CMS ESTABLISHES NEW MEDICARE EPISODE PAYMENT MODELS

On December 20, CMS posted for public inspection a final rule establishing three new Episode Payment Models ("EPMs"). Two of the EPMs pertain to cardiac care. The third EPM pertains to orthopedic care. CMS will officially publish the rule on January 3, 2017.

THE CARDIAC-RELATED EPMS

The first cardiac-related EPM is for episodes of care surrounding an acute myocardial infarction ("AMI"). The second EPM is for episodes of care surrounding a coronary artery bypass graft ("CABG"). Both EPMs are mandatory for all inpatient prospective payment system ("IPPS") hospitals located in any of the 98 metropolitan statistical areas ("MSAs") designated by CMS. (However, IPPS hospitals are excluded from participating in the EPMs for EPM anchor MS-DRGs that are included in BPCI model episodes in which the hospital participates.) Table 2 lists the 98 designated MSAs.

Furthermore, the rule creates a Cardiac Rehabilitation Incentive Payment Program ("CR Incentive Payment Program") for EPM and Medicare Fee-for-Service Participants. Participation is required for all IPPS hospitals that participate in the AMI and CABG EPMs and are located in the MSAs listed in Table 53. In addition, participation is required for all IPPS hospitals that do not participate in the AMI and CABG EPMs, but which would otherwise qualify for the EPMs, and are located in the MSAs listed in Table 54.

The AMI and CABG EPMs, and the CR Incentive Payment Program, will be in effect for five performance years from July 1, 2017 through December 31, 2021.

THE ORTHOPEDIC-RELATED EPM

The rule also establishes an EPM for episodes of care surrounding surgical hip/femur fracture treatment ("SHFFT"). The EPM is mandatory for all IPPS hospitals located in any of the MSAs where the Comprehensive Joint Replacement ("CJR") model is currently established. The rule also makes several amendments to the regulations governing the CJR model. The SHFFT EPM will also be in effect for five performance years from July 1, 2017 through December 31, 2021.

ADVANCED APM STATUS FOR THE EPMS

An EPM may be considered an Advanced APM under MACRA if certain criteria are satisfied. Generally, hospitals will incur downside risk (i.e., be required to make repayments to CMS for excessive costs) for EPM episodes ending in performance years 3 through 5 (performance years 3 through 5 are calendar years 2019, 2020, and 2021, respectively). However, hospitals may voluntarily elect to assume downside risk beginning with EPM episodes ending in performance year 2 (i.e., calendar year 2018). When a hospital incurs downside risk under an EPM, and when it uses CEHRT for purposes of the EPM in accordance with the definition of CEHRT under the MACRA regulations, the EPM, in regard to the hospital, will be deemed to be an Advanced APM, and certain health care providers with financial arrangements with the hospital may qualify as "Qualifying APM Participants" or "QPs" under MACRA.

OVERVIEW OF PAYMENTS UNDER THE EPMS

An "EPM episode of care" is defined as certain specified Medicare Part A and B items and services (including, but not limited to, physician services, inpatient and outpatient hospital services, skilled nursing facility services, outpatient therapy services, home health agency services, DME and Part B drugs and biologicals) furnished to Medicare fee-for-service beneficiaries discharged with a diagnosis grouped under certain MS-DRGs specified for, as applicable, the AMI, CABG or SHFFT EPMs. An EPM episode of care begins with a beneficiary's "anchor hospitalization" and includes all related care within 90 days of discharge.

For each performance year, CMS will calculate for each anchor hospital the total amount of Medicare payments for the applicable EPM episodes of care attributed to the hospital for the year. CMS will then reconcile that amount against the amount Medicare would have paid for those same episodes of care based on a "quality-adjusted target price." The quality-adjusted target price is based on a combination of historical payment data related to prior episodes of care attributed to the hospital and regional historical payment data (but, regional historical performance data will be used exclusively for performance years 4 and 5.) The quality-adjusted target price is calculated using this historical data with a further adjustment based on the hospital's scores on certain quality measures. If the total amount of actual Medicare payments for the EPM episodes of care during the performance year is less than the total amount that Medicare would have paid based on

the quality-adjusted target price, Medicare pays the difference to the anchor hospital (referred to as a "reconciliation payment"), subject to certain limitations. Conversely, beginning with EPM episodes ending in performance year 2 (for hospitals that elect early downside risk) or beginning with EPM episodes ending in performance year 3 (for hospitals that do not elect early downside risk), if the total amount of actual Medicare payments for the episodes of care during a performance year is greater than the total amount that Medicare would have paid based on the quality-adjusted target price, the anchor hospital pays the difference to Medicare (referred to as "repayment"), subject to certain limitations.

Also with regard to each EPM, CMS will financially incentivize hospitals to engage in care redesign efforts with other health care providers ("EPM collaborators") involved in EPM episodes of care. These EPM collaborators may include a variety of health care providers, including other hospitals (as well as critical access hospitals) and Medicare Shared Savings ACOs. Anchor hospitals may structure permissible financial arrangements with EPM collaborators involving both "gainsharing payments" (i.e., payments from the hospital to one or more EPM collaborators based upon reconciliation payments received by the hospital and/or internal cost savings derived from care redesign activities) and "alignment payments" (i.e., payment from an EPM collaborator to the hospital for purposes of sharing the hospital's responsibility to make a repayment to Medicare).

No waivers of any fraud and abuse authorities were issued in the rule. However, CMS did not rule out the possibility that OIG would issue waivers at a later date.

If you have any questions, or would like additional information about this topic, please contact Tim Kennedy at (317) 977-1436 or tkennedy@hallrender.com or your regular Hall Render attorney.

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