Note: Following is the section that summarizes the implementation of the *Cardiac Rehabilitation (CR) Incentive Payment Model*. The two other sections of this summary pertain to the three new *Episode Payment Models (EPMs)*, and the *Comprehensive Care for Joint Replacement (CJR) Model*.

V. Cardiac Rehabilitation (CR) Incentive Payment Model – Section III

A. Background

Despite strong and well-publicized evidence of benefit over several decades, CR and ICR remain significantly underutilized by Medicare beneficiaries after AMI and CABG clinical events.[1] Perceived barriers to CR utilization include low beneficiary referral rates; lack of strong CR endorsement by physicians to their patients; limited awareness of CR; associated financial burden of co-insurance and time lost from work; limited access to CR program sites; CR requirements for physician supervision of services during delivery, and insufficient reimbursement to providers.

Medicare Part B generally covers CR/ICR services for all Medicare beneficiaries who are referred by their physician after having an AMI or CABG.[2] As specified in section 1861(eee) of the Act, CR/ICR programs must include:

(1) physician-prescribed exercise;
(2) cardiac risk factor modification, including customized education, counseling, and behavioral intervention;
(3) psychosocial assessments;
(4) outcome assessments; and
(5) individualized treatment plan established, reviewed, and signed by a physician every 30 days that details how components are utilized for the patient.

To be covered, the services must be provided in a physician's office or a hospital outpatient department, and a physician must be immediately available and accessible throughout the delivery of all CR program services. CR service delivery is limited to 2 one-hour sessions per day for up to 36 sessions over up to 36 weeks; services may be extended for an additional 36 sessions over an extended time period if approved by the appropriate Medicare Administrative

[1] In 2013, only 15 percent of beneficiaries hospitalized for AMI had at least one claim for CR services, only 23 percent after hospitalizations including PCI, and only 45 percent after CABG.
[2] https://www.medicare.gov/coverage/cardiac-rehab-programs.html.

Contractor (MAC). ICR program sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

ICR program approval also requires that the program demonstrate through peer-reviewed published research that it has accomplished at least one of the following:

(1) positively affecting coronary heart disease progression;
(2) reducing the need for coronary bypass surgery; or
(3) reducing the need for PCI.[3]

B. Overview of the CR Incentive Payment Model

1. General Design of the CR Incentive Payment Model

Goal. CMS designed the payment model to test the effects on quality and Medicare expenditures of providing explicit financial incentives to hospitals to encourage care coordination and increased CR utilization during 90 days after hospital discharge for beneficiaries treated for AMI or undergoing CABG surgery. In the model, the beneficiary's overall care will be paid under either an EPM or Medicare FFS program.

Participants. The payments will be made to hospitals (termed CR participants) for patients admitted for AMI or CABG treatment; over 95 percent of CR/ICR services are provided to Medicare beneficiaries by hospitals. CR participants may also be selected as AMI and CABG EPM participants (EPM-CR participants) or not (FFS-CR participants). For EPM-CR participants, the incentive payment will be given to the hospital to whom cost and quality responsibilities are attributed. For beneficiaries receiving AMI or CABG care through traditional FFS Medicare, incentives will be paid only to hospitals specifically selected to participate in the CR model program.

Payment. CMS finalizes its proposal for a two-level, per service, CR incentive payment amount. The first level is designed to support initial beneficiary CR/ICR engagement, while the second, higher level would reward hospitals for fostering continued engagement above a session utilization benchmark. CMS will make the incentive payments annually on a retrospective basis.

C. CR Incentive Payment Model Participants

CMS defines CR incentive payment model participants as both EPM-CR and FFS-CR participants located in the selected MSAs. If a participant changes their eligibility status during the performance period, the participant will become eligible for the CR incentive payment model. A participant's eligible status may change because its participation as a BPCI initiating hospital may conclude or a new hospital may open. CMS plans to reassess and update hospital eligibility status on an ongoing period basis, which may be as frequent as quarterly.

[3] A list of ICR programs approved through the national coverage determination process is posted at the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/ICR.html

CMS selected CR areas with a two-step process. First, CMS selected the 98 cardiac EPM MSAs and then it selected the EPM-CR and the FFS-CR from within the CR selection groups. In the final rule, table 53 lists the 45 EPM-CR MSAs and table 54 lists the 45 FFS-CR MSAs.

For a list of markets that were selected for the CR program, visit CMS's website page at: https://innovation.cms.gov/initiatives/cardiac-rehabilitation/index.html

D. CR/IR Services that Count Towards Incentive Payments

CMS finalizes which CR/ICR services count towards CR incentive payments. Table 56 in the final rule and reproduced below lists the four HCPCS codes for CR/ICR services. CMS will count CR/ICR services identified by these HCPCS codes in the CR PY when the CR/ICR services are paid under the OPPS or to any supplier reporting place of service code (POS) 11 on a PFS claim.[4]

Table 56: HCPCS Codes for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services

HCPCS code	Descriptor
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session

EPM participant hospitals are eligible to receive CR incentive payments for the full duration of AMI or CABG episodes (throughout the 90-day post-hospital discharge period). EPM participant CR payment eligibility begins once Medicare has paid any CR/ICR provider for delivery of at least one CR service during an AMI or CABG episode to a beneficiary whose episode has been attributed to the EPM participant. At this point, the hospital becomes an EPM-CR participant.

For FFS-CR participants, CMS will use the terms "AMI care period" and "CABG care period" to refer to a period of AMI and CABG care, that meet the requirements to be an AMI or CABG model episode if the FFS-CR participant were an AMI or CABG model participant. Applying the care period concept, a FFS-CR participant hospital will be eligible for CR payments throughout the AMI or CABG care period, and eligibility begins once Medicare has paid any

[4] Place of Service Code 11, Office, is used for a location, other than a hospital, skilled nursing facility, military treatment facility, community health center, State or local public health clinic or intermediate care facility where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. (https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)

CR/ICR provider for delivery of at least one CR service during an AMI or CABG care period to a beneficiary whose care period is associated with that FFS hospital.

The National Coverage Determination (NCD) process will continue to be used to determine whether an ICR program falls within the scope of this Part B benefit. CR participants without their own CR/ICR programs will receive the CR incentive payment based on the CR/ICR utilization of beneficiaries attributed to them, regardless of the specific provider or supplier that furnishes the CR/ICR services to the beneficiary during the episode or care period.

CMS notes that CR/ICR services will continue to be paid by the Medicare program under the OPPS and PFS throughout the CR incentive payment model PYs for CR beneficiaries and must meet the billing requirements outlined in the Medicare Claims Processing Manual.[5] When a CR/ICR service is furnished in a hospital outpatient department, a physician cannot bill for CR/ICR unless the physician personally performs the service (74 FR 61879). To personally perform the service, the physician must provide direct care to a single patient for the entire session of CR/ICR that is being reported. In this case, the hospital reports the CR/ICR service and is paid the OPPS payment amount for the facility services associated with the CR/ICR services. The physician would report place of service code 19 or 22 (Off Campus-Outpatient Hospital or On Campus-Outpatient Hospital, respectively) on the PFS claim. A physician cannot bill under the PFS for CR/ICR services furnished in a hospital for which the physician furnishes only supervision or for services furnished in part by others.

E. Determination of CR Incentive Payments

1. Determination of CR Amounts that Sum to Determine a CR Incentive Payment

CMS will determine the amount of the CR incentive payments based on CR/ICR services paid by Medicare to any provider or any supplier reporting POS code 11 on the claim for CR beneficiaries. The CR amount means the dollars determined by the number of CR/ICR services paid by Medicare to any provider or to any supplier reporting POS code 11 on the claim for a beneficiary in an AMI or CABG model episode or AMI care period or CABG care period. Similarly, the CR service count means the number of CR/ICR services paid by Medicare to any provider or to any supplier reporting POS code 11 on the claim for a beneficiary in an AMI or CABG model episode or AMI care period or CABG care period.

For episodes or care periods with a CR count less than 12, CMS will multiply the CR service count by $25. For episode or care periods with a CR service count of 12 or more, the CR incentive payments will be the sum of $275 ($25 multiplied by 11 for the first 11 CR/ICR services) and $175 per service thereafter. CMS will not cap the number of services counted toward the CR amount but notes that Medicare program coverage limits already exist.[6] CMS

[5] Claims Processing Requirements for CR and ICR Services Furnished on or after January 1,2010. Chapter 32, Section 140.2.2 Medicare Claims Processing Manual.

[6] CR program sessions are limited to 2 one-hour sessions per day for up to 36 sessions over up to 36 weeks, with an option for 36 more sessions over an extended time period with MAC approval. For ICR services, the limits are 72 one-hours sessions, up to 6 sessions per day, over a period of up to 18 weeks.

will sum all the CR/ICR services across the CR participant's beneficiaries using OPPS and PFS claims during the relevant time periods. Payments will be made at the end of each CR PY from the Part B Trust Fund to CR participants, and beneficiary-specific payment data will be submitted to the CMS Master Database Management (MDM) system.

2. Relation of CR Incentive Payments to EPM Pricing and Payment Policies and Sharing Arrangements for EPM-CR participants

CMS finalizes its proposal to keep CR incentive payments, if any, separate from reconciliation payments and Medicare, repayments. CMS finalizes the following:

- CR incentive payments to EPM-CR participants will not be subject to the EPM limitation on gains;
- EPM-CR participants may not include CR incentive payments in their sharing arrangements; sharing with other entities must comply with all existing laws and regulations;
- FFS-CR participant payment sharing can be done only under circumstances that comply with all existing laws and regulations; and
- CR incentive payments will be excluded when updating quality-adjusted target prices for EPM-CR participants during EPM PYs 3-5.

F. Provisions for FFS-CR Participants

1. Access to Records and Retention for FFS-CR participants

CMS finalizes that FFS-CR participants will be required to:

- Allow appropriate access by government agencies to all materials necessary for audit, evaluation, inspection or investigation
- Maintain all related materials for 10 years from the participant's last day of CR incentive payment model participation or from the completion date of any audit, evaluation, inspection, or investigation, whichever is later. CMS finalizes two exceptions for when:
    1. CMS determines a particular record or group of records should be retained for a longer period and notifies the FFS-CR participant at least 30 calendar days before the disposition date, or
    2. There has been a dispute or allegation of fraud or similar fault against the FFS-CR participant, in which case the records must be maintained for 6 years from the date of any resulting final resolution.

2. Appeals Process for FFS-CR Participants

CMS finalizes its proposal to establish an appeals process for use by FFS-CR participants incorporating the same requirements as for EPM-CR participants (Section III.D.8.). However, the process and requirements would relate only to the CR payment and to non-payment related issues such as enforcement matters that are relevant to the CR incentive payment model.

a. Notice of Calculation Error (first level appeal)

CMS finalizes the following requirements in §512.720(a) for notice of calculation error:

- If a FFS-CR participant wishes to dispute calculations involving a matter related to the CR incentive payment, the FFS-CR participant is required to provide written notice of the calculation error, in a form and manner specified by CMS.
- In the absence of such written notice to CMS, CMS deems final the applicable CR incentive payment report 45 days after the applicable report is issued and will proceed with the applicable payment.
- If CMS receives a notice of calculation error within 45 days of issuance of the applicable CR incentive payment report, CMS will respond in writing within 30 days to either confirm the error or verify that the calculation is correct. CMS reserves the right to extension upon written notice to the FFS-CR participant.
- This process is restricted to use by FFS-CR participants.

b. Dispute Resolution Process (second level of appeal)

CMS finalizes the following requirements in §512.720(b) for the reconciliation process:

- If the FFS-CR participant is dissatisfied with CMS' response to the notice of calculation error, the FFS-CR participant may request a reconsideration review in a form and manner specified by CMS.
- The reconsideration request must provide an explanation of the basis for the dispute and supporting documentation for the FFS-CR participant's assertion that CMS or its representatives did not accurately calculate the CR incentive payment.
- If CMS does not receive a request within 10 days of the issue date of CMS' response to the FFS-CR participant's notice of calculation error, the CMS' response to the calculation error is deemed final and CMS proceeds with the applicable process.
- The CMS reconsideration official will notify the FFS-CR participant in writing within 15 calendar days of receiving the reconsideration request of the following: review meeting time and location; the issues in dispute; the review procedures; and the procedures (including format and deadlines) for submission of evidence. The CMS reconsideration official will take all reasonable efforts to schedule the review no later than 30 days after the receipt of the notification.
- The provisions at §425.804(b), (c), and (e) of this chapter are applicable to reviews conducted in accordance with the reconciliation process for the FFS-CR participant.
- The CMS reconsideration official will issue a written determination within 30 days of the review. The determination if final and binding.
- Only a FFS-CR participant may utilize this dispute resolution.

c. Exception to the Notice of Calculation Error Process and Notice of Termination

CMS finalizes the following requirements in §512.720(c) for an exception to the notice of calculation error process:

- A notice of calculation error is not required if the FFS-CR participant contests a matter that is unrelated to the CR incentive payment calculation. In such cases, if CMS does not

receive a request for reconsideration from the FFS-CR participant within 10 days of the notice of the initial determination, the initial determination is deemed final and CMS proceeds with the action indicated in the initial determination

CMS finalizes the following requirements in §512.720(d) for notice of termination:

- If a FFS-CR participant receives a termination notice, it must provide a written request for reconsideration to CMS requesting a review of the termination within 10 calendar days of the notice. CMS has 30 days to respond to the request for review. If the FFS-CR participant fails to notify CMS, the decision is deemed final.

d. Limitations on review

CMS finalizes the following requirements in §512.720(e) for limitations of review:

- In accordance with section 1115A(d)(2) of the Act, there is no administrative or judicial review under sections 1869 or 1878 of the Act for the following:
    - The selection of models for testing or expansion under section 1115A of the Act.
    - The selection of organizations, sites, or participants to test those models selected.
    - The elements, parameters, scope, and duration of models for testing or dissemination.
    - Determinations regarding budget neutrality under section 1115A(b)(3) of the Act.
    - The termination or modification of the design and implementation of a model under section 1115A(b)(3)(B) of the Act.
    - Decisions to expand the duration and scope of a model under section 1115A(c) of the Act, including the determination that a model is not expected to meet criteria described in this section in the final rule.

3. Data-Sharing for FFS-CR Participants

CMS finalizes that sharing beneficiary-identifiable data with CR program participants is consistent with the "health care operations" provisions of HIPAA. CMS notes that financial data sharing under the EPMs is detailed in Section II.K.2. and it believes that similar sharing with FFS-CR participants is appropriate. Because the CR incentive payment model is considerably narrower in focus and scope than the EPMs, CMS will provide FFS-CR participants with more limited data (upon request and in keeping will all applicable privacy and security laws and protections) consisting of:

- Inpatient claims – containing potential admissions for CABG and AMI MS-DRGs (and PCI MS-DRGs if paired with an AMI ICD-CM diagnosis as the principal or secondary diagnosis code) and
- Carrier and Outpatient claims – containing CR/ICR services occurring in the 90-day period after discharge for treatment of AMI or for CABG surgery (the AMI or CABG care period).

Similar to the data sharing with EPM participants, CMS will provide the data to FFS-CR participants in either summary or claims-level format, according to requestor preference. Data

files will be packaged and sent to a data portal, to which FFS-CR participants must request and be granted access, for retrieval in a binary format.

The data will be available no less frequently than on a quarterly basis throughout the FFS-CR participant's participation. If practicable, CMS states it will make the data available as frequently as on a monthly basis. Data files would be packaged and sent to a data portal, to which FFS-CR participants must request and be granted access, for retrieval in a binary format.

4. Beneficiary Engagement Incentives for FFS-CR Participants

CMS finalizes beneficiary engagement incentives provided by FFS-CR participants subject to the following conditions:

- The incentive must be provided directly by the FFS-CR participant or by an agent of the FFS CR participant under the FFS-CR participant's direction and control to the FFS-CR beneficiary during an AMI care period or CABG care period.
- The item or service must be reasonably connected to medical care provided to an FFS-CR beneficiary during the AMI or CABG care period.
- The item or service must be a preventive care item or service that advances a clinical goal for a beneficiary during the AMI or CABG care period by engaging the beneficiary in better managing their health.
- The item or service must not be tied to the receipt of items or services from a particular provider or supplier.
- The availability of items or services must not be advertised or promoted except that a beneficiary may be made aware of their availability.
- The cost of the item or service must not be shifted to another federal program.

Incentives involving technology provided to a beneficiary in a care period have the following additional conditions:

- Technology may not exceed $1,000 in retail value for any one beneficiary in any one care period
- Technology must be the minimum necessary to advance a clinical goal: beneficiary adherence to drugs, beneficiary adherence to a care plan, reduction of readmissions and complications resulting from treatment for AMI or CABG, and management of chronic diseases and conditions that may be affected by treatment for AMI or CABG.
- Required documentation includes at least the date the technology is provided, the identity of the beneficiary, and evidence to retrieve for technology exceeding $100 in retail value at the end of the care period. The FFS-CR participant must retain and provide access to the required documentation in accordance with §512.715.

Similar to the EPM requirements, the FFS-CR participant beneficiary engagement incentive requirements do not allow the FFS-CR participants to pay money to beneficiaries for any purpose, including completion of the CR program or as a rebate of CR copayments.

5. Waiver of Physician Definition for Providers and Suppliers of CR/ICR Services Furnished to FFS-CR Beneficiaries During an AMI or CABG Care Period

CR/ICR services require a physician[7] to serve as the medical director of the program; supervise the program such that the physician is immediately available for medical consultations and medical emergencies; prescribe individualized exercise programs; and establish, review and sign individualized treatment plans.

CMS finalizes that in addition to a physician, a nonphysician practitioner (physician assistants, nurse practitioners or clinical nurse specialists) can perform the functions of supervising physician; prescribe exercise; and establish, review, and sign an individualized treatment plan for FFS-CR beneficiaries. This waiver for FFS-CR participants is similar to the physician waiver definition for EPM-CR participants. This waiver would apply to CR/ICR services furnished by any provider or supplier to EPM beneficiaries during AMI or CABG model episodes and to FFS-CR beneficiaries during AMI or CABG care periods. This waiver would be terminated if the FFS-CR participant is terminated or is not in compliance with the CR incentive payment model.

G. Considerations Regarding Financial Arrangements Under the CR Incentive Payment Model

CMS finalizes its proposal not to allow EPM-CR participants to include CR incentive payments in their sharing arrangements and that all FFS-CR financial arrangements would be subject to all existing laws, regulations, and payment and coverage requirements.

[7] A physician is defined under 410.49(a) and 1861(r)(1) of the Act as a doctor of medicine or osteopathy.