Executive Summary – Episodic Payment Model for Cardiac and Hip Fractures Proposed Rule

Top 10 Issues Providers Need to Understand from the Episodic Payment Model (EPM) for Cardiac and Surgical Hip/Femur Fracture Treatment Proposed Rule:

The EPM proposed rule was published on July 25th. A full summary of the rule will be available shortly on the HFMA regulatory resources website.

1) *Episode of Care*: CMS proposes three new episodes of care models for cardiac (acute myocardial infarction (AMI) and Coronary Artery Bypass Graft (CABG)) and hip/femur fracture. An episode begins with a Medicare Part A beneficiary's admission that results in the assignment of MS-DRGs listed below.

   a. Surgical hip femur fracture treatment (SHFFT): MS-DRGs 480 – 482
   b. Acute myocardial infarction (AMI):
      i. AMI, discharged alive: 280 – 282
      ii. Percutaneous cardiovascular procedure (PCI): MS-DRGs 246 – 251, with an AMI ICD-CM diagnosis code in the principal or secondary diagnosis code position
   c. Coronary artery bypass graph (CABG): MS-DRGs 231 – 236

   The patient must be admitted to an inpatient prospective payment system (IPPS) hospital located in one of the selected metropolitan statistical areas (MSAs). Episodes include all Part A and Part B expenditures that occur within 90 days of discharge. A limited number of services CMS considers unrelated are excluded. Also, beneficiaries who are being treated in Bundled Payments for Care Improvement Initiative (BPCI) episodes are also proposed for exclusion.

2) *Model Duration*: The new models begin on July 1, 2017, through December 31, 2021.

3) *Selected MSAs*: In the proposed rule, CMS states it will select 90 MSAs for the AMI and CABG episodes. CMS proposes to select the 67 Comprehensive Care for Joint Replacement (CJR) MSAs for the SHFFT episode.

4) *Payment Method*: All providers involved in an episode of care will continue to be paid under the relevant fee-for-service (FFS) payment schedule. Expenditures for an episode will be compared to a target price.

5) *Target Price*: CMS will use three years of historical blended hospital specific and regional payment data grouped into episodes of care. The blended target price increasingly will be based on regional data.

Target Price Data Blend: Regional vs. Hospital Specific

Performance Year(s)	% Regional	% Hospital Specific
1 – 2	33	66
3	66	33
4 – 5	100	0

Low-episode volume hospitals (as defined by CMS in the proposed rule) will have their target price based on regional data for all five years.

The historical data will be updated to reflect current pricing in the various Medicare FFS payment systems involved. Certain special payment provisions designed to improve value will be excluded from both the target price and actual spending calculation. In subsequent years, CMS proposes to incorporate related gainsharing payments to/from providers into the target price calculation. Once CMS calculates a target price it will be reduced by up-to two percent in years two and three and three percent in years four and five based on how a facility scores on a quality composite. Beyond the MS-DRG weighting, CMS does not propose any additional risk adjustment mechanism for the episodes.

6) *Degree of Risk Transferred:* In the first year of the program (July 1, 2017 – March 31, 2018), hospitals have upside opportunity only if their actual episode expenditure is below the target price. Beginning in the second quarter of year two, hospitals must repay CMS if their actual expenditure is above the target price. The model incorporates a progressive stop-loss and stop-gain mechanism.

Stop-Loss

Facility Type	Year 2	Year 3	Year 4/5
Non-MDH/RRC/SCH	5%	10%	20%
MDH/RRC/SCH	3%	5%	5%

Stop-Gain

Facility Type	Year 2	Year 3	Year 4/5
Non-MDH/RRC/SCH	5%	10%	20%
MDH/RRC/SCH	3%	5%	5%

To protect hospitals against catastrophic cases, episode costs will be capped at two-standard deviations above the mean. Any episode that exceeds the ceiling amount will be assigned the ceiling amount instead of the actual episode cost.

7) *Quality Measures*: Each of the new episodic payment models have unique quality measures. For each Episodic Payment Model (EPM), CMS proposes an EPM *composite quality score* linking quality to payment. This score includes a composite *performance* score plus an *improvement* score; the performance component is more heavily-weighted. CMS proposes during reconciliation to reference individual EPM participant's most recent results to the national performance percentile distributions of measure results for subsection (d) IPPS hospitals meeting preset patient case or survey count minimums. Low volume EPM participants, new hospitals, and participants whose measure values are suppressed by CMS due to errors in the data are assigned to the 50th performance percentile.

CMS proposes adding into the EPM-specific composite quality score up to 10 percent of the measure's maximum value for participants demonstrating substantial improvement year-over-year; voluntary measures are excluded. EPM composite quality scores would be capped at 20 points. For the AMI and CABG models, improvement is defined as any year-over-year improvement in a participant's own measure point estimates if the participant falls into the top 10 percent of participants based on the national distribution of measure *improvement*. For the SHFFT model, CMS first proposes defining *improvement* as a year-over-year gain of 2 deciles or more referenced to the relevant national distributions. CMS also proposes to award up to 10 percent of the maximum

measure performance scores on both proposed measures, capping the SHFFT composite quality score at 20 points.

CMS encourages voluntary measure data submission with eligibility for additional composite quality score points, thereby fostering the continued development of these measures. CMS notes that data submitted by SHFFT participants also would be credited under the CJR model, eliminating duplicate submissions. Below are the model specific quality measures:

CMS proposes three required measures, plus one voluntarily reported measure for the AMI model:

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

CMS proposes two required measures for the CABG model:

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

CMS proposes two required and one voluntarily reported measures for the SHFFT model:

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

These are the same measures as used in CJR.

8) *Gainsharing*: Hospitals can enter into agreements with physicians, ACOs, other hospitals, and post-acute providers in order to align incentives. These agreements can be up-side only (gainsharing) or include downside risk (alignment payments) should the actual per episode cost exceed the target price. Gainsharing agreements with physicians can also include both savings generated for CMS and internal cost savings generated for the hospital through improved efficiency and supply cost management.

9) *Data Sharing*: CMS proposes to provide EPM participants in the AMI, CABG, and SHFFT models, upon request, beneficiary-level claims data for the historical period used to calculate episode benchmark and quality-adjusted target prices, as well as with ongoing quarterly beneficiary-identifiable claims data. It also proposes to provide EPM participants with aggregate regional data because it intends to incorporate regional pricing in the calculation of benchmark and quality-adjusted target prices.

10) _Waivers_: CMS and the OIG issued a joint statement waiving the federal anti-kickback and physician self-referral statutes to facilitate gainsharing arrangements for CJR participants.

The rule also waives Medicare regulations related to the:

- Skilled nursing facility (SNF) 3-Day Rule: During performance years 2 – 5 of the program, beneficiaries discharged from an anchor admission of an AMI episode to a SNF with an overall rating of three stars or more will receive coverage for their SNF stay even if they don't have a "qualifying" three-day stay in an acute hospital. CMS will not permit the waiver for SHFFT or CABG episodes due to concerns about the link between short hospital stays and increased mortality.

    Further, CMS clarifies the requirement for use of the SNF waiver in the EPM proposed rule. Where CMS determines that the waiver requirements were not met and the beneficiary was not provided adequate notice of their financial liability, CMS proposes to apply the following rules:

    - CMS would make no payment to the SNF for such services.
    - The SNF could not charge the beneficiary for the expenses incurred for such services, and the SNF would have to return to the beneficiary any monies collected for such services.
    - The hospital would be responsible for the cost of the uncovered SNF services furnished during the SNF stay.

- Home Health: While the rule does not waive the homebound requirement, it does waive the incident-to rule. Beneficiaries may receive a limited number of post-discharge home visits (AMI model – 13 visits, CABG model 9 visits).

- Telehealth: The geographic site requirements are waived for beneficiaries permitting beneficiaries involved in an AMI, CABG, or SHFFT episode to receive telehealth visits in their home related to the episode.