January 13, 2017

CMS Finalizes Testing of New Episode Payment Models and MSSP Track 1+ ACO

On January 3, 2017, CMS published a final rule addressing three care coordination models:

- **Cardiac care:** CMS added two new cardiac care episode payment models ("EPMs") for items and services furnished to patients receiving treatment for heart attacks and bypass surgery. CMS also created an incentive payment system to encourage use of cardiac rehabilitation following a heart attack or heart surgery.
- **Orthopedic care:** CMS added one new EPM applicable to items and services furnished to patients who receive surgery after a hip fracture, other than hip replacement. CMS also revised the existing CJR Model, which began in April 2016, to align it with the features of the new EPMs, and to allow it to potentially qualify as an advanced alternative payment model ("Advanced APM") under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") Quality Payment Program.
- **Medicare Shared Savings Program ACO:** CMS also added a MSSP Track 1+ ACO model that involves a lower downside risk than the current APM-qualifying MSSP ACO models. The new track is intended to encourage more provider practices, particularly small rural practices, to participate in APMs with performance-based risk.

The cardiac and orthopedic EPMs hold participating hospitals financially accountable for all episode-related expenditures during an episode of care. The goal is to encourage hospitals to coordinate with other providers regarding transition of care and post-discharge treatment. Medicare encourages physicians to participate in EPMs, such as the cardiac and orthopedic models, through a five percent (5%) incentive payment that is potentially available under the MACRA Advanced APM Quality Payment Program.

The Final Rule will become effective February 18, 2017, with participation in the EPMs **mandatory** for hospitals in designated counties beginning in July. However, uncertainty has been cast on implementation by threatened repeal of the Affordable Care Act, which created the Center for Medicare and Medicaid Innovation, which is driving the new models. Affected providers therefore face a dynamic environment, which may affect their decision-making over the upcoming months.

Cardiac and Orthopedic Care Coordination Models

Episode Payment Models

The cardiac and orthopedic care EPMs hold participating hospitals financially accountable for Medicare Part A- and Part B-covered items and services provided to beneficiaries in qualifying episodes of care, beginning with hospitalization for applicable cardiac or orthopedic diagnoses and extending for 90 days after hospital discharge. Items and services covered by the EPM episodes include the inpatient stay as well as post-acute care and physician services. Medicare pays providers and suppliers on a fee-for-service basis during the episode. Afterwards, Medicare performs a retrospective true-up, holding the hospitals responsible for excess costs, and rewarding hospitals and their networks with a share of cost savings if they meet specified quality goals and keep costs below certain thresholds. The final rule addresses three EPMs:

- **Acute Myocardial Infarction ("AMI") Model.** The AMI model will bundle payment for items and services provided to beneficiaries discharged for treatment of an acute myocardial infarction, or heart attack.

- **Coronary Artery Bypass Graft ("Coronary Artery Bypass Graft") Model.** The Coronary Artery Bypass Graft Model or ("CABG") bundles payments for items and services furnished to Medicare beneficiaries treated for coronary bypass surgery for blocked arteries.

- **Surgery after Hip or Femur Fracture Treatment ("SHFFT") Model.** The SHFFT model bundles payments for Medicare items and services provided to Medicare patients who receive surgery after a hip fracture, other than hip replacement.

Each EPM episode is defined by the Medicare severity diagnosis related group ("MS-DRG") assigned to a claim following hospital discharge. Medicare patients who initiate in one episode remain in that initial model and are precluded from initiating a simultaneous episode in another model. For example, a beneficiary with a surgical hip fracture who has an AMI during the hospitalization would be assigned to the SHFFT Model (if the hospital is participating), even if the hospital also participates in the AMI Model.

Quality-adjusted target prices. For each performance year, CMS will establish Medicare episode "quality-adjusted target prices" for each participant hospital that includes payment for all related items and services furnished to eligible beneficiaries treated and discharged for included clinical conditions during the hospitalization and 90 days post-discharge. Quality-adjusted target prices for each year will be based on a combination of provider-specific pricing and regional pricing, as well as the "composite quality score."

Composite quality score. The composite quality score assigns hospitals to four quality categories, based on their past quality performance as compared to other hospitals in the region. Points for quality performance and improvements will be awarded for each episode and then summed to develop a composite quality score. The quality category determines the discount factor that will be applied to the quality-adjusted target price—*i.e.*, the episode costs that hospitals must meet to "win" are adjusted by the hospitals' quality.

Reconciliation. At the end of each performance year, CMS will retrospectively calculate total Medicare payments made to the hospital, post-acute care entities, and suppliers for items and services furnished during the qualifying hospitalization and 90 days following discharge to arrive at an "actual episode payment." CMS will then compare the actual episode payment to the quality-adjusted target price. If the hospital's episode payment is below the quality-adjusted target price and if the hospital achieves a quality category of "Acceptable" or higher, the hospital will be eligible to receive a reconciliation payment. Beginning in the third performance year, if the hospital does not meet a certain quality category and its episode payment is above the quality-adjusted target price, the hospital may be required to repay Medicare the difference between the quality-adjusted target price and the episode payment.

Changes to the CJR Program. Separately, CMS finalized updates to the Comprehensive Care for Joint Replacement ("CJR") Model, which began in April 2016 and addresses lower-extremity joint replacement episodes of care. The changes generally extend to the CJR Model some flexibility-providing features provided in the new EPMs, and allow the CJR Model to potentially qualify as an Advanced APM under the MACRA Quality Payment Program, which would enable collaborating physicians potentially to qualify for incentive payments.

Cardiac Rehabilitation Incentive Payment Model

The Final Rule also creates a new Cardiac Rehabilitation Incentive Payment Model to test the effect of financial incentives on the use of cardiac rehabilitation ("CR") and intensive cardiac rehabilitation ("ICR") services following hospital discharge. Under this model, CMS will make incentive payments to participating hospitals whose Medicare beneficiaries receive CR and ICR services following hospitalization for treatment of AMI or CABG.

The CR incentive payments to which hospitals are eligible will be based on the number of CR or ICR services provided over a certain time period. The payment per CR or ICR service rises from $25 to $175 after 11 services paid by Medicare.

Participation

Participation in the new EPMs, the revised CJR Model, and the CR Incentive Payment Model is mandatory for acute care hospitals in specified Metropolitan Statistical Areas ("MSAs") identified by CMS. In Table 1, we list the MSAs by state.

Performance Years

The first performance-period for the new EPMs and the CR Incentive Payment Model will begin on July 1, 2017, and run through December 31, 2017, with the next two performance years being calendar years 2018 and 2019. Hospitals will receive payments or adjustments in the first quarter following each performance period. For the new models, downside risk is not required until the third performance period (beginning January 1, 2019). However, hospitals may choose to assume downside risk in the second performance period (beginning January 1, 2018) in order to offer Advanced APM eligibility to collaborating physicians in 2018.

Benefits for Participation

The EPMs provide flexibility for participating hospitals and collaborating providers and suppliers by waiving certain existent rules. For example, the EPMs:

- waive the requirement for three-day inpatient hospital stay as a precondition to a covered admission to a skilled nursing facility ("SNF");
- allow payment for certain telehealth services provided to a beneficiary at home;
- provide payment for certain physician-directed home visits for non-homebound beneficiaries;
- allow participating hospitals to share Medicare payments for episode cost savings with collaborating providers and suppliers (subject to certain requirements); and
- allow participating hospitals to share financial accountability for increased episode spending with collaborating providers and suppliers (subject to certain requirements).

A hospital's participation in an EPM provides an opportunity for hospitals and physicians to qualify as participants in a so-called "Advanced APM," assuming that the hospital and physicians meet the Advanced APM regulatory requirements in a performance period. Participation in an EPM that meets such criteria may thus provide a path for hospitals and physicians to receive a 5% incentive payment under MACRA's Advanced APM Program.

MSSP Track 1+ ACO

In the final rule, CMS announced a new MSSP Track 1+ ACO, which features limited downside risk and added flexibility to encourage greater participation by provider practices, especially small rural practices, in alternative payment models with performance-based risk.

The Track 1+ Model offers a lower shared savings rate than Tracks 2 and 3 of the MSSP, but also incorporates more limited downside risk, with a lower capped loss sharing rate and a more protective maximum loss limit. The maximum level of downside risk providers could assume would vary based on ACO composition; and risk would likely be lower for ACOs composed of smaller or rural hospitals or physicians.

The model also incorporates elements of Track 3 ACOs that offer greater flexibility to encourage coordination and delivery of care. Track 3 elements included in the model are: 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 combination of limited downside risk with added flexibilities is intended to encourage more ACOs to adopt performance-based risk and faster progression to Tracks 2 or 3. The model qualifies as an Advanced APM under MACRA, allowing clinicians to enroll in the program and to earn incentive payments for Medicare Part B. Both hospitals and provider practices may participate in ACO Track 1+. The model will be voluntary for those currently in Track 1 of the MSSP or planning to participate in the MSSP for the first time. According to HHS, the new track will allow approximately 70,000 clinicians potentially to qualify for Advanced APM incentive payments under the Quality Payment Program in 2018.

The Track 1+ Model application cycle for 2018 will align with the MSSP annual application cycle. Organizations interested in applying should submit the required Notice of Intent to Apply in May 2017. CMS will provide additional information on Track 1+ participation in the coming months.