Y	Y
19300	Daphne-Fairhope-Foley, AL	N	N	Y	Y	Y
19340	Davenport-Moline-Rock Island, IA-IL	N	N	N	N	Y
19500	Decatur, IL	Y	Y	N	N	N
19740	Denver-Aurora-Lakewood, CO	Y	Y	Y	Y	N
19780	Des Moines-West Des Moines, IA	N	N	Y	Y	N
20020	Dothan, AL	Y	Y	N	N	N
20100	Dover, DE	N	N	Y	Y	N
20260	Duluth, MN-WI	N	N	N	N	Y
20500	Durham-Chapel Hill, NC	Y	Y	Y	Y	Y
21060	Elizabethtown-Fort Knox, KY	N	N	Y	Y	Y
21500	Erie, PA	N	N	Y	Y	N
21660	Eugene, OR	N	N	Y	Y	Y
21780	Evansville, IN-KY	N	N	N	N	Y
22220	Fayetteville-Springdale-Rogers, AR-MO	N	N	N	N	Y
22420	Flint, MI	Y	Y	N	N	N
22500	Florence, SC	Y	Y	N	N	Y
22520	Florence-Muscle Shoals, AL	N	N	Y	Y	Y

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MSA	MSA Title	Comprehensive Care for Joint Replacement Model	Surgical Hip and Femur Fracture Treatment	Acute Myocardial Infarction	Coronary Artery Bypass Graft	Cardiac Rehabilitation Incentive Payment Model
22660	Fort Collins, CO	N	N	Y	Y	N
23060	Fort Wayne, IN	N	N	Y	Y	N
23540	Gainesville, FL	Y	Y	N	N	N
23580	Gainesville, GA	Y	Y	Y	Y	N
24300	Grand Junction, CO	N	N	Y	Y	Y
24660	Greensboro-High Point, NC	N	N	N	N	Y
24780	Greenville, NC	Y	Y	N	N	N
24860	Greenville-Anderson-Mauldin, SC	N	N	Y	Y	N
25060	Gulfport-Biloxi-Pascagoula, MS	N	N	N	N	Y
25420	Harrisburg-Carlisle, PA	Y	Y	N	N	Y
25620	Hattiesburg, MS	N	N	N	N	Y
25940	Hilton Head Island-Bluffton-Beaufort, SC	N	N	Y	Y	Y
26300	Hot Springs, AR	Y	Y	N	N	N
26580	Huntington-Ashland, WV-KY-OH	N	N	Y	Y	Y
26820	Idaho Falls, ID	N	N	Y	Y	Y
26900	Indianapolis-Carmel-Anderson, IN	Y	Y	Y	Y	N
26980	Iowa City, IA	N	N	Y	Y	N
27620	Jefferson City, MO	N	N	Y	Y	N
27860	Jonesboro, AR	N	N	Y	Y	Y
27900	Joplin, MO	N	N	Y	Y	Y
28020	Kalamazoo-Portage, MI	N	N	Y	Y	N
28140	Kansas City, MO-KS	Y	Y	Y	Y	N
28420	Kennewick-Richland, WA	N	N	Y	Y	N
28660	Killeen-Temple, TX	Y	Y	N	N	N
28940	Knoxville, TN	N	N	N	N	Y
29100	La Crosse-Onalaska, WI-MN	N	N	Y	Y	N
29420	Lake Havasu City-Kingman, AZ	N	N	Y	Y	N
29460	Lakeland-Winter Haven, FL	N	N	Y	Y	N
29620	Lansing-East Lansing, MI	N	N	Y	Y	N
30460	Lexington-Fayette, KY	N	N	Y	Y	N
30620	Lima, OH	N	N	Y	Y	Y
30700	Lincoln, NE	Y	Y	N	N	Y
30780	Little Rock-North Little Rock-Conway, AR	N	N	Y	Y	Y

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MSA	MSA Title	Comprehensive Care for Joint Replacement Model	Surgical Hip and Femur Fracture Treatment	Acute Myocardial Infarction	Coronary Artery Bypass Graft	Cardiac Rehabilitation Incentive Payment Model
31080	Los Angeles-Long Beach-Anaheim, CA	Y	Y	N	N	N
31180	Lubbock, TX	Y	Y	N	N	N
31540	Madison, WI	Y	Y	Y	Y	Y
31700	Manchester-Nashua, NH	N	N	Y	Y	N
32780	Medford, OR	N	N	Y	Y	N
32820	Memphis, TN-MS-AR	Y	Y	Y	Y	N
33100	Miami-Fort Lauderdale-West Palm Beach, FL	Y	Y	N	N	N
33340	Milwaukee-Waukesha-West Allis, WI	Y	Y	Y	Y	Y
33540	Missoula, MT	N	N	Y	Y	Y
33700	Modesto, CA	Y	Y	N	N	N
33740	Monroe, LA	Y	Y	N	N	Y
33860	Montgomery, AL	Y	Y	N	N	N
34060	Morgantown, WV	N	N	N	N	Y
34620	Muncie, IN	N	N	N	N	Y
34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	N	N	Y	Y	N
34940	Naples-Immokalee-Marco Island, FL	Y	Y	N	N	Y
34980	Nashville-Davidson--Murfreesboro--Franklin, TN	Y	Y	Y	Y	N
35100	New Bern, NC	N	N	Y	Y	Y
35300	New Haven-Milford, CT	Y	Y	N	N	N
35380	New Orleans-Metairie, LA	Y	Y	N	N	N
35620	New York-Newark-Jersey City, NY-NJ-PA	Y	Y	N	N	N
35660	Niles-Benton Harbor, MI	N	N	Y	Y	Y
35980	Norwich-New London, CT	Y	Y	N	N	N
36260	Ogden-Clearfield, UT	Y	Y	N	N	N
36420	Oklahoma City, OK	Y	Y	Y	Y	N
36540	Omaha-Council Bluffs, NE-IA	N	N	Y	Y	Y
36740	Orlando-Kissimmee-Sanford, FL	Y	Y	N	N	N
37340	Palm Bay-Melbourne-Titusville, FL	N	N	N	N	Y
37860	Pensacola-Ferry Pass-Brent, FL	Y	Y	N	N	Y
38060	Phoenix-Mesa-Scottsdale, AZ	N	N	N	N	Y

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MSA	MSA Title	Comprehensive Care for Joint Replacement Model	Surgical Hip and Femur Fracture Treatment	Acute Myocardial Infarction	Coronary Artery Bypass Graft	Cardiac Rehabilitation Incentive Payment Model
38300	Pittsburgh, PA	Y	Y	N	N	N
38900	Portland-Vancouver-Hillsboro, OR-WA	Y	Y	N	N	N
38940	Port St. Lucie, FL	Y	Y	N	N	Y
39140	Prescott, AZ	N	N	Y	Y	Y
39340	Provo-Orem, UT	Y	Y	N	N	N
39380	Pueblo, CO	N	N	Y	Y	Y
39460	Punta Gorda, FL	N	N	N	N	Y
39580	Raleigh, NC	N	N	Y	Y	N
39660	Rapid City, SD	N	N	Y	Y	N
39740	Reading, PA	Y	Y	Y	Y	Y
39900	Reno, NV	N	N	Y	Y	N
40060	Richmond, VA	N	N	Y	Y	N
40140	Riverside-San Bernardino-Ontario, CA	N	N	N	N	Y
40220	Roanoke, VA	N	N	Y	Y	Y
40340	Rochester, MN	N	N	N	N	Y
40420	Rockford, IL	N	N	N	N	Y
40660	Rome, GA	N	N	N	N	Y
40980	Saginaw, MI	Y	Y	N	N	N
41100	St. George, UT	N	N	Y	Y	Y
41140	St. Joseph, MO-KS	N	N	Y	Y	Y
41180	St. Louis, MO-IL	Y	Y	N	N	Y
41420	Salem, OR	N	N	Y	Y	Y
41500	Salinas, CA	N	N	Y	Y	N
41860	San Francisco-Oakland-Hayward, CA	Y	Y	N	N	Y
42140	Santa Fe, NM	N	N	N	N	Y
42200	Santa Maria-Santa Barbara, CA	N	N	N	N	Y
42340	Savannah, GA	N	N	Y	Y	N
42540	Scranton--Wilkes-Barre--Hazleton, PA	N	N	N	N	Y
42660	Seattle-Tacoma-Bellevue, WA	Y	Y	N	N	Y
42680	Sebastian-Vero Beach, FL	Y	Y	N	N	N
42700	Sebring, FL	N	N	N	N	Y
43300	Sherman-Denison, TX	N	N	Y	Y	N
43780	South Bend-Mishawaka, IN-MI	Y	Y	N	N	N

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MSA	MSA Title	Comprehensive Care for Joint Replacement Model	Surgical Hip and Femur Fracture Treatment	Acute Myocardial Infarction	Coronary Artery Bypass Graft	Cardiac Rehabilitation Incentive Payment Model
44060	Spokane-Spokane Valley, WA	N	N	Y	Y	N
44100	Springfield, IL	N	N	Y	Y	Y
44180	Springfield, MO	N	N	N	N	Y
44420	Staunton-Waynesboro, VA	Y	Y	N	N	N
45300	Tampa-St. Petersburg-Clearwater, FL	Y	Y	N	N	N
45780	Toledo, OH	Y	Y	N	N	Y
45820	Topeka, KS	Y	Y	N	N	N
46060	Tucson, AZ	N	N	Y	Y	Y
46140	Tulsa, OK	N	N	Y	Y	Y
46220	Tuscaloosa, AL	Y	Y	Y	Y	Y
46340	Tyler, TX	Y	Y	N	N	N
46540	Utica-Rome, NY	N	N	Y	Y	N
47380	Waco, TX	N	N	N	N	Y
47940	Waterloo-Cedar Falls, IA	N	N	Y	Y	Y
48300	Wenatchee, WA	N	N	Y	Y	N
48620	Wichita, KS	Y	Y	Y	Y	Y
48900	Wilmington, NC	N	N	Y	Y	N
49180	Winston-Salem, NC	N	N	Y	Y	N
49660	Youngstown-Warren-Boardman, OH-PA	N	N	Y	Y	N
49740	Yuma, AZ	N	N	Y	Y	N
	Total "Ys"	67	67	98	98	90

Participant hospitals in these selected geographic areas are all acute care hospitals paid under the Inpatient Prospective Payment System that are not concurrently participating in Models 2, 3, or 4 of the Innovation Center's Bundled Payment for Care Improvement initiative for AMI, CABG or SHFFT episodes. Geographic areas where all-payer models under the Innovation Center are operating — Maryland and Vermont — are excluded. Hospitals paid under a reasonable cost methodology, such as critical access hospitals, also are excluded.

The CR Incentive Payment Model will be implemented in 45 geographic areas also selected for the AMI and CABG Models as well as in 45 geographic areas that were not selected for the AMI and CABG Models. This test will cover the same five-year period as the episode payment models.

Approximately 1,120 hospitals will participate in the AMI and CABG models, 860 hospitals in the SHFFT Model and 1,320 hospitals in the CR Incentive Payment Model.

ADDITIONAL FLEXIBILITIES FOR PARTICIPANT HOSPITALS AND COLLABORATING PROVIDERS AND SUPPLIERS

The episode payment models waive certain existing payment system requirements "to assist participant hospitals in caring for beneficiaries in the most efficient, convenient setting; to encourage timely, accessible care; and to facilitate

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improved communication and treatment adherence." These include: a waiver of the requirement for a three-day inpatient hospital stay prior to admission for a covered skilled nursing facility stay under certain conditions beginning in performance year three for the AMI Model; allowing payment for certain telehealth services provided to a beneficiary in his or her home; and allowing payment for certain types of physician-directed home visits for non-homebound beneficiaries.

In addition, a participant hospital may wish to enter into certain financial arrangements with collaborating providers, suppliers and accountable care organizations that are engaged in care redesign with the hospital. Under these arrangements, a participant hospital may share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating entities. Participant hospitals may also share financial accountability for increased episode spending with collaborating entities. Finally, participant hospitals may provide beneficiaries with in-kind patient engagement incentives to advance the clinical goals of their care, under certain conditions.

No waivers of any fraud and abuse authorities are being issued in the final rule. Waivers of certain fraud and abuse laws for purposes of testing these models would be issued by CMS and the HHS Office of the Inspector General. These notices are published on the CMS and OIG websites.

QUALITY AND THE PAY-FOR-PERFORMANCE METHODOLOGY

The specific measures for each model and the pay for performance methodology can be found at https://innovation.cms.gov/initiatives/epm.

The AMI measure set consists of the following:

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

The CABG measure is as follows:

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

CMS is also incorporating the Society of Thoracic Surgeons composite measure data submission as a voluntary option weighted at 10 percent of the composite quality score.

The SHFFT measure set is:

- Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550) (Hip/Knee Complications).
- HCAHPS Survey (NQF #0166).
- Total Hip Arthroplasty/Total Knee Arthroplasty voluntary patient-reported outcome and limited risk variable data submission (Patient-reported outcomes and limited risk variable data following elective primary THA/TKA).

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COMMENT

The rule contains significant details about the quality measure, scoring, inclusion and exclusion criteria and calculations.

INTERACTION WITH OTHER MODELS AND PROGRAMS

Hospitals participating in other CMS models or programs such as the Shared Savings Program and other ACO initiatives are included in the episode payment models if they are located in a selected MSA. Episodes initiated by beneficiaries who are prospectively assigned to certain two-sided risk shared savings programs such as the Next Generation ACO Model, the Comprehensive ESRD Care Model, and in response to comments, a Shared Savings Program ACO in Track 3, will be excluded from the model.

CARDIAC REHABILITATION INCENTIVE PAYMENT MODEL

The CR Incentive Payment Model tests whether a payment incentive can increase the utilization of cardiac rehabilitative services, which have historically been under-used by Medicare beneficiaries. Medicare based on the frequency of beneficiary utilization of cardiac rehabilitation.

CMS established a two-part cardiac rehabilitation incentive payment to be paid retrospectively based on the total cardiac rehabilitation use of beneficiaries attributable to participant hospitals, and limited by coverage requirements for CR and Intensive CR. The initial payment is $25 per cardiac rehabilitation service for each of the first 11 services paid for by Medicare during the care period for an AMI or CABG care episode, and $175 per service during care period after 11 services. In response to comments, CMS is broadening final beneficiary engagement incentives to be the same as the episode payment models but as applicable to AMI care periods and CABG care periods under the CR Incentive Payment Model.

IMPROVEMENTS IN COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL

The final rule also makes several modest adjustments to the CJR Model that are largely conforming changes for consistency with the other episode payment models. These include refinements for use of the SNF waiver, exclusion of beneficiaries participating in selected ACOs, and revising target pricing methodology to include reconciliation and repayment amounts for performance years three, four and five.

CMS is finalizing revisions to the quality adjustment to incorporate improvement as well as absolute performance. CMS also finalized changes to align CJR with the episode payment models around financial arrangements and beneficiary engagement incentives, compliance enforcement, appeals processes, and beneficiary notifications.

NEW ACCOUNTABLE CARE ORGANIZATION MODEL OPPORTUNITY

Medicare ACO Track 1+ Model

CMS is announcing a new Medicare ACO Track 1+ Model. This will, beginning in 2018, allow clinicians to join Advanced Alternative Payment Models to improve care and potentially earn an incentive payment under the Quality Payment Program, created by the Medicare Access and CHIP Reauthorization Act of 2015.

The new Medicare ACO Track 1+ Model will test a payment model that incorporates more limited downside risk than is currently present in Tracks 2 or 3 of

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the Medicare Shared Savings Program in order to encourage more rapid progression to performance-based risk.

The new model is based on Shared Savings Program Track 1 with maximum 50 percent shared savings rate, but incorporates elements of Track 3 including: prospective beneficiary assignment to allow ACOs to know in advance the patient population for which they are responsible; choice of symmetrical thresholds from which to start sharing in savings or losses; and the option to elect the SNF 3-Day Rule Waiver. The model has a fixed 30 percent loss sharing rate and the maximum level of downside risk would vary based on the composition of ACOs with potentially lower levels of risk available to qualifying ACOs that include physicians or small rural hospitals.

In 2018, the maximum loss limit would be either 8 percent of ACO participant Medicare fee-for-service revenue (for ACOs that are physician-led or include small, rural hospitals); or 4 percent of the ACO's updated benchmark depending on the composition of the ACO (for other ACOs now in Track 1 or new or renewing ACOs). In later years, ACOs eligible for the lower sharing limit could opt for a higher percentage of revenue in 2019 and 2020 consistent with changes to the Advanced APM nominal risk requirement. The ACO's loss sharing limit, as a percentage of revenue, would not exceed the equivalent of 4 percent of the ACO's updated historical benchmark.

The Track 1+ Model 2018 application cycle will align with the annual application cycle for the Shared Savings Program. According to CMS, additional information about the application process is forthcoming, but organizations interested in applying should plan to submit the required Notice of Intent to Apply in May of 2017. The Track 1+ Model will be open to Shared Savings Program Track 1 ACOs that are within their current agreement period, initial applicants to the Shared Savings Program, and Track 1 ACOs renewing their agreement that meet Model eligibility criteria. For Track 1 ACOs that have renewed their agreements, the benchmark that would apply under the Model could also incorporate a regional benchmark adjustment consistent with the timing and phase-in of the regional benchmark adjustment, as outlined in the June 2016 final rule for the Shared Savings Program. ACOs will have additional opportunity to join the Model test as part of the 2019 and 2020 Shared Savings Program application cycles.

FINAL COMMENT

As noted previously this is a complex and detailed rule with fine aspects on conditions, quality, calculations, documentation, and so forth. Providers who will have to participate need to carefully understand all the issues being addressed in the document.

Please remember these models are intended to save Medicare outlays.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting