FINAL RULE: MEDICARE PROGRAM; ADVANCING CARE COORDINATION THROUGH EPISODE PAYMENT MODELS (EPMs); CARDIAC REHABILITATION INCENTIVE PAYMENT MODEL; AND CHANGES TO THE COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL (CJR) [CMS-5519-F]

SUMMARY

Note: This comprehensive final rule summary is broken down into three sections. Following is the first section on the final rule implementing three new Episode Payment Models (EPMs). The two other sections of this summary pertain to the Comprehensive Care for Joint Replacement (CJR) Model, and the Cardiac Rehabilitation (CR) Incentive Payment Model. These sections can also be accessed by clicking on their titles found in the table of contents below.

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I. & II. Executive Summary and Background

In this final rule, CMS modifies the ongoing CJR model and implements three new episode payment models (EPMs). The models address care of acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment (SHFFT). The rule also implements the Cardiac Rehabilitation Incentive Payment Model (CR), designed to complement the AMI and CABG EPMs. Participants for all four models (AMI, CABG, SHFFT, and CR) are Inpatient Prospective Payment System (IPPS) acute care hospitals in selected geographic areas and participation is mandatory. Under the three EPMs, inpatient and 90-day post-discharge payments will be retrospectively bundled, and quality-adjusted comparison of actual to target expenditures for each EPM hospital will result in reconciliation payments (from CMS to participants) or repayments (from participants to CMS). CR model hospitals will receive add-on payments for CR and intensive cardiac rehabilitation (ICR) services during follow-up care of AMI and CABG patients. CR model incentive payments will be made to a subset of AMI and CABG participants and to a matched group of Inpatient Prospective Payment System (IPPS) hospitals not chosen as EPM participants. The rule also finalizes tracks within the CJR and the EPMs that allow the CJR, AMI, CABG, and SHFFT models to meet requirements to be Advanced Alternative Payment Models (APMs)\(^1\), as established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)\(^2\) and interpreted by CMS in the Quality Payment Program (QPP) final rule with comment.\(^3\)

Highlights of the final rule include:

- Episodes remain defined by specific Medicare Severity-Diagnosis Related Groups (MS-DRGs), extend through 90 days after discharge from the initial hospitalization, and include all related Part A and Part B services.
- EPM participation is mandatory (with very limited exceptions) for IPPS acute care hospitals located in Metropolitan Statistical Areas (MSAs) chosen by random sampling.
- CR model participation is mandatory for a prospectively-defined subset of AMI or CABG model hospitals and for a matched control group that excludes AMI and CABG model participants. CR payments are based upon the number of CR sessions attended.
- The first EPM performance year starts July 1, 2017 and the EPMs run through 2020. The beginning of downside risk is delayed until performance year (PY) 3 (January 1, 2019).
- AMI episode initiation and attribution for inpatient-to-inpatient (i-i) transfers are simplified, so that a single episode starts with the transfer (receiving) hospital admission.
- Exclusion from the EPMs is extended beyond the Next Generation ACO and the Comprehensive End-Stage Renal Disease (ESRD) Care models to beneficiaries prospectively assigned to MSSP Track 3.
- Tracks including Certified Electronic Health Record Technology (CEHRT) usage requirements and attestation are incorporated into the EPMs and CJR models (“Track 1”) to allow these models to meet criteria to become Advanced APMs.
- A quality measure is added to the CABG model for voluntary reporting.

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\(^1\) As of this summary, the CMS Comprehensive List of APMs has not been updated to reflect Track 1 CJR and EPMs. [https://qpp.cms.gov/education](https://qpp.cms.gov/education)
\(^2\) Pub.L. #114-10, April 16, 2015
\(^3\) The Quality Payment Program final rule with comment was issued November 4, 2016 (81 FR 77008-77831).
ACOs, critical access hospitals (CAHs), nonphysician practitioner groups and therapist groups are added as EPM and CJR collaborators.

Waivers are finalized related to telehealth services, home nursing visits, the qualifying inpatient stay prior to Skilled Nursing Facility admission, and eligible CR services providers. Fraud and abuse regulations are not changed at this time.4

III. Episode Payment Models – Section I

A. Selection of Episodes, Advanced APM Considerations, and Future Directions

1. Selection of Episodes for Episode Payment Models (EPMs) in this Rulemaking

a. Overview

CMS finalizes its proposals to test simultaneously three new mandatory, bundled payment episode models for care related to AMI, CABG, SHFFT model, excluding hip arthroplasty. CMS makes certain modifications to its proposals, as discussed in more detail below.

b. SHFFT Model

The SHFFT model was selected for testing as a complement to the CJR model. Together the models allow a single set of hospitals to implement bundled care episodes for all hip fracture surgical treatment options (arthroplasty and fixation). Historical SHFFT episodes5 demonstrate high spending for readmissions and high post-acute care usage along with significant mortality.6

c. AMI and CABG models

Together, in a single set of hospitals, the AMI and CABG models address medical and revascularization treatments (percutaneous coronary intervention {PCI}, and CABG) for acute myocardial infarctions. The CABG model examines care when the same intervention is applied in clinical settings that are importantly different, with and without acute infarction. The AMI and CABG models both trigger a need for long-term beneficiary care plans for coronary artery disease (CAD), and the CR Incentive Payment Model can support those care plans.

CMS finalizes proceeding with the AMI and CABG models though with multiple modifications that are detailed in subsequent sections of this rule (e.g., simplified AMI transfer algorithms, delay of downside risk assumption).

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4 The announcement of this final rule states that CMS and the HHS Office of the Inspector General (OIG) will jointly issue waivers of certain fraud and abuse laws for purposes of testing these models. The notice will be published on the CMS and OIG websites. See https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

5 Historical episodes for AMI, CABG, and SHFFT models were constructed by CMS from Part A and Part B claims data for 2012-2014.

6 Death rates associated with hip fracture are 5-10 percent after one month and nearly 33 percent at one year.
2. **Advanced APM Considerations**

   **a. Overview for the EPMs**

In the EPM proposed rule\(^7\), CMS outlined “Track 1” in each of the AMI, CABG, and SHFFT EPMs. The proposed Track 1 was designed to satisfy the Advanced APM criteria and required that the EPM participant hospital attest to CEHRT use. (A parallel Track 2 in each model did not require CEHRT attestation, thereby not satisfying Advanced APM criteria.) In tandem with Track 1, CMS proposed a mechanism by which EPM participant hospitals could provide sufficient information to CMS about their Track 1 eligible clinician collaborators to allow CMS to make individual clinician QP status determinations annually for them (Affiliated Practitioner Lists).

In the QPP final rule\(^8\), CMS modified and finalized the Advanced APM criteria, including changes to the nominal risk standard (eliminating minimal loss and marginal risk requirements, retaining but lowering the total risk, and introducing a revenue-based risk standard). CMS also modified the QP status determination process, retaining the use of Affiliated Practitioner Lists while making QP determinations three times during each QPP performance year.

In the current EPM final rule, CMS adopts provisions to maintain alignment of Track 1 EPMs with the QPP final rule’s Advanced APM criteria (changes are specifically discussed in the next section). CMS reprises at length the above sequence of rules and their evolving Advanced APM provisions.

   **b. EPM Participant Tracks**

CMS included CEHRT use (as defined in the Act) and attestation to CEHRT usage by EPM participants as elements of the proposed Track 1. Before the start of PY 2, EPM participants would choose whether to use and attest to CEHRT (Track 1) or not (Track 2). Track 2 participants will also not be considered a “MIPS APM.” CMS also declined a suggestion to reverse the EPM track numbering to avoid confusion with existing MSSP tracks, because CMS always includes the program name with the track number (e.g., EPM Track 1 and MSSP Track 3).

CMS finalizes its proposal for PYs 3-5 with modifications at §512.120(a); each EPM participant hospital will choose whether or not to use and attest to usage of CEHRT to document and communicate clinical care with patients and other healthcare professionals. No attestation is required if CEHRT use is not chosen. CMS adds that the CEHRT use and attestation choice will similarly apply in PY 2 for hospitals electing to assume downside risk in that year. (Voluntary downside risk assumption for PY 2 is discussed later in Section III.D.1.c.)

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\(^7\) Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model 81 FR (50798-51040)

\(^8\) Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models 81 FR 77008-77831
c. Clinician Financial Arrangements Lists under the EPMs

Eligible clinicians who enter into financial arrangements that require them to support the cost or quality goals of their EPM Track 1 participant hospital may become Qualifying APM Participants under the QPP. To select those clinicians for QP determinations, CMS proposed that EPM Track 1 hospitals submit lists of practitioners with whom they have relevant financial arrangements. Lists would include clinician identifiers (e.g., TIN/NPI), arrangement period (start and end dates), and arrangement type (e.g., collaboration agent). An EPM participant hospital without any such practitioners would be required to attest to having none to report. CMS would utilize the financial arrangements information to construct and maintain EPM Affiliated Practitioner lists for use in QP determinations. Financial arrangements list submission would be required no more often than quarterly.9

CMS clarifies that some but not all financial arrangements may involve sharing by clinicians of a hospital’s risk (e.g., sharing arrangement versus distribution arrangement). CMS finalizes plans for construction of EPM Affiliated Practitioner Lists from Track 1 clinician financial arrangements lists at §512.120(b).

To correct a proposed rule oversight (and for consistency with the QPP and EPM final rules), CMS also is revising the eligible clinician categories to be included on financial arrangements lists and clarifying the information to be reported. Clinician financial arrangements lists submitted to CMS by EPM Track 1 hospitals must include information on all physicians, nonphysician practitioners, and therapists with financial arrangements under the EPM and, if applicable, identifying information for the related parties (e.g., ACO, practitioner group practice) having sharing arrangements, distribution arrangements, and downstream distribution arrangements under the EPM. (The spectrum of EPM collaborators is described and defined in section III.I.3., and the various financial arrangements are discussed in section III.I.4.)

d. Documentation Requirements.

CMS proposed that EPM Track 1 hospitals must maintain documentation of their CEHRT attestations and clinician financial arrangements lists, as well as retain the required documents and provide access to them to facilitate monitoring and audits. CMS finalizes this proposal without change.

3. Future Directions for Episode Payment Models

a. Refinements to the BPCI Initiative Models

BPCI is set to expire in 2018. In the proposed rule, CMS noted that the Innovation Center was planning to build upon BPCI by implementing a new voluntary payment bundle model whose design would meet Advanced APM criteria.

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9 This submission interval remains appropriate, as under the QPP final rule CMS will make QP determinations as three “snapshots” (March 31, June 30, August 31). An EPM may voluntarily submit lists to CMS more often.
B. Definition of the Episode Initiator and Selected Geographic Areas

1. Background

CMS finalizes that AMI, CABG, and SHFFT episodes will be initiated only at IPPS acute care hospitals and will begin with hospital admissions for specified MS-DRGs. CMS also finalizes the exclusion of Maryland and Vermont hospitals from EPM participation.

2. Financial Responsibility for Episode of Care

CMS finalizes, without modification, that hospitals will be the only episode originators and that the hospital to whom an episode is attributed will be financially responsible for that episode.

3. Geographic Unit of Selection and Exclusion of Selected Hospitals

CMS finalizes without modification the proposal to implement the SHFFT EPM in MSAs selected for CJR and to implement the AMI and CABG models together in a randomly selected set of MSAs (without regard to overlap with SHFFT/CJR MSAs). CMS also states that it will be undertaking a review of risk-adjustment approaches in time for proposing related changes through notice and comment rulemaking for fiscal year (FY) 2019 (before mandatory assumption of downside risk begins in PY 3). For a list of selected markets, visit the CMS web page at: https://innovation.cms.gov/initiatives/epm.

4. Overview and Options for Geographic Area Selection for AMI and CABG Episodes

CMS finalizes its proposal to implement the AMI and CABG models together in the same MSAs (without regard to SHFFT/CJR status). CMS expects hospitals will achieve some economies of scale across the two models and notes that treatment decisions might be inappropriately influenced were hospitals assigned only to the AMI or CABG model.

CMS also finalizes its proposal to use hospitals’ CMS Certification Numbers (CCNs) to determine their locations, so that the address used for cardiac EPM MSA selection would be the same for all hospitals under a single CCN (i.e., the CCN’s physical address). CMS intends to maintain the same cohort of hospitals throughout the 5-year test of the models.

C. Episode Definitions for the EPMs

1. Clinical Dimensions of AMI, CABG, and SHFFT Model Episodes

a. Definition of the Clinical Conditions Included in AMI, CABG, and SHFFT Model Episodes

   (1) AMI (Medical Management and PCI) Model

CMS finalizes without modification the following proposals defining the AMI model:
• Including in the AMI model those eligible beneficiaries discharged under an AMI MS-DRG (280-282) under the IPPS (see §512.100(c)(1))
  o this patient cohort represents medical therapy without revascularization.
• Including in the AMI model those eligible beneficiaries discharged under a PCI MS-DRG (246-251) along with an International Classification of Diseases-10-Clinical Modification (ICD-10-CM) AMI diagnosis code\textsuperscript{10} in the primary or secondary position on the IPPS anchor hospitalization claim (see §512.100(c)(1))
  o this patient cohort represents medical therapy.
• Defining AMI historical episodes for beneficiaries discharged under PCI MS-DRGs (246-251) under the IPPS as those that do not include intracardiac procedures\textsuperscript{11} (see §512.100(d)(4)).
• Establishing the sub-regulatory process to update the AMI ICD-10-CM code list and to address related issues raised by the public\textsuperscript{12} (see §§512.100(d)(1)-(3)).

(2) CABG Model

CMS finalizes without modification the proposal at §512.100(c)(2) to define the CABG model as including those eligible beneficiaries discharged under a CABG MS-DRG (231-236) under the IPPS.

(3) SHFFT (Excludes Lower Extremity Joint Replacement) Model

CMS finalizes without modification the proposal at §512.100(c)(3) to define the SHFFT model as including those eligible beneficiaries discharged under a SHFFT MS-DRG (480-482) under the IPPS.

b. **Definition of the Related Services Included in EPM Episodes**

CMS takes a variety of actions to address the multiple proposals outlined in the proposed rule for defining “related services” for inclusion in the EPM episodes (AMI, CABG, and SHFFT).\textsuperscript{13}

First, CMS finalizes without modification that the following services, (if they are paid under Medicare Parts A and B) are included in the calculation of episode expenditures:
- Physician
- inpatient hospital
- inpatient psychiatric facility (IPF)
- long-term care hospital

\textsuperscript{10} Finalized AMI diagnosis codes for this model are listed in Table 6; this table is provided in section III.C.4.a.(3). of the final rule.
\textsuperscript{11} Finalized intracardiac ICD-9-CM codes are listed in Table 4; this table is provided in section III.C.a.(1). of the final rule.
\textsuperscript{12} CMS has reviewed the FY 2017 ICD-10-CM diagnosis code changes; none pertain to AMI reporting so CMS will not initiate the sub-regulatory process at this time.
\textsuperscript{13} Medicare spending for related items and services is included in setting historical EPM-episode-benchmark prices and in calculating actual EPM episode payments for comparison against the quality-adjusted target price during reconciliation. Spending for unrelated items and services is not included in either the historical episode price setting or the actual episode payment calculations.
- (LTCH),
- inpatient rehabilitation facility (IRF)
- SNF
- home health agency (HHA)
- hospital outpatient
- independent outpatient therapy
- clinical laboratory
- durable medical equipment (DME)
- Part B drugs
- hospice

Second, CMS finalizes, without modification the following exclusions:

- Hospital readmissions for MS-DRGs that group to the categories of oncology; trauma, medical; chronic disease, surgical; and acute disease, surgical.
- Part B items and services for acute disease diagnoses unrelated to a condition resulting from or likely affected by care during the EPM episode and for certain chronic disease diagnoses\(^{14}\) (“unrelated services”).
- Hemophilia clotting factors, IPPS new technology add-on payments, and Outpatient Prospective Payment System (OPPS) transitional pass-through payments.

Relatedly, CMS modifies then finalizes the exclusions for readmissions and for Part B services furnished within the EPM 90-day post-discharge period plus Part B-covered DME claims during anchor hospitalizations. MS-DRGs 326-328 (upper gastrointestinal procedures) are placed on the AMI exclusion list and MS-DRGs 266-267 (endovascular cardiac valve replacement) are placed on the AMI and CABG exclusion lists.

CMS also declined suggestions to substitute Medicaid/All-Payer cardiac bundled initiatives ongoing in some states for Medicare AMI and CABG bundles; CMS regards the state and CMS bundled payment models as complementary efforts that will yield overlapping but distinct data.

Next, CMS is not finalizing the proposed AMI model inpatient-to-inpatient transfer episode initiation and attribution policy, so that the terms “chained anchor hospitalization” and “price MS-DRG will not be used in the final AMI episode definition and pricing policies. As a result, the applicable EPM related services exclusion list is applied to each EPM episode based upon the MS-DRG that anchors the EPM episode. The final EPM exclusion lists (using ICD-9-CM and ICD-10-CM diagnostic codes plus MS-DRGs as of FY 2016) are available on the CMS website at [https://innovation.cms.gov/initiatives/epm/](https://innovation.cms.gov/initiatives/epm/).

Finally, will update the exclusion lists by sub-regulatory guidance at least annually to include ICD-10-CM and MS-DRG changes as well as to address issues raised by the public.

\(^{14}\) Specified by CMS on a diagnosis-by diagnosis basis, depending upon whether the condition likely was affected by EPM episode care or likely required substantial services to be provided during the EPM episode. Similar “unrelated” diagnosis lists were developed for use in BPCI and are adapted by CMS for use in the EPMs.
2. EPM Episodes
   
   a. **Beneficiary Care Inclusion Criteria and Beginning EPM Episodes**

   (1) General Beneficiary Care Inclusion Criteria

   CMS modifies the general beneficiary inclusion criteria by removing all references to chained anchor hospitalizations and by adding the exclusion of beneficiaries prospectively assigned to an ACO in MSSP Track 3. The following finalized inclusion criteria, all of which must be met on admission to the anchor hospitalization, define those beneficiaries whose care is included in the EPM:
   
   - Enrolled in Medicare Parts A and Part B.
   - Eligibility for Medicare is not on the basis of ESRD.
   - Not enrolled in any managed care plan (e.g., Medicare Advantage).
   - Not covered under a United Mine Workers of America health plan.
   - Have Medicare as their primary payer.
   - Not prospectively assigned to a Next Generation ACO, an ESRD Care model ACO incorporating downside risk, or a MSSP Track 3 ACO.
   - Not under the care of a physician belonging to a physician group practice (PGP) that initiates BPCI Model 2 episodes at the EPM participant hospital for what would be the anchor MS-DRG under the EPM.
   - Not already in any BPCI model episode.
   - Not already in an AMI, CABG, SHFFT, or CJR episode whose definition does not exclude what would be the anchor MS-DRG under the applicable EPM.

   CMS notes that most commenters advocated simplified attribution policies for AMI episodes involving transfers (adopted in the final rule, see below), even though such simplification will increase the number of episodes in which beneficiaries are treated outside their home areas. CMS clarifies that patients who buy in to Medicare Parts A and B and who meet all other beneficiary inclusion criteria are included in the EPMs.

   (2) Beginning AMI Episodes

   CMS finalizes without modification that AMI episodes begin when an EPM-eligible Medicare beneficiary is admitted to an IPPS hospital for any of the MS-DRGs listed below. The assigned MS-DRG serves as the “anchor MS-DRG” for the episode.
   
   - AMI MS-DRGs 280-282, and
   - PCI MS-DRGs 246-251 whenever the IPPS claim includes (as principal or primary) an ICD-10-CM AMI diagnosis specified in Table 6 (the table appears at the end of section III.C.4.a.(2) of the final rule; the table also includes the crosswalks from ICD-9-CM AMI diagnoses used to construct historical AMI episodes to ICD-10 codes).

   Commenters asked whether beneficiaries with uncomplicated AMIs having short hospital stays that are classified as outpatients (two-midnight rule) would nevertheless initiate AMI episodes.
CMS states that the AMI model does not change Medicare’s current patient classification policies (i.e., such beneficiaries would not initiate AMI episodes). CMS clarifies model assignment when CABG is performed in the context of AMI. Patients undergoing CABG during the anchor AMI admission will initiate CABG episodes. Patients who initiate AMI episodes and are subsequently discharged but are readmitted for CABG during the AMI 90-day post-discharge period would remain under AMI episodes. (In both scenarios pricing adjustments will be applied (see final rule sections III.D.4.(b.).

(3) Beginning CABG Episodes

CMS finalizes without modification that a CABG episode begins when an EPM-eligible beneficiary is admitted to a participant hospital for coronary artery bypass grafting paid under a CABG MS-DRG (the specific MS-DRG serves as the episode’s “anchor MS-DRG”). The CABG MS-DRGs are defined as MS-DRGs 231-236.

(4) Beginning SHFFT Episodes

CMS finalizes without modification that a SHFFT episode begins when an EPM-eligible beneficiary is admitted to a participant hospital for hip/femur fracture fixation paid under a SHFFT MS-DRG (the specific MS-DRG serves as the episode’s “anchor MS-DRG”). The SHFFT MS-DRGs are defined as MS-DRGs 480-482.

(5) Special Policies for Hospital Transfers of Beneficiaries with AMI

Cardiac care resources have a heterogeneous geographic distribution; cardiovascular intensive care (CVICU) and revascularization (PCI and/or CABG) services are not available at many hospitals, particularly small and rural. CMS data analysis found that about 20 percent of patients presenting acutely with infarctions were transferred from one hospital to a second, with transfers occurring both before and after inpatient admissions to the first hospital. To account for the asymmetric resource distribution while incentivizing collaboration and AMI care redesign, CMS proposed a multifaceted policy for attribution to the sending or receiving hospitals of quality and financial responsibility.

The proposed attribution policy, particularly the inpatient-to-inpatient (i-i) transfer component, evoked many comments and considerable opposition. With modifications, CMS finalizes a multipart decision addressing AMI beneficiary hospital transfers. Elements of the final decision are described below.

- CMS does not finalize the proposed attribution of AMI episodes to the initial treating hospital for an inpatient to inpatient (i-i) transfer occurring during the anchor hospitalization.
- An AMI episode initiated at the initial (AMI participant) treating hospital will be canceled when a subsequent i-i transfer occurs. (An AMI or CABG episode may then be initiated at the transfer (receiving) hospital if the transfer hospital is an AMI model participant; transfer to a nonparticipant removes the beneficiary’s care from being attributed to any AMI or CABG episode.)
The terms “chained anchor hospitalization” and “price MS-DRG” are not used in final episode definition and pricing policies for the AMI model; definition and pricing are solely determined by the anchor MS-DRG for each AMI or CABG model episode.

The final initiation and attribution policies for AMI and CABG episodes (whether no transfer, or an i-i, or an outpatient-to-inpatient {o-i} transfer\(^{15}\) occurs) are summarized in Table 8. Table 8 is reprinted below from the final rule, with the addition that sections with changes from the proposed rule are identified in **bold** font.

**TABLE 8: FINAL INITIATION AND ATTRIBUTION OF AMI AND CABG EPISODES THAT INVOLVE NO TRANSFER, OR OUTPATIENT-TO-INPATIENT TRANSFERS AT THE BEGINNING OF AMI CARE**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Final Episode Initiation and Attribution Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No transfer (participant): Beneficiary admitted to an initial treating hospital that is a participant in the AMI or CABG model for an AMI MS-DRG, PCI MS-DRG with AMI ICD-CM diagnosis code, or CABG MS-DRG.</td>
<td>Initiate AMI or CABG model episode based on anchor hospitalization MS-DRG. Attribute episode to the initial treating hospital.</td>
</tr>
<tr>
<td>No transfer (nonparticipant): Beneficiary admitted to an initial treating hospital that is not a participant in the AMI or CABG model for an AMI MS-DRG, PCI MS-DRG with AMI ICD-CM diagnosis code, or CABG MS-DRG.</td>
<td>No AMI or CABG model episode is initiated.</td>
</tr>
<tr>
<td>Inpatient-to-inpatient transfer (nonparticipant to participant): Beneficiary admitted to an initial treating hospital that is not an AMI or CABG model participant and later transferred to an i-i transfer hospital that is an AMI or CABG model participant for an AMI MS-DRG, PCI MS-DRG with AMI ICD-CM diagnosis code, or CABG MS-DRG.</td>
<td>Initiate AMI or CABG model episode based on the MS-DRG at i-i transfer hospital. Attribute episode to the i-i transfer hospital.</td>
</tr>
<tr>
<td>Inpatient-to-inpatient transfer (participant to nonparticipant): Beneficiary admitted to an initial treating hospital that is an AMI or CABG model participant for an AMI MS-DRG, PCI MS-DRG with AMI ICD-CM diagnosis code and later transferred to an i-i transfer hospital for an AMI, PCI, or CABG MS-DRG, where the i-i transfer hospital is not an AMI or CABG model participant.</td>
<td>Cancel AMI episode. No other AMI or CABG episode is initiated.</td>
</tr>
</tbody>
</table>

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\(^{15}\) An outpatient-to-inpatient transfer occurs when a patient presents to the initial hospital but is transferred to the receiving hospital without inpatient admission to the initial hospital. Evaluation plus treatment to stabilize the patient typically occur in the initial hospital’s emergency department prior to the transfer.
### Scenario

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Final Episode Initiation and Attribution Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient-to-inpatient transfer (participant to participant): Beneficiary admitted to an initial treating hospital that is an AMI or CABG model participant for an AMI MS-DRG, PCI MS-DRG with AMI ICD-CM diagnosis code later transferred to an i-i transfer hospital for an AMI, PCI, or CABG MS-DRG, where the i-i transfer hospital is an AMI or CABG model participant.</td>
<td>Cancel AMI episode at the initial treating hospital. Attribute episode to the i-i transfer hospital.</td>
</tr>
<tr>
<td>Outpatient-to-inpatient transfer (nonparticipant to participant to participant): Beneficiary transferred without admission from the initial treating hospital, regardless of whether the initial treating hospital is an AMI or CABG model participant, to a o-i transfer hospital that is an AMI or CABG model participant and is discharged from the o-i transfer hospital for an AMI MS-DRG, PCI MS-DRG with AMI ICD-CM diagnosis code, or CABG MS-DRG.</td>
<td>Initiate AMI or CABG model episode based on anchor hospitalization MS-DRG at o-i transfer hospital. Attribute episode to the o-i transfer hospital.</td>
</tr>
<tr>
<td>Outpatient-to-inpatient transfer (participant to nonparticipant): Beneficiary transferred without admission from the initial treating hospital that is an AMI or CABG participant to an o-i transfer hospital that is not an AMI or CABG model participant.</td>
<td>No AMI or CABG model episode is initiated.</td>
</tr>
</tbody>
</table>

**b. Middle of EPM Episodes (includes episode cancellation)**

This section of the proposed rule applies to all three EPMs (AMI, CABG, and SHFFT). CMS modifies the proposed policy for EPM cancellation to cancel any EPM episode during which the beneficiary dies during any part of the episode (as proposed, only death during the anchor hospitalization canceled the episode). CMS then finalizes the modified proposal so that EPM episodes are canceled if the beneficiary meets any of the following criteria:

- Ceases to meet any of the general beneficiary inclusion criteria (except those related to inclusion in other payment models).
- Dies (during the anchor hospitalization or the post-discharge 90-day period).
- Initiates any BPCI model episode.

Multiple commenters strongly encouraged CMS to inform hospitals in a timely manner whenever an episode is canceled regardless of reason. Cancellation has multiple potentially significant impacts on hospital tasks such as performing real-time running tallies of EPM episode spending; compliance with beneficiary notification requirements; provision of beneficiary engagement incentives; and determination of beneficiary eligibility for EPM-related Medicare program waivers. CMS acknowledges the importance of timely communication and will explore

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16 Includes Next Generation ACO, ESRD comprehensive care ACOs with downside risk, and MSSP Track 3 ACOs
the feasibility of adding an indicator for cancellation with the beneficiary-level claims data or summary beneficiary claims reports that will be provided to hospitals as frequently as quarterly.

c. End of EPM Episodes

(1) AMI and CABG models & (2) SHFFT model

For the AMI, CABG, and SHFFT models, CMS finalizes that each episode ends on the 90th day after the date of discharge (from the anchor hospitalization), with the day of discharge itself being counted as the first day in the 90-day post-discharge period.

D. Methodology for Setting EPM Episode Prices and Paying EPM Participants in the AMI, CABG, and SHFFT Models

1. Background

a. Overview

Section III.D. of the rule describes final policies with respect to the methodology for setting episode prices and paying participants in the AMI, CABG, and SHFFT models. Given the general similarity between the design of the CJR model and these EPMs, CMS adopts the general payment and pricing parameters used under the CJR model taking into account necessary modifications related to the different clinical conditions. In this section, CMS describes the following proposals:

- PY, retrospective episode payments, and two-sided risk EPMs.
- Adjustments to actual EPM-episode payments and to historical episode payments used to set episode prices.
- EPM episode price-setting methodologies.
- Process for reconciliation.
- Adjustments for overlaps with other Innovation Center models and CMS programs.
- Limits or adjustments to EPM participants' financial responsibility.

b. Key Terms for EPM Episode Pricing and Payment

For purposes of understanding the technical discussion, CMS provides these definitions:

- Anchor hospitalization - hospitalization that initiates an EPM episode and has no subsequent inpatient-to-inpatient transfer chained anchor hospitalization.
- Chained anchor hospitalization - an anchor hospitalization that initiates an AMI model episode and has at least one subsequent inpatient-to-inpatient transfer.17
- Anchor MS-DRG - MS-DRG assigned to the first hospitalization discharge, which initiates an EPM episode.

17 CMS removes chained anchor hospitalization from its final regulations due to change made in the final rule. Related, CMS changes “Price MS-DRGs” to “Anchor MS-DRGs”.

• Episode benchmark price - dollar amount assigned to EPM episodes based on historical EPM-episode data.
• CABG readmission AMI model episode benchmark price - episode benchmark price assigned to certain AMI model episodes with anchor MS-DRG 280-282 or 246-251 and with a readmission for MS-DRG 231-236.
• Quality-adjusted target price - dollar amount assigned to EPM episodes as the result of reducing the episode benchmark price by the EPM participant's effective discount factor based on the EPM participant's quality performance.
• Excess EPM-episode spending - dollar amount corresponding to the amount by which actual EPM-episode payments for all EPM episodes attributed to an EPM participant exceed the quality-adjusted target prices for the same EPM episodes.

2. Performance Years, Retrospective Episode Payment, and Two-sided Risk EPMs

a. Performance Period

CMS finalizes, without modification, its proposal for 5 PYs beginning with EPM episodes that start on or after July 1, 2017 (displayed in Table 10, reproduced below). Note that PY 1 is shorter than the other PYs with respect to the length of time over which an episode could occur. PYs 2 through 5 could include episodes that began in a prior year.

<table>
<thead>
<tr>
<th>Performance Year (PY)</th>
<th>Calendar Year</th>
<th>EPM Episodes Included in Performance Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2017</td>
<td>EPM episodes that start on or after July 1, 2017 and end on or before December 31, 2017</td>
</tr>
<tr>
<td>2</td>
<td>2018</td>
<td>EPM episodes that end between January 1, 2018 and December 31, 2018, inclusive</td>
</tr>
<tr>
<td>3</td>
<td>2019</td>
<td>EPM episodes that end between January 1, 2019 and December 31, 2019, inclusive</td>
</tr>
<tr>
<td>4</td>
<td>2020</td>
<td>EPM episodes that end between January 1, 2020 and December 31, 2020, inclusive</td>
</tr>
<tr>
<td>5</td>
<td>2021</td>
<td>EPM episodes that end between January 1, 2021 and December 31, 2021, inclusive</td>
</tr>
</tbody>
</table>

A large number of commenters requested that CMS delay implementation of the models. In response, CMS states that while it is not delaying implementation of these models, it is modifying its proposals to allow participants an additional 9 months of experience in the models without assuming financial risk—now participants are not required to assume downside risk until PY 3.

b. Retrospective Payment Methodology

Consistent with the CJR model, CMS finalizes its proposal to apply a retrospective payment methodology to the EPMs. All providers and suppliers caring for Medicare beneficiaries in EPM
episodes will continue to bill and be paid as usual under the applicable Medicare payment system throughout the PYs. After the completion of an EPM PY, CMS will group Medicare claims for services into episodes, aggregate payments, assess episode quality and actual payment performance against quality-adjusted target prices, and determine if Medicare will make a payment to the hospital (reconciliation payment) or if the hospital owes money to Medicare (resulting in Medicare repayment). CMS considered an alternative approach of paying for EPM episodes prospectively by paying one lump sum amount, but believed that such an option would be challenging to implement given the payment infrastructure changes needed for EPM participants and Medicare.

c. Two-sided Risk Model

CMS finalizes its proposal, with modification, to establish two-sided risk for hospitals participating in EPMs. Specifically, CMS delayed the requirement to assume downside risk by 9 months so that episodes ending on or after January 1, 2019 would assume downside risk. EPM participants meeting or exceeding quality performance thresholds and achieving cost efficiencies related to their quality-adjusted target prices will receive EPM-episode reconciliation payments for each of PYs 1 through 5.

Likewise, all EPM participants will be responsible for repaying Medicare when their actual EPM-episode payments exceed their quality-adjusted target prices beginning in PY 3 (episodes ending on or after January 1, 2019). CMS is allowing participants to voluntarily elect downside risk beginning in PY 2 (for episodes ending on or after January 1, 2018 with anchor discharges that occur on or after October 4, 2017).

Table 12 (reproduced from the final rule) shows the timing of the repayment responsibility, as well as the phase-in of the stop-loss limits and the discount percentages.

| TABLE 12: FINAL STOP-LOSS THRESHOLDS AND DISCOUNT PERCENTAGE RANGES FOR MEDICARE REPAYMENTS BY PY |
|--------------------------------------------------|---------|---------|---------|---------|
| **Downside Risk for All Participants— DR effective for episodes ending on or after 1/1/2019 (anchor discharges occurring on or after 10/4/2018)** |
| Stop-loss threshold | PY1 | PY2 | PY3 | PY4 | PY5 |
| Stop loss threshold for certain hospitals* | 5% | 10% | 20% |
| Discount percentage (range) for Repayment, Depending on Quality Category | 3% | 5% | 5% |
| Voluntary Downside Risk – DR effective for episodes ending on or after 1/1/2018 (anchor discharges occurring on or after 10/4/2017) |
| | 0.5%-2.0% | 0.5%-2.0% | 1.5%-3.0% |
### Adjustments to Actual EPM-Episode Payments and to Historical Episode Payments used to Set Episode Prices

**a. Overview**

CMS finalizes its proposals to make certain adjustments to Medicare Part A and Part B payments included in the EPM episode definition to:

1) account for special payment provisions under existing Medicare payment systems;
2) adjust payment for services that straddle episodes; and
3) adjust for high payment episodes.

CMS also will include an adjustment for reconciliation payments and Medicare repayments when updating EPM participant episode benchmark and quality-adjusted target prices. CMS discusses the adjustments for overlaps with other Innovation Center models and CMS programs in a separate section.

Each of these areas is discussed below.

**b. Special Payment Provisions**

Consistent with its approach under the CJR model, CMS finalizes its proposal to exclude the following special payment provisions in setting EPM-episode benchmark and quality-adjusted target prices and in calculating actual episode payments:

- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing (HVBP) Program
- Hospital-Acquired Condition (HAC) Reduction Program
- Hospital Inpatient Quality Reporting Program (IQR) and Outpatient Quality Reporting Program (OQR)
- Medicare Electronic Health Record (EHR) Incentive Program for IPPS and critical access hospitals (CAHs)
- Medicare Disproportionate Share Hospital (DSH) and Uncompensated Care
- Indirect Medical Education (IME)
- Low volume add-on payments
- New technology add-on payments
- Enhanced payments to sole community hospitals (SCHs) or Medicare-dependent hospitals (MDH) based on cost-based hospital-specific rates
- Quality programs affecting IRFs, SNFs, IPFs, HHAs, LTCHs, hospice facilities and ambulatory surgical centers (ASCs)
- Physician quality programs, including the Medicare EHR Incentive Program for Eligible Professionals, the Physician Quality Reporting System (PQRS), and the Physician Value-based Modifier Program
- All special add-on payments for IRFs (rural add-on, low-income percentage (LIP) payments, teaching program payments), HHAs (rural add-on), and SNFs (payments for treating beneficiaries with human immunodeficiency virus (HIV))

These adjustments will be excluded in calculating actual episode payments, setting episode target prices, comparing actual episode payments with target prices, and determining whether a reconciliation payment should be made to the hospital or funds should be repaid by the hospital.

To operationalize the exclusions, CMS will apply the CMS Price (Payment) Standardization Detailed Methodology, which is described on the QualityNet website at http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350. CMS will also adjust actual episode payments to account for the effects of sequestration.

CMS clarifies that IPPS capital payments will be included in EPM-episode calculations and goes on to say that including such payments affords participants an opportunity to achieve greater reconciliation payments.

c. Services that Straddle Episodes

CMS finalizes its proposal to apply the CJR model methodologies to prorate payments for post-discharge services when Medicare payment for services begin before the start of or continues beyond the end of an EPM episode that extends 90 days post-hospital discharge. Under the CJR model, CMS prorates payments so that they include only the portion of the payment that is included in the CJR model episode using separate approaches to prorate payments under each payment system. For example, under this approach, proration is based on the percentage of actual length of stay (in days) that falls within the episode window for stays involving non-IPPS inpatient hospitals (for example, CAH) and inpatient PAC providers (for example, SNF, IRF, LTCH, IPF) services.

d. High Payment Episodes

Consistent with its approach under CJR, CMS finalizes its proposal to apply a high-payment episode ceiling when calculating actual EPM-episode payments and when calculating historical EPM-episode payments used to set EPM-episode benchmark and quality-adjusted target prices. A high-payment episode would be an episode with payments 2 standard deviations or more above the mean calculated at the regional level. Consistent with its changes elsewhere, CMS is not finalizing its proposal to apply ceilings separately to the payments that occurred during and after the chained anchor hospitalization with respect to AMI model episodes with MS-DRG 231-
236. Instead, CMS will simply apply ceilings separately for each of these MS-DRGs at the regional level, consistent with its approach for other groupings.

CMS finalizes its proposal with the modification to not apply ceilings separately for chained anchor hospitalizations as CMS did not finalize its proposed AMI model inpatient-to-inpatient transfer attribution policy and will not use the term chained anchor hospitalization.

e. Treatment of Reconciliation Payments and Medicare Repayments

CMS finalizes its proposal to include both reconciliation payments and Medicare repayments when calculating historical EPM-episode payments to update EPM-episode benchmark and quality-adjusted target prices. CMS also modifies its policy for the CJR model to also include reconciliation payments and Medicare repayments when updating target prices in that model. CMS notes that, all else equal, including an EPM reconciliation payment will modestly increase the quality-adjusted target prices in PYs 3 through 5, whereas including a Medicare repayment would reduce the next PY’s quality-adjusted target price. Consistent with this logic, CMS also will include BPCI Net Payment Reconciliation Amounts in its calculations when updating EPM-episode benchmark and quality-adjusted target prices.

CMS notes that with respect to CABG model episodes, CMS will allocate EPM reconciliation payments and BPCI Net Reconciliation Payment Amounts proportionally to the anchor hospitalization and post-anchor hospitalization portions of CABG model historical episodes. CMS also will calculate the proportions based on regional average historical episode payments that occurred during the anchor hospitalization portion of CABG model episodes and regional average historical episode payments that occurred during the post-anchor hospitalization portion of CABG model episodes that were initiated during the 3 historical years.

4. Episode Price Setting Methodology

a. Overview

CMS finalizes its proposal to establish EPM-episode benchmark and quality-adjusted target prices for each EPM participant based on the following MS-DRGs and diagnoses included in the AMI, CABG, and SHFFT models.

1. AMI model
   - AMI MS-DRGs – MS-DRGs 280-282
   - PCI MS-DRGs, when the claim includes an AMI ICD-CM diagnosis code in the principal or secondary position on the inpatient claim and when the claim does not include an intracardiac ICD-CM procedure code in any position on the inpatient claim – MS-DRGs 246-251.

2. CABG model DRGs- MS-DRGs 231-236

3. SHFFT model DRGs- MS-DRGs 480-482
CMS will generally apply the CJR model methodology to set EPM-episode benchmark and quality-adjusted target prices, with the addition of some adjustments based on the specific clinical conditions and care patterns for EPM episodes.

The price-setting methodology incorporates the following features:

- Set different EPM benchmark and quality-adjusted target prices for EPM episodes based on the assigned anchor MS-DRG in one of the included MS-DRGs to account for patient and clinical variations that impact EPM participants' costs of providing care.
- Adjust EPM benchmark and quality-adjusted target prices for certain EPM episodes involving specific readmissions, or the presence of an AMI ICD-CM diagnosis code for CABG MS-DRGs.
- Use 3 years of historical Medicare FFS payment data grouped into EPM episodes. The specific set of 3 historical years would be updated every other PY.
- Apply Medicare payment system (for example, IPPS, OPPS, IRF PPS, SNF, Medicare Physician Fee Schedule (PFS)) updates to the historical EPM-episode data. Because different Medicare payment system updates become effective at two different times of the year, CMS would calculate one set of EPM-benchmark and quality-adjusted target prices for EPM episodes initiated between January 1 and September 30 and another set for EPM episodes initiated between October 1 and December 31.
- Blend together EPM-participant hospital-specific and regional historical EPM-episode payments, transitioning from primarily hospital-specific to completely regional pricing over the course of the 5 PYs. Regions are defined as each of the nine U.S. Census divisions.
- Normalize for hospital-specific wage-adjustment variations in Medicare payment systems when combining hospital-specific and regional historical EPM episodes.
- Pool together EPM episodes by groups of anchor MS-DRGs to allow a greater volume of historical cases and for more stable prices.
- Apply an effective discount factor on EPM-episode benchmark prices to serve as Medicare's portion of reduced expenditures from the EPM episode, with any remaining portion of reduced Medicare spending below the quality-adjusted target price potentially available as reconciliation payments to the EPM participant.

CMS also finalizes its proposal to calculate and communicate EPM-episode benchmark and quality-adjusted target prices to EPM participants prior to the performance period in which the prices apply (that is, prior to January 1, 2018, for prices covering EPM episodes that start between January 1, 2018, and September 30, 2018; prior to October 1, 2018, for prices covering EPM episodes that start between October 1, 2018, and December 31, 2018). CMS believes that by doing so, this would help EPM participants make infrastructure, care coordination and delivery, and financial refinements they may deem appropriate to prepare for the new episode target prices under the model.

b. **EPM-Episode Benchmark and Quality-Adjusted Target Price Features**

(1) Risk-Stratifying EPM-Episode Benchmark Prices based on MS-DRG and Diagnosis,
CMS finalizes its proposal to risk-stratify episodes based on adjustments to recognize the combination of MS-DRGs and pathways associated with an episode. CMS will generally apply the episode pricing methodology that was applied to the CJR model, referred to by CMS as the “standard EPM-episode benchmark price.” In addition, for each EPM participant, CMS will risk stratify and establish special EPM-episode benchmark prices for episodes in different pricing scenarios.¹⁸

Tables 14 through 16 of the final rule (consolidated and reproduced below) summarize the standard pricing methodologies and the adjustments (discussed in the next section) that will occur for AMI, CABG, and SHFFT model episodes.

**TABLES 14-16: EPM MODEL PRICING SCENARIOS**

<table>
<thead>
<tr>
<th>Table 14: AMI MODEL PRICING SCENARIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single hospital AMI MS-DRG or PCI MS-DRG (with AMI diagnosis)</td>
</tr>
<tr>
<td>An AMI MS-DRG or PCI MS-DRG (with AMI diagnosis) anchored episode with CABG readmission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 15: CABG MODEL PRICING SCENARIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single hospital CABG MS-DRG with AMI diagnosis</td>
</tr>
<tr>
<td>Single hospital CABG MS-DRG without AMI diagnosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 16: SHFFT MODEL PRICING SCENARIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHFFT MS-DRG</td>
</tr>
</tbody>
</table>

(2) Adjustments to Account for EPM-Episodes Price Variation

¹⁸ For purposes of the final rule, risk-stratification means the methodology for developing the EPM-episode benchmark price that accounts for clinical and resource variation in historical EPM episodes so that the quality-adjusted target price (calculated from the EPM-episode benchmark price) can be compared to actual EPM episode payments for EPM beneficiaries with similar care needs to those in historical EPM episodes.
CMS considered further adjustments to account for clinical and resource variation, but states that no standard national risk adjustment approach exists that is widely accepted for the EPM episodes.

Based on feedback that CMS received from HFMA and other commenter, CMS will explore additional options to better account for cost variation associated with risk. CMS’s stated goal of is to refine the pricing methodology to reflect risk adjustment effective beginning in PY 3 – to be established based on a notice and comment rulemaking process. As such, the additional measures will apply to episodes ending on or after January 1, 2019 and that had anchor discharges occurring after October 1, 2018 and thus be in place at the time downside risk is required.

CMS identified several scenarios in the proposed rule where certain pricing adjustments could be appropriate.

- Adjustments for Certain AMI Model Episodes with Chained Anchor Hospitalizations
- Adjustments for CABG Model Episodes
- Adjustments for Certain AMI Model Episodes with CABG Readmissions

The details of each of these scenarios is discussed in greater detail below.

(a) Adjustments for Certain AMI Model Episodes with Chained Anchor Hospitalizations

In the proposed rule, CMS stated its belief that it would be appropriate to adjust the AMI model-episode benchmark prices for certain AMI model episodes involving a chained anchor hospitalization as there could be significant differences between the discharge MS-DRG from the hospital that initiates the AMI episode and the hospital to which a beneficiary is transferred. CMS proposed to set a chain-adjusted AMI model-episode benchmark price or "price MS-DRG" based on the AMI, PCI, or CABG MS-DRG in the chained anchor admission with the highest IPPS weight.

CMS was persuaded by commenters to not finalize its proposal that once an AMI model episode is initiated at an AMI model participant, the AMI model episode would continue under its responsibility even if a beneficiary was transferred to another hospital. Given that CMS is not finalizing its original proposal. CMS is also not finalizing the terms “chained anchor hospitalization” or “price MS-DRG” as all episodes under the model will be priced based on their assigned anchor MS-DRG. CMS will replace the term “price MS-DRG” with “anchor MS-DRG” and delete references to “chained-anchor hospitalizations.”

(b) Adjustments for CABG Model Episodes

CMS finalizes its proposal to set CABG model-episode benchmark prices by splitting historical CABG model-episode expenditures into expenditures that occurred during anchor hospitalizations and expenditures that occurred after discharge from the anchor hospitalizations. CMS will follow the general payment methodology that was applied to the CJR model. The CABG model-episode benchmark price for an episode would be the sum of the corresponding
CABG anchor hospitalization benchmark price and the corresponding CABG post-anchor hospitalization benchmark price.

(c) Adjustments for Certain AMI Model Episodes with CABG Readmissions

CMS finalizes its proposal, without modification, to adjust episodes with CABG readmissions. CMS will establish an adjusted CABG-readmission AMI model benchmark episode price for AMI model episodes with an anchor MS-DRG of 280-282 or 246-251 that have a readmission for a CABG MS-DRG 231-236.

Specifically, if a CABG readmission occurs during an AMI model episode with an anchor MS-DRG of 280-282 or 246-251, CMS will calculate a CABG-readmission AMI model-episode benchmark price equal to the sum of the standard AMI model-episode benchmark price corresponding to the anchor MS-DRG (AMI MS-DRGs 280-282 or PCI MS-DRGs 246-251) and the CABG anchor hospitalization benchmark price corresponding to the MS-DRG of the CABG readmission. In the event of any other readmission other than CABG during an AMI episode, the usual rules of EPM-episode pricing will apply.

Several commenters expressed concern about the proposal for adjusting episodes involving CABG readmissions—specifically, the proposal does not sufficiently account for the increased post-acute care that a beneficiary typically receives after a CABG, but which they would not receive after only an AMI. In light of these comments, CMS conducted further analysis of its proposal and while it agrees that spending after discharge from the anchor stay for AMI episodes with CABG readmission is higher than for episodes without these readmissions, the number of these episodes is relatively small. CMS believes that incorporating such an adjustment would impede its ability to establish reliable prices that would be an improvement over what was proposed. As a result, CMS finalizes its policy, without modification.

(3) Three Years of Historical Data

As was the case for the CJR model, CMS finalizes its proposal to use 3 years of historical EPM episodes for calculating EPM-episode benchmark prices and to update the set of 3 historical years every other year.

- January 1, 2013 and December 31, 2015 for PYs 1 and 2;
- January 1, 2015 and December 31, 2017 for PYs 3 and 4; and
- January 1, 2017 and December 31, 2019 for PY 5.

(4) Trending of Historical Data to the Most Recent Year

To mitigate the effects of Medicare payment system updates and changes in national utilization practice patterns within the 3 years of historical episodes, CMS finalizes its proposal to update the older two historical years using national trend factors. This is the same approach used for the CJR model. Specifically, CMS will apply separate national trend factors for the following pricing scenarios:

- SHFFT model episodes, separately by each anchor MS-DRG in 480-482.
- AMI model episodes without CABG readmissions, separately by each anchor MS-DRG in 280-282 and 246-251; and
• The anchor hospitalization portion of CABG model episodes, separately by each anchor MS-DRG in 231-236.
• The post-anchor hospitalization portion of CABG model episodes, separately for:
  o With AMI ICD-CM diagnosis code on the anchor inpatient claim and CABG anchor MS-DRG with major complication or comorbidity (231, 233, or 235);
  o With AMI ICD-CM diagnosis code on the anchor inpatient claim and CABG anchor MS-DRG without major complication or comorbidity (232, 234, or 236);
  o Without AMI ICD-CM diagnosis code on the anchor inpatient claim and CABG anchor MS-DRG with major complication or comorbidity (231, 233, or 235); and
  o Without AMI ICD-CM diagnosis code on the anchor inpatient claim and CABG anchor MS-DRG without major complication or comorbidity (232, 234, or 236).

To trend historical payments to the most recent year in an historical window, CMS will create a ratio based on national average historical EPM-episode payment for that episode type in a previous year and for the most recent year. For example, for SHFFT model episodes for MS-DRG 480, CMS will create a ratio of national average SHFFT model historical episode payment with anchor MS-DRG 480 in CY 2015 as compared to that national average SHFFT model historical episode payment in CY 2013 in order to trend the CY 2013 historical SHFFT model episode payments to CY 2015. Likewise, CMS will determine the ratio of the national average SHFFT model historical episode payment for CY 2015 to national average SHFFT model historical episode payment in CY 2014 to trend 2014 SHFFT model episode payments to CY 2015. CMS will repeat this process for each pricing scenario listed above.

CMS clarifies that trending would occur on a semi-annual basis when it updates target prices rather than annually.

(5) Update Historical Episode Payments to Account for Ongoing Payment System updates

CMS finalizes its proposal to update the historical episode payments to reflect ongoing payment system updates for these programs: IPPS, IRF PPS, SNF PPS, PFS, HHA, and other services. Under this policy, CMS will apply the same methodology developed for the CJR model to incorporate Medicare payment updates.

As noted, CMS calculates target prices separately for episodes initiated between January 1 and September 30 versus October 1 and December 31 of each PY to account for calendar year versus fiscal year program updates. The target price in effect as of the day an episode is initiated is the target price for the entire episode.

Corresponding to the different target prices, a different set of update factors is calculated for January 1 through September 30 versus October 1 through December 31 episodes each PY. The six update factors reflecting each of the six programs are EPM-participant hospital-specific and are combined to create a single update factor by weighting and summing each of the six update percentages according to the proportion of Medicare payments each of the six components represents in the EPM participant’s historical EPM episodes. If, for example, 50 percent of an EPM participant’s episode payments were for inpatient acute care services, then the update factor for acute care services would have more influence on the weighted update factor than a service,
such as physician services that accounted for 15 percent of episode payments. The weighted update factors are applied to the historical EPM-participant hospital-specific average payments.

Region-specific factors are calculated in the same manner as the EPM hospital-specific update factors. Rather than using historical episodes attributed to a specific hospital, region-specific update factors are based on all historical EPM episodes initiated at any IPPS hospital within the region with historical EPM episodes. This is regardless of whether or not the MSAs in which the hospitals are located were selected for inclusion in the models.

(6) Blend Hospital-specific and Regional Historical Data

CMS finalizes its proposal to calculate EPM-episode benchmark prices using a blend of EPM-participant hospital-specific and regional historical average EPM-episode payments, including historical EPM-episode payments for all IPPS hospitals in the same region.

The blend proportions are shown in the table below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Blend Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>PYs 1 and 2 (2017 and 2018)</td>
<td>Two-thirds of the EPM-participant hospital-specific episode payments and one-third of the regional EPM-episode payments</td>
</tr>
<tr>
<td>PY 3 (2019)</td>
<td>One-third of the EPM-participant hospital-specific episode payments and two-thirds of the regional EPM-episode payments</td>
</tr>
<tr>
<td>PYs 4 and 5 (2020 and 2021)</td>
<td>Based fully on regional historical EPM-episode payments</td>
</tr>
</tbody>
</table>

Consistent with the methodology for the CJR model, CMS finalizes two exceptions. First, CMS will use only regional EPM-episode payments to calculate benchmark prices for EPM participants with low historic EPM-episode volume. The number of episodes considered low volume for each model is shown in the table below:

<table>
<thead>
<tr>
<th>Model</th>
<th>Low volume threshold (in total across 3 historical years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHFFT Model</td>
<td>Fewer than 50 SHFFT model episodes</td>
</tr>
<tr>
<td>AMI model episodes anchored by MS-DRGs 280-282</td>
<td>Fewer than 75 of these AMI model episodes</td>
</tr>
<tr>
<td>AMI model episodes anchored by PCI MS-DRGs 246-251</td>
<td>Fewer than 125 of these AMI model episodes</td>
</tr>
<tr>
<td>CABG model episodes</td>
<td>Fewer than 50 CABG model episodes</td>
</tr>
</tbody>
</table>

CMS notes that the thresholds for these models are higher than the CJR model threshold for low historical volume of 20 episodes across 3 historical years. CMS set higher thresholds for these models (SHFFT, AMI, and CABG) based on internal analysis from BPCI episode data that shows higher within-hospital episode spending variation relative to between-hospital episode spending variation for episodes anchored by the EPM MS-DRGs.
Second, CMS will in the case of an EPM participant that has undergone a merger, consolidation, spin-off, or other reorganization that results in a new hospital entity without 3 full years of historical claims data base episode payments on its predecessor(s), as in the CJR model (80 FR 73544).

(7) Define Regions as U.S. Census Divisions

As CMS does for the CJR model, CMS finalizes its proposal to define “region” as one of the nine U.S. Census divisions, as shown in Figure 1 below.

**FIGURE 1: U.S. CENSUS DIVISIONS**

CMS clarifies that selected MSAs that span U.S. Census divisions will be attributed to one U.S. Census (the one in which the majority of people in the MSA resides).

(8) Normalize for Provider-Specific Wage Adjustment Variations

CMS finalizes its proposal to normalize for wage index differences in historical episode payments when calculating and blending the regional and hospital-specific components of blended EPM-episode benchmark prices to avoid having the wage level for one hospital influence the regional-component of another hospital’s EPM episode benchmark price with a different wage level. Such an effect could introduce unintended pricing distortions not based on utilization pattern differences.

CMS will use the following algorithm to create a wage index normalization factor: \((0.7 \times \text{IPPS wage index} + 0.3)\). The 0.7 approximates the labor share in IPPS, IRF PPS, SNF PPS, and HHA Medicare payments.

(9) Combining Episodes to Set Stable Benchmark and Quality-Adjusted Target Prices

CMS finalizes its proposal to generally follow the process from the CJR model to calculate severity factors (referred to as anchor factors in the CJR final rule), in order to have sufficient
episode volume to set stable EPM-episode benchmark and quality-adjusted target prices. CMS uses the term “severity factors” instead of “anchor factors” to avoid confusion when discussing calculations pertaining to expenditures that occurred during the anchor hospitalization and after the anchor hospitalization in the CABG model episodes.

**SHFFT Model Episodes**

CMS will combine episodes with anchor MS-DRGs 480-482 to use a greater historical episode volume to set more stable SHFFT episode benchmark and quality-adjusted target prices. The two severity factors for this model, which will have the same value for all participant hospitals, will be calculated and used as follows:

i. CMS will calculate severity factors for episodes with anchor MS-DRGs 480 and 482 as follows:

\[
MS - DRG\ 480\ severity\ factor = \frac{\text{Natl. avg. MS - DRG} \ 480\ episode\ spend}{\text{Natl. avg. MS - DRG} \ 482\ episode\ spend}
\]

\[
MS - DRG\ 481\ severity\ factor = \frac{\text{Natl. avg. MS - DRG} \ 481\ episode\ spend}{\text{Natl. avg. MS - DRG} \ 482\ episode\ spend}
\]

The national average will be based on SHFFT model episodes attributed to any IPPS hospital.

ii. For each SHFFT model participant, CMS will calculate a hospital weight using the formula below, where SHFFT model episode counts are SHFFT-model-participant hospital-specific and based on the SHFFT model episodes in the 3 historical years used in SHFFT model episode benchmark and quality-adjusted target price calculations for the hospitals and severity factors from the first step:

\[
\text{Count of episodes with price MS - DRG} \ 480 - 482 = \frac{\text{MS - DRG} \ 480\ episode\ count \times MS - DRG\ 480\ severity\ factor + MS - DRG \ 481\ episode\ count \times MS - DRG\ 481\ severity\ factor + MS - DRG\ 482\ episode\ count \times 1}{MS - DRG \ 480\ episode\ count \times MS - DRG\ 480\ severity\ factor + MS - DRG \ 481\ episode\ count \times MS - DRG\ 481\ severity\ factor + MS - DRG \ 482\ episode\ count \times 1}
\]

iii. For each hospital, CMS will calculate a hospital-specific average episode payment by multiplying such participant's hospital weight by its combined historical average episode payment (sum of historical episode payments for historical episodes with anchor MS-DRGs 480-482 divided by the number of historical episodes with anchor MS–DRGs 480-482).

Similar to how case-mix indices are used, the hospital weight essentially will count each episode with price MS–DRGs 480 and 481 as more than one episode (assuming episodes with price MS–DRGs 480 and 481 have higher average payments than episodes with price MS–DRG 482) so that the pooled historical average episode payment, and subsequently the SHFFT model episode benchmark and quality-adjusted target prices, are not skewed by the SHFFT model participant's
relative breakdown of historical episodes with price MS–DRGs 480 and 481 versus historical episodes with anchor MS–DRG 482. CMS states that it will calculate region-specific weights and region-specific pooled historical average payments following the same steps.

In the final step of the calculation of episode target prices, the blended pooled calculations will be "unpooled" by setting the episode benchmark price for episodes with anchor MS–DRG 482 to the resulting calculation, and by multiplying the resulting calculation by the severity factors to produce the episode benchmark prices for episodes with anchor MS–DRGs 480 and 481. CMS will then apply the relevant discount factor resulting in the SHFFT model quality-adjusted target prices for episodes with anchor MS–DRGs 480-482.

AMI Model Episodes

CMS will follow a comparable computational process for the AMI model episodes with the following four modifications.

i. Group episodes with anchor MS–DRGs 280-282 separately from episodes with anchor MS–DRGs 246-251 for the calculations and make the following calculations:

ii. Calculate severity factors for episodes with anchor MS–DRGs 280-282 as follows:

\[
MS \text{– DRG 280 severity factor} = \frac{\text{Natl. avg. MS–DRG 280 episode spend}}{\text{Natl. avg. MS–DRG 282 episode spend}}
\]

\[
MS \text{– DRG 281 severity factor} = \frac{\text{Natl. avg. MS–DRG 281 episode spend}}{\text{Natl. avg. MS–DRG 282 episode spend}}
\]

iii. For each AMI model participant, calculate hospital-specific weights and region-specific weights for episodes with anchor MS–DRGs 280-282 as follows:

\[
\text{Count of episodes with price MS–DRG 280–282} = \frac{MS \text{– DRG 280 episode count} \times MS \text{– DRG 280 severity factor} + MS \text{– DRG 281 episode count} \times MS \text{– DRG 281 severity factor} + MS \text{– DRG 282 episode count} \times 1}{MS \text{– DRG 280 episode count} \times MS \text{– DRG 280 severity factor} + MS \text{– DRG 281 episode count} \times MS \text{– DRG 281 severity factor} + MS \text{– DRG 282 episode count} \times 1}
\]

iv. Calculate five severity factors for episodes with anchor MS–DRG 246-251. For example, the MS–DRG 246 severity factor equals the following:

\[
MS \text{– DRG 246 severity factor} = \frac{\text{Natl. avg. MS–DRG 246 episode spend}}{\text{Natl. avg. MS–DRG 251 episode spend}}
\]

Repeat for MS–DRG 247-250, where MS–DRG 251 remains the denominator in each calculation.
v. CMS will calculate hospital-specific weights and region-specific weights for episodes with anchor MS-DRG 246-251 as --

<table>
<thead>
<tr>
<th>Count of episodes with price MS – DRG 246 – 251</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS – DRG 246 episode count * MS – DRG 246 severity factor +</td>
</tr>
<tr>
<td>MS – DRG 247 episode count * MS – DRG 247 severity factor +</td>
</tr>
<tr>
<td>MS – DRG 248 episode count * MS – DRG 248 severity factor +</td>
</tr>
<tr>
<td>MS – DRG 249 episode count * MS – DRG 249 severity factor +</td>
</tr>
<tr>
<td>MS – DRG 250 episode count * MS – DRG 250 severity factor +</td>
</tr>
<tr>
<td>MS – DRG 251 episode count * 1</td>
</tr>
</tbody>
</table>

After blending historical and regional pooled episode payments for episodes with anchor MS-DRGs 280-282, CMS will “unpool” the blended pooled calculations by setting the episode benchmark price for anchor MS–DRG 282 to the resulting calculation, and by multiplying the resulting calculation by the severity factors to produce the episode benchmark prices for anchor MS-DRGs 280 and 281.

Similarly, after blending historical and regional pooled episode payments for episodes with anchor MS-DRGs 246-251, CMS will “unpool” the blended pooled calculations by setting the episode benchmark price for price MS–DRG 251 to the resulting calculation, and by multiplying the resulting calculation by the severity factors to produce the episode benchmark prices for anchor MS-DRGs 246-250.

CMS will then apply the relevant discount factor that would result in the quality-adjusted target prices for anchor MS-DRGs 280-282 and 246-251.

CABG Model

For episodes in the CABG model with anchor MS-DRGs in 231-236, CMS will apply severity factors, hospital-specific weights, and region-specific weights separately for:

- the anchor hospitalization portion of CABG model episodes and,
- the post-anchor hospitalization portion of CABG model episodes.

CABG Model: Anchor Hospitalization Portion

i. CMS will calculate anchor hospitalization severity factors for MS-DRGs 231-235. For example, the MS-DRG 231 anchor severity factor calculation is shown below. CMS would repeat to calculate the anchor severity factors for MS-DRG 232-235, where MS-DRG 236 remains the denominator in each calculation.

\[
MS – DRG 231 anchor hosp. severity factor = \frac{Natl. avg. MS – DRG 231 anchor hosp. spend}{Natl. avg. MS – DRG 236 anchor hosp. spend}
\]

ii. CMS will calculate hospital-specific weights and region-specific weights for the anchor hospitalization portion of CABG model episodes as the following:
After blending historical and regional pooled anchor hospitalization payments for the CABG model episodes, the blended pooled calculations will be "unpooled" by setting the MS–DRG 236 anchor hospitalization benchmark price to the resulting calculation, and by multiplying the resulting calculation by the severity factors to produce the anchor hospitalization benchmark prices for MS-DRGs 231-235.

**CABG Model: Post-Anchor Hospitalization Portion**

The post-anchor hospitalization portion of CABG model episodes will be grouped in the following manner:

- With AMI diagnosis on the anchor inpatient claim and CABG anchor MS-DRG with major complication or comorbidity (231, 233, or 235)
- With AMI diagnosis on the anchor inpatient claim and CABG anchor MS-DRG without major complication or comorbidity (232, 234, or 236)
- Without AMI diagnosis on the anchor inpatient claim and CABG anchor MS-DRG with major complication or comorbidity (231, 233, or 235)
- Without AMI diagnosis on the anchor inpatient claim and CABG anchor MS-DRG without major complication or comorbidity (232, 234, or 236).

i. Specifically, CMS will calculate post-anchor hospitalization severity factors as follows:

\[
\text{w/AMI and MS – DRG w/MCC post – anchor hospseverity factor} = \frac{\text{Natl. avg. w/AMI and MS – DRG w/MCC post – anchor hosp. spend}}{\text{Natl. avg. w/o AMI and MS – DRG w/o MCC post – anchor hosp. spend}}
\]

\[
\text{w/AMI and MS – DRG w/o MCC post – anchor hospseverity factor} = \frac{\text{Natl. avg. w/AMI and MS – DRG w/o MCC post – anchor hosp. spend}}{\text{Natl. avg. w/o AMI and MS – DRG w/o MCC post – anchor hosp. spend}}
\]

\[
\text{w/o AMI and MS – DRG w/MCC post – anchor hospseverity factor} = \frac{\text{Natl. avg. w/o AMI and MS – DRG w/ MCC post – anchor hosp. spend}}{\text{Natl. avg. w/o AMI and MS – DRG w/o MCC post – anchor hosp. spend}}
\]

ii. CMS also will calculate hospital-specific weights and region-specific weights for the post-anchor hospitalization portion of CABG model episodes as follows:
After blending historical and regional pooled post-anchor hospitalization payments for the CABG model episodes, the blended pooled calculations will be "unpooled" by setting the without AMI ICD-CM diagnosis code on the anchor inpatient claim and CABG anchor MS-DRG without major complication or comorbidity (232, 234, or 236) post-anchor hospitalization benchmark price to the resulting calculation, and by multiplying the resulting calculation by the severity factors to produce the post-anchor hospitalization benchmark prices for CABG anchor MS-DRGs 231-235.

CMS will calculate episode benchmark prices for CABG model episodes by summing combinations of CABG anchor hospitalization benchmark prices and CABG post-anchor hospitalization benchmark prices. Applying the discount factor will result in the quality-adjusted target prices for CABG model episodes.

CMS states that for episodes in the AMI model with CABG readmissions, CMS will perform no additional blending of hospital-specific and regional-specific episode payments.

CMS received no comments on its proposal to combine episodes. CMS finalizes its proposal, without modification. The final policy to combine episodes to set stable benchmark and quality-adjusted target prices are included in §512.300(c)(13).

(10) Effective Discount factors

CMS finalizes its policies, with modifications, to establish discount factors that would apply to the quality categories. CMS maintains the same discount factors as in the proposed rule, but modifies how the discount factors are phased in over the performance periods. Specifically, for repayment amounts in performance year 2, its final applicable discount factor would apply only to participants that elected downside risk in that year. Also, in conformance with its final policy for phasing-in repayment responsibility, the applicable discount factor is extended so that it will apply to all EPM participants in performance year 4.

Given the phase-in of repayment responsibility, EPM participants would owe Medicare less than would otherwise result from this calculation.

5. Process for Reconciliation

a. Net Payment Reconciliation Amount (NPRA)
With respect to the process for reconciliation, CMS finalizes its proposal that each EPM participant’s actual episode payments would be compared to its quality-adjusted target prices. An EPM participant could have multiple quality-adjusted target prices for EPM episodes ending in a given PY, based on:

- the anchor MS-DRG for the EPM episode;
- whether the EPM episode included readmission for CABG MS-DRGs;
- whether the EPM episode included an AMI ICD-CM diagnosis code on the anchor inpatient claim;
- the PY when the EPM episode was initiated;
- when the EPM episode was initiated within a given PY (January 1 through September 30 of the PY, October 1 through December 31 of the PY, October 1 through December 31 of the prior PY);
- and the potential effective discount factors.

CMS will determine the applicable target price for each episode, and the difference between each EPM episode's actual payment and that target price (calculated as target price minus the EPM actual episode payment). These episode calculations will be aggregated for all EPM episodes for an EPM participant within the PY. The aggregate result is referred to as the Net Payment Reconciliation Amount (NPRA).

CMS will not include any reconciliation payments or repayments to Medicare under the EPMs for a given PY when calculating actual episode spending and, therefore, the NPRA for a subsequent year. CMS provides the following example: if an EPM participant receives a $10,000 reconciliation payment in the second quarter of 2018 for achieving episode spending below the quality-adjusted target price for PY 1, that $10,000 reconciliation payment amount will not be included in the PY 2 calculations of actual EPM-episode payments.

b. Payment Reconciliation

CMS finalizes its proposal to reconcile an EPM participant’s actual episode payments against the quality-adjusted target price 2 months after the end of the PY. It will calculate the NPRA based on claims submitted by March 1 following the end of the PY and make a reconciliation payment or initiate repayment from hospitals responsible for repayment, as applicable, within the 2nd quarter of following year.

CMS also finalizes its proposal to calculate the prior PY’s episode spending and NPRA a second time during the following PY’s reconciliation process in order to account for final claims run-out (i.e., calendar year claims submitted after March 1) and any canceled EPM episodes due to overlap with other CMS payment models. The subsequent reconciliation calculation will occur approximately 14 months after the end of the prior PY. If the re-calculation produces a result other than zero, then this amount will be applied to the NPRA for the subsequent PY (as well as the post-episode spending and ACO overlap calculation) to determine the payment Medicare would make to the EPM participant or such participant’s repayment amount. CMS will also apply the stop-loss and stop-gain limits to the calculations in aggregate for that PY (the initial reconciliation and the subsequent calculation) to ensure the amount does not exceed these limits.
For the PY 1 reconciliation process, CMS will calculate an EPM participant’s NPRA (as described previously) and, if positive, the participant would receive a reconciliation payment from Medicare, subject to the stop-gain limit for PY 1. If negative, the EPM participant would not responsible for repayment to Medicare, consistent with its proposal to phase-in the repayment responsibility.

Table 18 (reproduced below) displays the reconciliation timeframes for the EPMs.

**TABLE 18: TIMEFRAME FOR RECONCILIATION FOR EPMs**

<table>
<thead>
<tr>
<th>EPM Performance Year</th>
<th>EPM Performance Period</th>
<th>Reconciliation Claims Submitted By</th>
<th>NPRA Calculation</th>
<th>Second Reconciliation, ACO Overlap, and Post-Episode Spending Calculations</th>
<th>Calculation Amounts Included in Reconciliation Payment and Repayment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1*</td>
<td>Episodes beginning on or after July 1, 2016 and ending through December 31, 2017</td>
<td>March 1, 2018</td>
<td>Q2 2018</td>
<td>March 1, 2019</td>
<td>Q2 2019</td>
</tr>
<tr>
<td>Year 2</td>
<td>Episodes ending January 1, 2018 through December 31, 2018</td>
<td>March 1, 2019</td>
<td>Q2 2019</td>
<td>March 1, 2020</td>
<td>Q2 2020</td>
</tr>
<tr>
<td>Year 3</td>
<td>Episodes ending January 1, 2019 through December 31, 2019</td>
<td>March 1, 2020</td>
<td>Q2 2020</td>
<td>March 1, 2021</td>
<td>Q2 2021</td>
</tr>
<tr>
<td>Year 4</td>
<td>Episodes ending January 1, 2020 through December 31, 2020</td>
<td>March 1, 2021</td>
<td>Q2 2021</td>
<td>March 1, 2022</td>
<td>Q2 2022</td>
</tr>
<tr>
<td>Year 5</td>
<td>Episodes ending January 1, 2021 through December 31, 2021</td>
<td>March 1, 2022</td>
<td>Q2 2022</td>
<td>March 1, 2023</td>
<td>Q2 2023</td>
</tr>
</tbody>
</table>

* Note that the reconciliation for Year 1 will not include repayment responsibility from EPM participants.

CMS finalizes its proposal, without modification.
Reconciliation Report

CMS finalizes its proposal, without modification, to annually issue a reconciliation report. These reports will contain the following information:

- Information on the EPM participant's composite quality score described in section III.E.3.a. through e below.
- The total actual episode payments for the EPM participant.
- The NPRA.
- Whether the EPM participant is eligible for a reconciliation payment or must make a repayment to Medicare.
- The NPRA and subsequent reconciliation calculation amount for the previous performance year, as applicable.
- The post-episode spending amount and ACO overlap calculation for the previous performance year, as applicable.
- The reconciliation payment or repayment amount.

6. Adjustments for Overlaps with Other Innovation Center Models and CMS Programs

a. Overview

CMS identified 3 overlap situations that it addresses: provider overlap, beneficiary overlap, and payment reconciliation issues.

b. Provider Overlap

(1) BPCI Participant Hospitals in Geographic Areas Selected for EPMs

CMS notes that provider overlap exists when a hospital in a geographic area selected for the AMI, CABG or SHFFT model is also an episode initiator in BPCI for an episode anchored by that EPM's DRG. This is more likely to occur because BPCI is an episode payment model testing AMI, CABG, SHFFT, and 45 other episodes in acute care, post-acute care, or both acute care and post-acute care settings.

In cases of provider overlap, CMS finalizes its proposal that a hospital is excluded from participating in EPMs for EPM anchor MS-DRGs that are included in BPCI episodes in which the hospital currently participates. In other words, the BPCI model takes precedence. If a BPCI hospital in an EPM-selected area withdraws from BPCI episodes anchored by EPM-MS-DRGs, then the BPCI hospital would participate in these EPMs.

(2) BPCI Physician Group Practice (PGP) Episodes Initiators in Hospitals Participating in EPMs

CMS finalizes its proposal that if a beneficiary is admitted to an EPM participant for an episode anchored by EPM MS-DRGs covered under the PGP's BPCI agreement and the attending or operating physician on the admission's inpatient claim is a member of the BPCI PGP, the BPCI episode will take precedence over the EPM episode for which the hospital would otherwise be the accountable entity. In other words, if, for any portion of the EPM episode, a beneficiary
would also be in a BPCI PGP episode, CMS will cancel or never initiate the EPM episode. CMS provides several examples in the final rule.

c. **Beneficiary Overlap**

(1) **Beneficiary Overlap with BPCI**

CMS finalizes its proposal that any BPCI Model 2, 3 or 4 episode, regardless of its anchor DRG exclusion status from an EPM episode definition, takes precedence over an AMI, CABG or SHFFT episode such that it would cancel or prevent the initiation of an AMI, CABG or SHFFT episode. CMS notes that given the current scheduled end date for the BPCI, CMS will give precedence to episodes covered under BPCI Models 2, 3 and 4 initiated on or before September 30, 2018.

CMS acknowledges this BPCI-EPM overlap policy differs from the CJR beneficiary overlap policy, where a beneficiary may be in a CJR LEJR episode and a non-LEJR BPCI episode concurrently. However, CMS states that in CJR this overlap is rare. CMS further states that the high incidence of included readmissions for AMI, CABG and SHFFT episodes necessitates a different policy to avoid double-paying savings and double-counting losses, as well as not initiating new episodes when the readmission is a complication of care during the first episode that could be managed.

(2) **Beneficiary Overlap with the CJR Model and other EPMs**

CMS finalizes its proposed policy that gives precedence to the ongoing episode over subsequent episodes initiated during the post-hospital discharge period, except where the second admission is explicitly excluded. CMS believes that this policy will establish an operationally straightforward policy for future EPMs and align with its stated goal of encouraging more accountable care. CMS provides a few illustrative examples:

- The CJR model episode definition does not exclude the MS-DRGs that would initiate a SHFFT model episode. If a beneficiary is in the CJR model and receives SHFFT at an EPM participant in the SHFFT model during the ongoing CJR episode, the CJR episode will continue and the SHFFT model episode will not initiate.

- The SHFFT model episode definition does not exclude the MS-DRGs that would initiate a CJR LEJR episode. If a beneficiary is in the SHFFT model and receives an LEJR at a CJR hospital during the ongoing SHFFT episode, the SHFFT episode will continue and the CJR episode will not initiate.

- The AMI model episode definition does not exclude the MS-DRGs that would initiate a CABG model episode. If a beneficiary is in the AMI model and is readmitted for a CABG to the same or another EPM participant in the CABG model during the ongoing AMI model episode, the AMI model episode will continue and the CABG model episode will not initiate.

CMS finalizes its proposal without modification.
(3) **Beneficiary Overlap with Shared Savings Models and Programs**

CMS notes that it expects many beneficiaries in an AMI, CABG or SHFFT model episode will also be aligned or attributed to a MSSP participant or a participant in an ACO model initiated by the CMS Innovation Center. As with CJR, CMS finalizes its proposal to attribute savings achieved during an EPM episode to the EPM participant, and include EPM reconciliation payments for ACO-aligned beneficiaries as ACO expenditures.

Further, CMS finalizes its proposal, with modification, to exclude beneficiaries from EPMs who are aligned to ACOs in the Next Generation ACO model and End Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) in the Comprehensive ESRD Care initiative in tracks with downside risk for financial losses. CMS will also exclude beneficiaries prospectively assigned to MSSP Track 3 ACOs. CMS will not exclude beneficiaries aligned to MSSP ACOs in Tracks 1 and 2 at this time.

To ensure that the ACO model overlap adjustment policy is aligned with the MSSP policy, CMS finalizes its proposal that under EPMs, it will make an adjustment to the reconciliation amount to account for any of the applicable discount for an episode resulting in Medicare savings that is paid back through shared savings under the MSSP or any other ACO model, but only when an EPM hospital also participates in the ACO and the beneficiary in the EPM episode is also aligned to that ACO. CMS will not make an adjustment when a beneficiary is aligned to an ACO in which the hospital is not participating.

CMS notes that its policy entails CMS reclaiming from the EPM participant any discount percentage paid out as shared savings for the MSSP or ACO models only when the hospital is an ACO participant and the beneficiary is aligned with that ACO, while other total cost of care models such as the Comprehensive Primary Care Plus initiative (CPC+) would adjust for the discount percentage in their calculations.

d. **Payment Reconciliation of Overlap with non-ACO CMS Models and Programs**

As with CJR, CMS finalizes its proposal to determine whether the services paid by Per Beneficiary-Per-Month (PBPM) payments are excluded from the EPM episode on a model-by-model basis depending on their funding source and clinical relationship to the EPM episode.

CMS specifically excludes these Innovation Center models from AMI, CABG, and SHFFT episodes:

- Oncology Care Model (OCM): episode-based payment initiated by chemotherapy treatment, a service generally reported with ICD-9-CM (or their ICD-10-CM equivalents) codes that are specifically excluded.
- Medicare Care Choices Model: palliative care for beneficiaries with a terminal illness means the PBPM payments would pay for services that are clinically unrelated to EPM episodes.

7. **Limits or Adjustments to EPM Participants’ Financial Responsibility**

a. **Limit on Actual EPM-Episode Payment Contribution to Repayment Amounts and Reconciliation Payments**
(1) Limit on Actual EPM-Episode Payment Contribution to Repayment Amounts

To provide additional protection to participant hospitals from owing large repayment amounts to Medicare, CMS finalizes its proposal to establish the same stop-loss limits that were adopted for the CJR model.

Table 19 in the final rule shows the final stop loss limits for each PY. These stop-loss limits apply to all EPM participants, except for those with additional stop-loss protections, such as rural and sole-community hospitals.

**TABLE 19: FINAL STOP-LOSS LIMITS BY PY**

<table>
<thead>
<tr>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
<th>PY4</th>
<th>PY5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Final Stop-Loss Limits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Downside Risk for All Participants</strong> – DR effective for episodes ending on or after 1/1/2019 (anchor discharges occurring on or after 10/4/2018)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2</td>
<td>5%</td>
<td>10%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td><strong>Voluntary Downside Risk</strong> – DR effective for episodes ending on or after 1/1/2018 (anchor discharges occurring on or after 10/4/2017)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n/a as no downside risk in PY1</td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Note: Rural and sole-community hospitals, rural referral centers, Medicare Dependent Hospitals and hospitals determined to be EPM volume protection hospitals within an EPM have additional stop-loss protections that begins at 3 percent and phases to 5% in PY 4 and PY 5.

(2) Limitation on Reconciliation Payments

CMS finalizes its proposal, with modification, to establish a cap on an EPM participant’s reconciliation payment. Its final policy includes conforming adjustments so that the stop-loss and stop-gain limits are symmetrical. The final stop-gain limits are 5 percent in PYs 1, 2, and 3; 10 percent in PY 4; and 20 percent in PY 5 for each EPM.

b. Additional Protections for Certain EPM Participants

(1) Policies for Certain EPM Participants to Further Limit Repayment Responsibility

CMS finalizes its proposal, with modification, to provide additional protections for rural hospitals, SCHs, Medicare Dependent Hospitals (MDHs), and Rural Referral Centers (RRCs). For purposes of these models, CMS defines a rural hospital as an IPPS hospital that is either...
located in a rural area in accordance with §412.64(b) or in a rural census tract within an MSA defined at §412.103(a)(1) or has reclassified to rural in accordance with §412.103. Similarly, for the purpose of these additional protections, CMS refers to the definitions of SCHs in §412.92, MDHs in §412.108, and RRCs in §412.96.

CMS extends the separate financial loss protections to EPM participants determined to have a low volume of episodes within a model. An EPM participant will qualify as an EPM volume protection hospital if their volume of historical EPM episodes that started in calendar years 2013 through 2015 is at or below the 10th percentile of the number of hospital-specific historical EPM episodes for hospitals located in the MSAs eligible for selection into that specific EPM. CMS will use the same historical periods used to determine an EPM participant’s benchmark and quality-adjusted target price to determine the 10th percentile threshold. Based on its analysis, CMS anticipates that 10 percent of hospitals with any episodes would be subject to these additional protections, which represents 1 percent or less of episode volume.

Table 21 in the final rule (reproduced below) shows the proposed and final separate stop-loss limits by performance year for hospitals afforded special protections.

**TABLE 21: PROPOSED AND FINAL SEPARATE STOP-LOSS LIMITS BY PY**

<table>
<thead>
<tr>
<th></th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
<th>PY4</th>
<th>PY5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proposed Separate Stop-Loss Limits Rural Hospitals, SCHs, MDHs, and RRCs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n/a as no downside risk in PY1</td>
<td>n/a during non-downside risk period and 3% during downside risk period</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td><strong>Final Separate Stop-Loss Limits Rural Hospitals, SCHs, MDHs, RRCs, and EPM Volume Protection Hospitals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Downside Risk for All Participants— DR effective for episodes ending on or after 1/1/2019 (anchor discharges occurring on or after 10/4/2018)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2</td>
<td>3%</td>
<td>5%</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Voluntary Downside Risk – DR effective for episodes ending on or after 1/1/2018 (anchor discharges occurring on or after 10/4/2017)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(2) Considerations for Hospitals Serving a High Percentage of Potentially Vulnerable Populations

CMS notes that other EPM participants could also face factors affecting their ability to achieve savings under the EPMs that are unrelated to their practice patterns. This could reflect, for example, the EPM participant’s responsibilities for a relatively high percentage of potentially vulnerable populations with higher than average historical spending, such as a high percentage of beneficiaries dually eligible for Medicare and Medicaid. At this time, CMS does not finalize additional changes for EPM participants with large vulnerable populations, but states that it will take into account the results of studies and its own experience during the implementation and evaluation of these models.

c. Application of Stop-Gain and Stop-Loss Limits

CMS finalizes its proposal, without modification, to establish stop-gain and stop-loss limits at the model level. Specifically, CMS would establish stop-loss and stop-gain thresholds at the model level; that is, separately for each of the AMI, CABG, and SHFFT models, in addition to the limits that already exist for the CJR model. Thus, the stop-loss limit for CJR model episodes in PY 4 would be 20 percent for the hospital's CJR model episodes, while the stop-loss limit for SHFFT model episodes for PY 3 would be 10 percent. CMS believes this option is superior to the participant level option in that it better maintains appropriate incentives and protections under each of the models.

CMS notes, that it has incorporated other protections – capping high cost-cases and stop-loss protections – in this final rule that should be sufficient and thus is not adopting changes to this policy for low volume hospitals.

d. EPM Participant Responsibility for Increased Post-Episode Payments

CMS finalizes its proposal to calculate, for each PY, the total Medicare Parts A and B expenditures in the 30-day period following completion of each episode for all services covered under Medicare Parts A and B, regardless of whether or not the services are included in the EPM episode definition. This is consistent with BPCI Model 2 and the CJR model. The calculation will include prorated payments for services that extend beyond the 30-day period following completion of each EPM episode, such as home health services.

CMS will identify whether the average 30-day post-episode spending for an EPM participant in any given PY is greater than three standard deviations above the regional average 30-day post-episode spending, based on the 30-day post-episode spending for episodes attributed to all regional hospitals participating in the EPM in the same region as the EPM participant. If the hospital’s average post-episode spending exceeds this threshold, the participant hospital will
repay Medicare for the amount that exceeds such threshold. CMS believes that this threshold is a high one and believe cases in which an EPM participant would be responsible for such repayments would be rare. This will not be subject to stop-loss limits.

8. **Appeals Process**

   **a. Notice of Calculation Error (first level appeal)**

   CMS finalizes its calculation error process for EPM participants to contest payment- or reconciliation-related matters. This could include, for example, among other matters, the calculation of the EPM participant’s reconciliation amount or repayment amount as reflected in the reconciliation report, the calculation of NPRA, and the successful reporting of the voluntary PRO THA/TKA data to adjust the reconciliation payment. An EPM participant will need to review its Reconciliation Report and payment report for a PY, and provide written notice to CMS of any error in the report through a calculation error form specified by CMS within 45 calendar days of the Reconciliation Report issuance date. The default position is that the Reconciliation Report will be deemed final unless the participating hospital submits the written notice within the 45-day timeframe. Failure to timely submit the calculation error form will also result in the loss of appeal rights on matters contained in that report, including (but not limited to) the following:

   1. The calculation of the reconciliation amount or repayment amount reflected in the reconciliation report;
   2. The calculation of the CR incentive payments as reflected in the CR incentive payment report;
   3. The calculation of NPRA;
   4. The calculation of the percentiles of quality measure performance to determine eligibility to receive a reconciliation payment; and
   5. The successful reporting of voluntary PRO THA/TKA data to adjust the reconciliation payment.

   If CMS receives a notification of a calculation error within the 45-day period, CMS states it will respond within 30 calendar days to either confirm that there was an error in the calculation or verify that the calculation is correct (CMS also reserves the right to an extension upon written notice). Only EPM participants may use the notice of calculation error process.

   **b. Dispute Resolution Process (second level of appeal)**

   The dispute resolution process is only available to EPM participants. For payment matters, the participant must submit a timely calculation error form for any matters related to payment. Assuming a properly submitted calculation error form, if the EPM participant is dissatisfied with the CMS response, it would be permitted to submit a request for reconsideration review by a CMS reconsideration official. The reconsideration review would include a detailed explanation of the basis for the dispute and supporting documentation with respect to payment matters. If CMS does not receive a request for reconsideration from the EPM participant within 10 calendar days of the issue date of CMS’ response to the EPM participant’s notice of calculation error, then
the CMS response to the calculation error is deemed final and proceeds with reconciliation or repayment processes, as applicable.

Reconsideration review is on-the-record (i.e., limited to review of briefs and evidence). The CMS reconsideration official is supposed to “make reasonable efforts” to send the EPM participant a Scheduling Notice within 15 days of receipt of the review request and to issue a written determination within 30 days of review. That determination would be final and binding.

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

For reconsideration review requests that are not related to payment matters, CMS finalizes its proposal to require a timely submitted request for review. Under the proposed rule and similar to the CJR model and the BPCI initiative, if CMS does not receive a request for reconsideration from the participating hospital within 10 calendar days of the notice of the initial determination, the initial determination is deemed final and CMS will proceed with the action indicated in the initial determination. The procedures for the Scheduling Notice and written determination are the same as described above.

d. Limitations on review

CMS finalizes its proposal that there is no administrative and judicial review in §512.310 (e) in accordance with section 1115A (d) (2) of the Act for the following activities:

- 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 such models for testing or dissemination.
- Determinations regarding budget neutrality under section 1115A (b) (3) of Act.
- The termination or modification of the design and implementation of a model under section 1115A (b) (3)(B) of 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 paragraph (e)(1) or (2) of this section.

E. EPM Quality Measures, Public Display, and Use of Quality Measures in the EPM Payment Methodology

a. AMI Model Quality Measures

After consideration of comments, CMS finalizes its proposal for three required measures plus one voluntary reported measure for the AMI model:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (NQF #0230) (MORT-30-AMI)

19 A Scheduling Notice should include the date and time of the review (which should be no later than 30 days after the date of the Scheduling Notice) and a description of the issues in dispute, the review procedures, and the evidence submission requirements.
Excess Days in Acute Care after Hospitalization for AMI (AMI Excess Days)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)
- Voluntary Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #2473) (Hybrid AMI Mortality data submission).

b. CABG Model Quality Measures

CMS finalizes its proposal with modifications. The finalized measures for the CABG model are:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558) (MORT-30-CABG),
- HCAHPS Survey (NQF #0166), and
- STS composite measure (includes 11 distinct measures - voluntary)

Reporting of the STS composite measure will be voluntary and the measure will count for 10 percent of the score (2 points). CMS re-weighted the CABG and the HCAHPS scores out of a total point basis of 18 and will offer 2 points on top of that if participants voluntarily submit data for this measure.

c. SHFFT Model Quality Measures

CMS finalizes its proposal for two required and one voluntary measure 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).

1. Use of Quality Measures in the EPM Payment Methodologies

CMS finalizes its proposal to use an EPM composite quality score methodology linking quality to payment. This score includes a composite performance score plus an improvement score; the performance component is more heavily weighted. This methodology is similar to that used in the CJR model, Shared Savings Program, the Hospital Value-Based Purchasing Program (HVBP), and the Hospital Acquired Conditions Reduction Program (HACRP).

d. Determining Quality Performance

CMS finalizes its proposal to use relative performance results during reconciliation for each EPM performance year. Specifically, during reconciliation, CMS will reference an 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. CMS will apply this approach to the measures that are NQF-endorsed, for which minimum reporting thresholds are detailed in Table 22 of the final rule (reproduced below). Low
volume EPM participants, new hospitals that are EPM participants, and EPM participants whose measure values are suppressed by CMS due to errors in the data will be assigned to the 50th performance percentile.

**Table 22: Requirements For Use of Subsection (d) Hospitals that are Eligible for Payment Under the IPPS Measure Results in Developing National Distribution of Required Measures for EPMs**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Required for Use in National Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI (NQF #0230)</td>
<td>At least 25 patient cases in the 3-yr measure performance period</td>
</tr>
<tr>
<td>AMI Excess Days</td>
<td>At least 25 patient cases in the 3-yr measure performance period</td>
</tr>
<tr>
<td>MORT-30-CABG (NQF #2558)</td>
<td>At least 25 patient cases in the 3-yr measure performance period</td>
</tr>
<tr>
<td>Hip/Knee Complications (NQF # 1550)</td>
<td>At least 25 patient cases in the 3-yr measure performance period</td>
</tr>
<tr>
<td>HCAHPS survey (#0166)</td>
<td>At least 100 complete surveys in the 4-quarter reporting period</td>
</tr>
</tbody>
</table>

**e. Determining Quality Measure Improvement**

CMS finalizes its proposal to add 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 will 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 moves into the top 10 percent of participants based on the national distribution of measure improvement over the 2 years for subsection (d) hospitals that are eligible for payment under the IPPS reporting the measure. The determination of improvement is independent of the participant’s measure point estimates starting and ending values.

For the SHFFT model, CMS finalizes its proposal to define improvement as a year-over-year gain of 2 deciles or more, referenced to the relevant national distributions. CMS will also award up to 10 percent of the maximum measure performance scores on both finalized required measures, capping the SHFFT composite quality score at 20 points. CMS finalizes similar changes in the CJR model methodology and notes these changes bring the SHFFT and CJR models composite into greater alignment with existing CMS programs.

**Submission of Voluntary Data.** CMS encourages voluntary measure data submission with eligibility for additional composite quality score points. CMS notes that data submitted by SHFFT participants also would be credited under the CJR model, eliminating duplicate submissions.

**f. Calculation of the EPM-Specific Composite Quality Score**

For each EPM model, CMS finalizes its proposal to assign a composite quality score to each EPM and that the SHFFT and CJR scores (based upon the same measures) will be identical. Tables 23-30 in the final rule provide measure performance weights and individual measure scoring (referenced to national distributions). The final measures and associated performance weights in each EPM model (Tables 23, 27, and 29) are reproduced below.
Table 23: Measures and Associated Performance Weights in an AMI Model Composite Quality Score

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Weight in Composite Quality Score</th>
<th>Quality Domain/Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI (NQF #0230)</td>
<td>50%</td>
<td>Outcome/80%</td>
</tr>
<tr>
<td>AMI Excess Days</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Hybrid AMI Mortality (NQF #2473) Voluntary Data</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>HCAHPS Survey (NQF #0166)</td>
<td>20%</td>
<td>Patient Experience/20%</td>
</tr>
</tbody>
</table>

CMS will first score individually each AMI model participant on the required measures based on the AMI model participant’s performance percentile as compared to the national distribution and assign scores according to the point values displayed in Table 24 in the final rule. The point ranges for the required measures are:

- MORT-30-AMI from 0 to 10.00,
- AMI Excess Days from 0 to 4.00, and
- HCAHPS Survey from 0 to 4.00.

CMS will assign a measure quality score of 2 points for successful submission of the Hybrid AMI Mortality measure and 0 points for participants that do not successfully submit this measure. CMS will award improvement scores on a measure-by-measure basis with improvement points awarded up to 10 percent of the maximum measure performance points available. For example, the improvement score would be up to 1.0 points for the MORT-30-AMI measure and the total composite quality score capped at 20.

Table 27: Measures and Associated Performance Weights in CABG Model Composite Quality Score

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Weight in Composite Quality Score</th>
<th>Quality Domain/Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-CABG (NQF #2558)</td>
<td>70%</td>
<td>Outcome/80%</td>
</tr>
<tr>
<td>STS Composite CABG voluntary data submission (NQF # 0696)</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>HCAHPS Survey (NQF #0166)</td>
<td>20%</td>
<td>Patient Experience/20%</td>
</tr>
</tbody>
</table>

CMS will first score individually each CABG model participants on the required measures based on the CABG model participant’s performance percentile as compared to the national distribution and assign scores according to the point values displayed in Table 28 in the final rule. The point ranges for the required measures are:

- MORT-30-CABG from 0 to 14 and
- HCAHPS Survey from 0 to 4.

CMS will assign a measure quality score of 2 points for successful submission of the STS Composite CABG measure and 0 points for participants that do not successfully submit this measure. CMS will award improvement scores on a measure-by-measure basis with
improvement points awarded up to 10 percent of the maximum measure performance points available.

**Table 29: Measures and Associated Performance Weights in SHFFT Model Composite Quality Score**

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Weight in Composite Quality Score</th>
<th>Quality Domain/Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Knee Complications (NQF #1550)</td>
<td>50%</td>
<td>Outcome/50%</td>
</tr>
<tr>
<td>THA/TKA voluntary PRO and limited risk variable submission</td>
<td>10%</td>
<td>Patient Experience/50%</td>
</tr>
<tr>
<td>HCAHPS Survey (NQF #0166)</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>

As with the other models, CMS will first score individually each SHFFT model participant on the required measures based on the SHFFT model participant’s performance percentile as compared to the national distribution and assign scores according to the point values displayed in Table 30 in the final rule. The point ranges for the required measures are:

- Hip/Knee complications from 0 to 10.00 and
- HCAHPS Survey range from 0 to 8.

CMS will assign a measure quality score of 2 points for successful submission of the THA/TKA voluntary PRO and limited risk variable measure and 0 points for participants that do not successfully submit this measure. CMS will award improvement scores on a measure-by-measure basis with improvement points awarded up to 10 percent of the maximum measure performance points available. CMS notes that for CJR model participants (the majority of the SHFFT model participants) the SHFFT model composite score will be the same as the participant’s score for the CJR model.

g. **EPM Pay-for-Performance Methodologies to Link Quality and Payment**

For incorporation into quality-adjusted target prices, CMS proposes a maximum effective discount factor for all EPM participants of 3.0 percent. CMS provides detailed narrative and tabular descriptions (Tables 31-39) of the pay-for-performance methodology applicable to each EPM. CMS finalizes four quality categories for each model based upon their respective composite quality scores: “Below Acceptable”, “Acceptable”, “Good”, and “Excellent”. Three tables are provided for each model that relate quality categories to reconciliation payment eligibility, effective discount factor for reconciliation payment, and discount factors for repayment amounts. Multiple tables are required to account for the phased-in repayment responsibility assumption (the downside risk) by EPM participants. Discount factors are termed “applicable” until responsibility phase-in is completed and then discount factors are termed “effective”.

1. **Form, Manner, and Timing of Quality Measure Data Submission**

CMS finalizes the following claims-based measures will be reported through the existing HIQR Program processes:
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (NQF #0230) (MORT-30-AMI)
- Excess Days in Acute Care after Hospitalization for AMI (AMI Excess Days)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558) (MORT-30-CABG), and
- Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary THA and/or TKA (NQF #1550) (Hip/Knee Complications).

CMS finalizes the same mechanism used in the HIQR Program to collect HCAHPS survey (NQF #0166) measure data to be used in the AMI, CABG, and SHFFT models.

For hospitals that voluntarily submit data for the Hybrid AMI mortality measures, CMS anticipates, if it is technically feasible, for data submission processes to be broadly similar to those for the HIQR Program for electronic quality measures. CMS finalizes that for performance year 1, hospitals can use either QRDA-I or a spreadsheet. CMS will create a template for data reporting, provide a secure portal for data submission, and provide education and outreach on how to use these mechanisms for data collection and where to submit the hybrid AMI voluntary data. (CMS described a process for voluntary data collection in section III.E.4.c.(2)(ii) of the proposed rule (81 FR 50907).) CMS finalizes its proposal to collect EHR data through only QDRA-1 in performance years 2 through 5.

Tables 41-45 in the final rule (reproduced below) summarize the final quality measure performance period for required and voluntary measures.

### Table 41: Summary of Quality Measure Performance Periods by Year of the AMI Model

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
</table>

* Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0230) (MORT-30-AMI)

** Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (AMI Excess Days)

### Table 42: Summary of Quality Measure Performance Periods by Year of the CABG Model

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
</table>

* Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558) (MORT-30-CABG)
### Table 43: Summary of Quality Measure Performance Periods by Year of the Voluntary Data Submission

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Model Performance Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission of EHR data elements for the Hybrid AMI Mortality Measure</td>
<td>1st: July 1, 2017 – August 31, 2017</td>
</tr>
<tr>
<td></td>
<td>2nd: Sept 1, 2017 – June 30, 2018</td>
</tr>
<tr>
<td></td>
<td>3rd: July 1, 2018 – June 30, 2019</td>
</tr>
<tr>
<td></td>
<td>4th: July 1, 2019 – June 30, 2020</td>
</tr>
<tr>
<td></td>
<td>5th: July 1, 2020 – June 30, 2021</td>
</tr>
<tr>
<td>Submission of STS CABG Composite Measure data</td>
<td>1st: July 1, 2017 – August 31, 2017</td>
</tr>
<tr>
<td></td>
<td>2nd: Sept 1, 2017 – June 30, 2018</td>
</tr>
<tr>
<td></td>
<td>3rd: July 1, 2018 – June 30, 2019</td>
</tr>
<tr>
<td></td>
<td>4th: July 1, 2019 – June 30, 2020</td>
</tr>
<tr>
<td></td>
<td>5th: July 1, 2020 – June 30, 2021</td>
</tr>
<tr>
<td>Submission of functional status data for elective primary THA/TKA procedures</td>
<td>1st: Sept 1, 2016 – June 30, 2017</td>
</tr>
<tr>
<td></td>
<td>2nd: July 1, 2017 – June 30, 2018</td>
</tr>
<tr>
<td></td>
<td>3rd: July 1, 2018 – June 30, 2019</td>
</tr>
<tr>
<td></td>
<td>4th: July 1, 2019 – June 30, 2020</td>
</tr>
<tr>
<td></td>
<td>5th: July 1, 2020 – June 30, 2021</td>
</tr>
</tbody>
</table>

### Table 44: Summary of Quality Measure Performance Periods by Year of the SHFFT Model

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Model Performance Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Knee Complications*</td>
<td>1st: April 1, 2014 – March 31, 2017</td>
</tr>
<tr>
<td></td>
<td>2nd: April 1, 2015 – March 31, 2018</td>
</tr>
<tr>
<td></td>
<td>3rd: April 1, 2016 – March 31, 2019</td>
</tr>
<tr>
<td></td>
<td>4th: April 1, 2017 – March 31, 2020</td>
</tr>
<tr>
<td></td>
<td>5th: April 1, 2018 – March 31, 2021</td>
</tr>
</tbody>
</table>

*Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550) (Hip/Knee Complications)

### Table 45: Summary of Quality Measure Performance Periods by Year for Required Measures for All EPMs

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Model Performance Year</th>
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<tr>
<td>HCAHPS*</td>
<td>1st: July 1, 2016 – June 30, 2017</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>5th: July 1, 2020 – June 30, 2021</td>
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</tbody>
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*Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)

2. Display of Quality Measures and Availability of Information for the Public from AMI, CABG, and SHFFT Models

CMS finalizes its proposal to display required quality measure results on the Hospital Compare Website (http://www.hospitalcompare.hhs.gov). For the voluntary STS CABG measure, for year one, CMS intends to publicly report the data if it is operationally feasible. CMS does not plan to publicly report the voluntary PRO data collection because the voluntary PRO data collection for
patients undergoing elective primary THA/TKA procedures is being collected to develop a future PRO-based performance measure.

F. Compliance Enforcement and Termination of an Episode Payment Model (§512.460)

Noting that it must have mechanisms to enforce compliance with the requirements of EPMs under part 512, CMS finalizes the enforcement structure it proposed with one clarification described below. The EPM compliance enforcement structure is similar to and consistent with the CJR model; for example, an EPM participant will be held responsible for its own as well as its EPM collaborators’ compliance with the EPM requirements.

CMS may take several remedial actions against any EPM participant where the EPM participant (or EPM collaborator, collaboration agent or downstream collaboration agent) does not comply with applicable requirements. They include the following:

- Sending a warning letter to the EPM participant;
- Requiring a corrective action plan (CAP) developed by the EPM participant;
- Reducing or eliminating an EPM participant’s reconciliation payment or CR incentive payment;
- Requiring an EPM participant to terminate a sharing arrangement with an EPM collaborator and prohibiting further engagement by the EPM participant in sharing arrangements with the EPM collaborator; and
- Terminating the EPM participant’s participation in the EPM.

When an EPM participant is terminated from an EPM, the participant will remain liable for all negative NPRA generated from episodes of care that occurred before termination. CMS also intends to share with its program integrity contractors as well as the Department of Justice and its designees any information CMS collects in relation to termination of an EPM participant from the model.

The list of requirements for which CMS may take one or more remedial actions in the case of noncompliance is expansive. For example, remedial actions could be imposed if an EPM participant (or its related EPM collaborators, collaboration agents or downstream collaboration agents) fails to comply with any applicable requirement of part 512 or is identified as noncompliant because it:

(i) avoids high cost or high severity patients or targets low cost or low severity patients;
(ii) fails to provide medically appropriate services or systematically engages in over- or under-delivery of appropriate care;
(iii) fails to provide beneficiaries with complete and accurate information, including required notices;
(iv) fails to allow beneficiary choice of medically-necessary options, including non-surgical options; or
(v) fails to follow the requirements related to sharing arrangements.

CMS may also add 25 percent to a repayment amount on an EPM participant’s reconciliation report if all of the following criteria apply:
• CMS requires a CAP from the EPM participant;
• The EPM participant owes a repayment amount to CMS; and
• The EPM participant fails to timely comply with the CAP or is noncompliant with the EPM’s requirements.

CMS may terminate any EPM for other reasons, including that the agency no longer has the funds to support the model or that the model does not meet the criteria to expand to phase II of an Innovation Center demonstration. CMS reminds readers that termination of an Innovation Center model is not subject to administrative or judicial review.

Concerned by possible limits to CMS’ ability to take remedial action under §512.460(b)(1)(vii) (relating to actions that are not in the best interest of the applicable EPM for or failure to take an action that should be taken for program integrity reasons), one commenter asked for examples of actions that do not violate the fraud and abuse laws that could be addressed under this authority. CMS notes that this provision was developed precisely to include noncompliance that is not a clear violation of the fraud and abuse laws, such as the failure to respond to a CMS request for records relating to potential physician self-referral prohibitions or where an audit shows a high error rate in payment due to coding errors by a collaboration agent. In response to another comment, CMS declines to establish a reasonable knowledge standard for EPM awareness of a collaborator’s involvement in violations of the fraud and abuse laws. CMS believes the EPM participant should be aware of all circumstances where EPM collaborators, collaboration agents and downstream collaboration agents are subject to action for violations of the fraud and abuse and other applicable Medicare laws and regulations.

G. Monitoring and Beneficiary Protection

1. Beneficiary Choice

CMS finalizes it proposal that EPM participation will be mandatory for all hospitals (with some limited exceptions) in the selected geographic areas where the EPM demonstration will take place. An individual beneficiary will retain full choice of providers, but upon being admitted to an EPM participant hospital that results in discharge from an MS-DRG that initiates an EPM episode, the beneficiary will not be able to opt out of his or her care being included in an EPM episode under the responsibility of that EPM participant.

The finalized requirements for EPM participants supplement the discharge planning requirements under existing CoPs. Neither the CoPs nor the finalized transparency requirement preclude EPM participants from recommending preferred providers and suppliers within the constraints created by current laws and regulations.

After consideration of comments, CMS finalizes the provisions of the proposed rule with the following modifications:

• As part of discharge planning and referral, the EPM participant is not required to provide a complete and comprehensive list of all post-acute providers in the area to the beneficiary. Only a list of post-acute care provider types relevant to the type of post-acute care the patient
needs is required (e.g. a list of SNFs would not have to be provided if the patient only requires home health services).

- The proposed rule mandated that EPM participants provide beneficiary cost-sharing and quality information for post-acute care providers on the list. The final rule makes this provision voluntary. If the EPM participant voluntarily provides cost-sharing and quality information, it must be comparable for all the post-acute care providers on the list.

CMS finalizes the following beneficiary choice provisions:

- The EPMs do not restrict Medicare beneficiaries' ability to choose any Medicare enrolled provider or supplier, or any physician or practitioner who has opted out of Medicare.
- As part of discharge planning and referral, EPM participants must provide a complete list of HHAs, SNFs, IRFs, or LTCHs that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient.
  - This list must be presented to EPM beneficiaries for whom home health care, SNF, IRF, or LTCH services are medically necessary.
  - EPM participants must specify those post-acute care providers on the list with whom they have a sharing arrangement.
- EPM participants may recommend preferred providers and suppliers, consistent with applicable statutes and regulations.
- EPM participants may not limit beneficiary choice to any list of providers or suppliers in any manner other than that permitted under applicable statutes and regulations.
- EPM participants must take into account patient and family preferences when they are expressed.
- EPM participants may not charge any EPM collaborator a fee to be included on any list of preferred providers or suppliers, nor may the EPM participant accept such payments.

2. Beneficiary Notification

CMS finalizes with modifications, its proposals for required beneficiary notifications under the EPMs. The modifications streamline the detailed beneficiary notification and EPM collaborator notice requirements. Highlights of the required beneficiary notifications are summarized below. CMS lists the entire final requirements at 82 FR 640-641.

(1) As part of the discharge planning process, hospitals in EPMs are required to inform beneficiaries of all Medicare participating post-acute providers with whom they have sharing arrangements.

(2) *Hospital Detailed Notification.* At admission or immediately following the decision to schedule a procedure or service resulting in a patient being included in the episode, participating hospitals are required to provide a notice that includes the elements listed below. The notice must be provided to all beneficiaries in the EPM and if it isn’t feasible to provide the notice on admission or immediately following a decision to schedule a procedure that would begin an episode, then it is required to be provided to the beneficiary or his or her representative as soon as is reasonably practicable but no later than discharge. The hospital is
required to be able to generate a list of beneficiaries who receive the notification including the date of receipt for monitoring purposes. The notice needs to explain:

- The model and how it might affect the beneficiary's care;
- That the beneficiary retains his or her freedom to choose their own providers and services;
- How he or she can access their records and claims data, and how they can share access to their electronic health information with caregivers; and
- That all existing Medicare beneficiary protections continue to apply including the ability to report concerns of substandard care to Quality Improvement Organizations and 1-800-MEDICARE.

(3) Physician, Non-Physician Practitioner, Physician Group Practice, PAC Provider, Collaborating Hospital, and ACO notice. A participating hospital is required to ensure that collaborating entities (as listed in the title of this section) provide notice to Medicare beneficiaries regarding the structure of the model and the existence of any cost sharing arrangements they have with the hospital. The notice is required at the time of a decision to schedule a procedure or service resulting in a patient being included in the episode. (If not feasible, the notice can be provided to the beneficiary or his or her representative as soon as is reasonably practicable but no later than at discharge.) The provider is required to be able to generate a list of beneficiaries who receive the notification including the date of receipt for monitoring purposes.

(4) Discharge Planning Notice. CMS requires each participating beneficiary receive a discharge planning notice informing them of any potential financial liability associated with non-covered services. The notice is required to be provided at the earlier of when such service is recommended or at discharge. If a hospital knows or should have known that a beneficiary is considering using such a service or supply, the hospital is required to notify the beneficiary that the service will not be covered by Medicare. If a beneficiary is being discharged to a SNF prior to a 3-day hospital stay, and the SNF will not qualify under the SNF 3-day waiver described in §512.610, the hospital will be required to notify the beneficiary that he or she will be responsible for costs associated with that stay except those which will be covered by Medicare Part B during a non-covered inpatient SNF stay.

In addition, CMS adopts the following modifications for the beneficiary notification requirements:

- If the admission is scheduled in advance, then the EPM participant must provide notice as soon as the admission is scheduled. The notification must be provided upon admission to the EPM participant hospital if the admission that initiates the EPM episode is not scheduled with the EPM participant in advance. (Even though the hospital may not know if the patient is grouped to a specific MS-DRG, CMS believes that the hospital can predict based on the patient’s condition whether the patient will be in an EPM episode.)
- In circumstances where, due to the patient's condition, it is not feasible to provide notification at such times, the notification must be provided to the beneficiary or his or her
representative as soon as is reasonably practicable but no later than discharge from the EPM participant hospital accountable for the EPM episode.

- The disclosure of the EPM participant's sharing arrangements, as part of the detailed beneficiary notification, may be satisfied if the EPM participant provides a web address where beneficiaries may access the list of providers, suppliers, and ACOs with whom the EPM participant has a sharing arrangement.

- The EPM participant is required to publicly post (and update on at least a quarterly basis) accurate current and historical lists of all EPM collaborators on its website.

- An EPM participant must require every EPM collaborator that furnishes an item or service to an EPM beneficiary during an EPM episode (including EPM collaborators that are ACOs, physician group practices, non-physician practitioner group practices and therapy group practices) to provide written notice to the beneficiary of the structure of the EPM and the existence of the individual's or entity's sharing arrangement.

CMS plans to make a detailed beneficiary notification template that EPM participants can use prior to the effective date of the final rule on July 1, 2017. CMS is also exploring the possibility of preparing notice templates that may be used for individuals and entities with sharing arrangements under the EPMs that are required to provide notice to EPM beneficiaries.

3. Monitoring for Access to Care

CMS finalizes its proposal to monitor the EPM participant's episode claims data – for example, to compare each EPM participant's case mix relative to a pre-model historical baseline – to determine whether complex patients are being systematically excluded from the EPM participant's EPM episodes. CMS will publish these data as part of each EPM's evaluation to promote transparency and an understanding of the EPM's effects. CMS will also continue to review and audit EPM participants if it has reason to believe the participants are compromising beneficiary access to care such as an unusual pattern of referral to regional hospitals located outside of the EPM participant's catchment area or a clinically unexplained increase or decrease in CABG or rates of other related surgical procedures that do not initiate EPM episodes.

4. Monitoring for Quality of Care

CMS believes it has the authority and responsibility to audit EPM participants' and their EPM collaborators' medical records and claims and finalizes its proposal to audit as necessary. CMS also finalizes its proposal to monitor financial arrangements between EPM participants and their EPM collaborators to ensure that such arrangements do not result in the denial of medically necessary care or other programmatic or patient abuses consistent with policies that have been established for the CJR model.

5. Monitoring for Delayed Care

CMS finalizes its proposal that certain post-episode payments occurring in the 30-day window subsequent to the end of the EPM episode would be counted as an adjustment against savings achieved by the EPM participant. CMS believes that including such a payment adjustment would
create an additional deterrent beyond the quality measures and other safeguards already in existence that protect against delays in providing medically necessary care under the EPMs.

CMS indicates that EPM participants with post-episode spending in the 30 days following the end of EPM episodes that exceeds a threshold set at 3 standard deviations above average spending in their region for that period may be required to repay Medicare for the amounts in excess of the threshold. EPM participants found to engage in delaying medically necessary care would be noncompliant with the finalized EPM provisions in §512.460(b)(1) due to actions that threaten the health or safety of patients. Such behavior could lead to the EPM participant being required to develop a corrective action plan; reducing or eliminating the EPM participant's reconciliation payment; adding a 25 percent penalty to the repayment amount on the EPM participant's reconciliation report under certain conditions, or terminating the EPM participant's participation in the EPM.

H. Access to EPM Records and Record Retention (§512.110)

In addition to similar EPM record retention requirements as found in CJR (located in Subpart B of the EPM Rule) CMS finalizes:

- EPM participants, EPM collaborators, collaboration agents, downstream collaboration agents, and any other individuals or entities performing EPM activities must allow both scheduled and unscheduled access to all books, contracts, records, documents, and other evidence (including data related to utilization and payments, quality of care criteria, billings, lists of EPM collaborators, sharing arrangements, distribution arrangements, downstream distribution arrangements, and the documentation required under §§512.500(d) and 512.525(d)) sufficient to enable the audit, evaluation, inspection, or investigation of six categories of information.

- All such books, contracts, records, documents, and other evidence be maintained for a period of 10 years from the last day of the EPM participant's participation in the EPM or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless CMS determines a particular record or group of records should be retained for a longer period and notifies the EPM participant at least 30 calendar days before the disposition date; or there has been a dispute or allegation of fraud or similar fault against the EPM participant, EPM collaborator, collaboration agent, downstream collaboration agents, or any other individual or entity performing EPM activities in which case the records must be maintained for 6 years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault.

For the EPM model, CMS finalizes its proposal to apply the record access and retention obligations to EPM participants and all individuals and entities with EPM financial arrangements where payments are substantially based on quality of care and the provision of EPM activities, as well as to other individuals and entities providing EPM activities. CMS adopted similar changes to the individuals and entities subject to record access and retention obligations under the CJR model as discussed in the final rule.
CMS finalizes its proposal to apply the record access and retention requirements to the following six categories of information:

(1) Documents related to the individual's or entity's compliance with EPM requirements.
(2) Documents related to the calculation, distribution, receipt, or recoupment of gainsharing payments, alignment payments, distribution payments, and downstream distribution payments. CMS proposed similar changes to the record access and retention requirements for the CJR model as discussed further in section V.L. of the final rule.
(3) Documents related to an EPM participant's obligation to repay to CMS any reconciliation payment or CR incentive payments owed.
(4) Documents related to the quality of the services furnished to an EPM beneficiary during an EPM episode.
(5) Documents related to the sufficiency of EPM beneficiary notifications (also proposed to be added for the CJR model as discussed further in section V.L. of the final rule).
(6) CEHRT use attestations so that an EPM participant could be in a Track 1 EPM that meets the requirements in the Quality Payment Program final rule with comment period (81 FR 77008) to be an Advanced APM as discussed in section III.A.2 of the final rule. CMS proposed to add this same category of information for the CJR model as discussed further in section V.L. of the final rule.

I. Financial Arrangements under the EPM

Financial Arrangements and Beneficiary Incentives (Subpart F of Part 512)

CMS finalizes requirements for financial arrangements and beneficiary incentives among hospitals and other providers of services and suppliers caring for beneficiaries in EPM episodes of care, which are largely similar to those applicable to the CJR model. The specific final policies and modifications from the proposed rule are discussed below.

Sharing arrangements under the EPM (§512.500)

CMS discusses several key terms related to EPM financial arrangements that are defined in §512.2.

EPM collaborator

EPM collaborators means an ACO or one of the following Medicare-enrolled individuals or entities that enters into a sharing agreement: skilled nursing facility (SNF), HHA, LTCH, IRF, physician, nonphysician practitioner (NPP), therapist in private practice, CORF, provider of outpatient therapy services, physician group practice (PGP), hospitals, critical access hospital (CAH), NPPGP, and TGP.

CMS clarifies that individual nonphysician practitioners and groups of nonphysician practitioners are permitted to be EPM collaborators and thus adds the term nonphysician practitioner group practice (NPPGP). A NPPGP is defined as an entity that is enrolled in Medicare as a group practice, includes at least one owner or employee who is a nonphysician practitioner, does not include a physician owner or employee, and has a valid and active TIN.
CMS also provides greater clarity with respect to the providers and suppliers of outpatient therapy services that can be EPM collaborators. CMS defines a new term therapist in private practice, revises its definition of provider of outpatient therapy services, and defines and adds the term therapy group practice to the list.

With respect to adding other entities to the EPM collaborator list, such as medical device companies, CMS notes that an EPM collaborator must have contributed to EPM activities and have been clinically involved in the care of EPM beneficiaries in order to be eligible to receive a gainsharing payment, and at this point CMS remains unconvinced that any EPM entities, other than ACOs, could meet these eligibility criteria. CMS continues to believe that it is not appropriate to include Next Generation ACOs in the definition of ACOs that may be EPM collaborators; for, CMS is also excluding MSSP ACOs in Track 3 from the definition of ACOs that may be EPM collaborators. CMS modifies its definition of ACO to read “ACO means an accountable care organization, as defined in §425.20 of this chapter, that participates in the Shared Savings Program and is not in Track 3.”

Sharing arrangement
Means a financial arrangement between a participating hospital and an EPM collaborator for the sole purpose of sharing the following: (i) Reconciliation payments, (ii) the participating hospital’s internal cost savings; and (iii) the participating hospital's responsibility for repayment to CMS.

Sharing arrangements under the EPM (§512.500).
CMS finalizes the general requirements for EPM sharing agreements, with modification to clarify that an EPM collaborator selection criterion that considers whether a potential collaborator has performed a reasonable minimum number of services that would qualify as EPM activities will be deemed not to violate the volume or value standard if the purpose of the criterion is to ensure the quality of care furnished to EPM beneficiaries.

An EPM sharing arrangement must comply with the following general provisions:

- An EPM participant may enter into a sharing arrangement with an EPM collaborator to make a gainsharing payment, or to receive an alignment payment, or both. An EPM participant must not make a gainsharing payment or receive an alignment payment except in accordance with a sharing arrangement.
- A sharing arrangement must comply with the provisions of this section and all other applicable laws and regulations, including the applicable fraud and abuse laws and all applicable payment and coverage requirements.
- The EPM participant must develop, maintain, and use a set of written policies for selecting individuals and entities to be EPM collaborators. These policies must contain criteria related to, and inclusive of, the quality of care delivered by the potential EPM collaborator.
- If an EPM participant enters into a sharing arrangement, its compliance program must include oversight of sharing arrangements and compliance with the applicable requirements of the EPM.
**Requirements for sharing arrangements (§512.500(b)).**

CMS finalizes its proposals for the requirements for EPM sharing arrangements, with modification, to specify that the EPM collaborator must have or be covered by a compliance program, which must include oversight of the sharing arrangement. CMS also removes the proposed requirement that the written agreement of the sharing arrangement include management and staffing information.

Participation in any sharing arrangement is required to be voluntary and there could be no penalties for nonparticipation. The sharing arrangement cannot pose a risk to beneficiary access, freedom of choice or quality of care. The sharing arrangement needs to obligate the parties to comply (and an EPM collaborator to require any of its employees, contractors or designees to comply) with the following:

- Beneficiary notice requirements and record maintenance requirements.
- Requirements to cooperate with HHS site visits and other evaluation, monitoring, oversight and enforcement activities, including access to records and other information.
- All Medicare provider enrollment requirements and all other applicable laws and regulations.
- The EPM collaborator’s compliance program.

The board or governing body of the EPM must oversee participation in the EPM, arrangements with collaborators, gainsharing & alignment payments and beneficiary incentives.

CMS requires that a collaborator agreement is entered into before care is furnished to an EPM beneficiary. The agreement needs to specify the purpose and scope of the arrangement, the identities and obligations of the parties, the date of the sharing arrangements, financial and economic terms for payments including eligibility criteria for a gainsharing or alignment payment; their frequency, methodology and accounting formula for calculating as well as for distribution and verification of those payments. The methodology for gainsharing payments must be substantially based on quality of care.

CMS prohibits the agreement from inducing a participant collaborator or any employee, contractor or subcontractor to reduce or limit medically necessary services to a beneficiary, or restricting the ability of an EPM collaborator to make decisions in the best interests of patients.

Further, CMS clarifies that the CJR compliance program requirement did not mandate that such a program take a particular form or include particular components, consistent with guidance from the Inspector General of HHS which has repeatedly emphasized that there is no “one size fits all” compliance program.

**Gainsharing and Alignment Payments (§512.500(c)).**

*Gainsharing* payments are required to meet the following conditions and restrictions
• Be derived solely from reconciliation payments or internal cost savings, or both.
• Not be a loan or payment for referrals or other business generated from the parties.
• Not be an inducement to reduce or limit medically necessary services.
• Be determined using methodologies that use quality criteria directly related to EPM episodes of care.
• Be distributed annually.
• Be able to be recouped if paid to collaborators if they involved funds from a CMS overpayment or were based on the submission of false or fraudulent data.

Gainsharing payments cannot be made to a collaborator who is subject to program integrity issues, such as noncompliance actions under the model, fraud or abuse, or providing substandard care. Total Gainsharing payments for any individual physician or NPP cannot exceed 50 percent of total approved MPFS payments for services furnished to EPM beneficiaries. A similar 50 percent limit applies to PGPs.

To receive a Gainsharing payments or be required to make an Alignment payment CMS requires that:

• An EPM collaborator must have directly furnished a billable item or service during the EPM episode in the same performance year for which the EPM participant accrued the internal cost savings or earned the reconciliation payment.
• An EPM collaborator that is a PGP or an ACO qualifies for a gainsharing payment if the PGP has billed for, or the ACO has had a provider/supplier that furnished or billed for, a service during the EPM episode in the same performance year for which the EPM participant accrued the internal cost savings or earned the reconciliation payment. To qualify, a PGP or ACO must be clinically involved in and have a role in implementing quality strategies, for example, by providing care coordination, and implementing strategies to address or manage comorbidities, etc. These same conditions apply to a NPPGP or TGP.

Alignment payments under this rule:

• Can be made at any interval as agreed on by both parties;
• Cannot be made before the Reconciliation Report reflects a negative NPRA; and
• Cannot be in the form of a loan, advance, or payment for referrals/other business generated.

For Alignment payments under this rule, CMS also provided that:

• Total payments received by the hospital cannot exceed 50 percent of the hospital’s repayment amount owed to CMS, and the most a single collaborator that is not an ACO can pay to a single hospital is 25 percent of the repayment amount owed to CMS. For a collaborator that is an ACO that ceiling is 50 percent of the repayment amount owed to CMS.
• No other payments except for alignment payments can be made under a sharing arrangement from an EPM collaborator to an EPM participant.
All Gainsharing and Alignment payments are required to be administered in accordance with generally accepted accounting principles (GAAP).

CMS prohibits conditioning the opportunity to make or receive gainsharing or alignment payments on the volume or value of referrals or business generated by collaborators and participants and that the methodology for determining alignment payment cannot directly take those factors into account. CMS notes that accounting for the relative amount of EPM activities by an EPM collaborator for the purpose of determining gainsharing payments is allowed but the selection of those collaborators based on referrals or the value of business generated would be prohibited.

Internal cost savings.
CMS proposed that the methodology for accruing, calculating & verifying internal cost savings would need to be transparent and be administered by the hospital in accordance with GAAP.

Documentation and Records Maintenance (§512.500(d)).
CMS finalizes its proposal for EPM documentation requirements with the modification to require the EPM participant to publicly post the written policies for selecting EPM collaborators on a webpage on the EPM participant’s website and reorganization to consolidate and streamline the documentation requirements related to public posting.

EPM sharing arrangements must meet the following documentation requirements:

- Document the sharing arrangement contemporaneously with its establishment.
- Publicly post (and update on a quarterly basis) the arrangement on a webpage on the EPM participant’s website.
- Maintain accurate current and historical lists of EPM collaborators, including names and addresses.
- Have written policies for selecting individuals and entities to be EPM collaborators.
- Require collaborators to maintain contemporaneous documentation of payment or receipt of any gainsharing payment or alignment payment including at least the:
  - Type of payment (gainsharing payment or alignment payment), the identity of those making/receiving the payment, and date and amount of the payment; and
  - Date, amount, and explanation of any recoupment of a gainsharing payment (for example, an explanation would document whether the recoupment contained funds derived from a CMS overpayment or was based on the submission of false or fraudulent data.)
- In addition to records required in §512.110 (described in section H. above,) an EPM participant would be required to keep records regarding:
  - Its process for determining and verifying collaborators’ eligibility to participate in Medicare;
  - Its plan and accounting system for tracking internal cost savings; and
  - Its current health information technology, including systems to track reconciliation payments, internal cost savings, gainsharing and alignment payments.
CMS received no specific comments on the proposed documentation requirements.

_Distribution & Downstream Distribution Arrangements under the EPM (§§512.505(a))_

CMS finalizes its proposals for the general requirements for EPM distribution arrangements, with modification, to allow non-physician practitioner group practices or therapy group practices to enter into distribution arrangements with non-physician practitioner group practice members or therapy group practice members.

“Distribution arrangements” are made for the sole purpose of sharing a gainsharing payment received by an ACO or PGP. These distribution arrangements will be subject to many of the same requirements described above for sharing arrangements. Distributions under those arrangements must:

- Not be conditioned on the volume or value of referrals or business generated by collaborators and participants;
- Not be an inducement to reduce or limit medically necessary services;
- Be determined substantially based on quality of care and the provision of EPM activities;
- For a collaboration agent, be based on an item or services furnished or billed for during the EPM episode in the same performance year for which the EPM participant accrued the internal cost savings or earned the reconciliation payment; and
- For a physician or NPP, not exceed 50 percent of total approved MPFS payments for services furnished to EPM beneficiaries. A similar 50 percent limit applies to PGPs.

Total gainsharing payments received by a PGP or ACO could not exceed the total amount of the gainsharing payment received by the EPM collaborator from the EPM participant.

Certain of those rules include an exception for collaborators who comply with existing §411.352(g), a provision that prohibits physicians in a group practice from being directly or indirectly compensated based on the volume or value of his or her referrals. CMS incorporates an exception to allow for the flexibility for an individual PGP provider to share in the practice’s financial benefit without consideration of the PGP member’s _individual_ quality of care or provision of services.

CMS summarizes its policies for the defined terms and financial arrangements in Figure 3.
Enforcement authority under the EPM (§512.520).

CMS finalizes its proposal that the Office of Inspector General (OIG) have unlimited authority to audit, evaluate, investigate, or inspect EPM participants and collaborators.

Beneficiary engagement incentives under the EPM (§512.525).

CMS allows EPM participants to provide in-kind incentives to beneficiaries of EPMs, conditional on meeting certain standards. Incentives are required to go directly to the EPM beneficiary during the episode, be reasonably connected to medical care provided to an EPM beneficiary during the episode, and be an item or service that advances a clinical goal by engaging the beneficiary in better managing his or her own health. The incentives cannot be tied
to the receipt of items or services outside the EPM episode or be tied to a particular provider or supplier nor be advertised or promoted.

CMS provides additional conditions for incentives that involve technology. Technology incentives can have a retail value of no more than $1,000 and must be the minimum necessary for advancing the clinical goal. Items or services that have a retail value greater than $100 will remain the property of the EPM participant and would need to be returned by the beneficiary at the end of the episode. The EPM participant will need to document retrieval attempts if the item is not returned by the beneficiary at the end of the episode.

EPM participants will be required to maintain documentation of beneficiary engagement incentives that exceed $25 in value and as noted above. Documentation must include the dates that items or services were furnished as well as the identity of the beneficiary to whom they were provided.

J. Waivers of Medicare Program Requirements (Subpart G of Part 512)

CMS finalizes the following for EPMs.

Post-Discharge Home Visits (§§512.600, 512.615)
CMS will waive the “incident to” rule under §410.26(b)(5) to permit an EPM beneficiary who does not qualify for home health services (e.g., who is not homebound) to receive post-discharge visits in his or her home or place of residence any time during the episode. The waiver will not apply to beneficiaries who would qualify for home health services under the Medicare program. CMS will permit licensed clinical staff (e.g., nurses) to furnish the service under the general supervision of a physician, who may be either an employee or a contractor of the hospital.

Services furnished under the waiver may be billed under the PFS by the physician or nonphysician practitioner, or by the hospital to which the supervising physician has reassigned benefits. CMS finalizes the following model-specific limits on the number of post-discharge home visits:

- **AMI Model.** A beneficiary in the AMI model is limited to 13 home visits (i.e., an average of one home visit per week for the entire 90-day AMI episode).
- **CABG and SHFFT Models.** A beneficiary in the CABG or SHFFT model is limited to 9 home visits (i.e., an average of one home visit per week for 60 days (two-thirds of the entire 90-day episode)).

The additional post-discharge home visits can be billed with HCPCS code G9863 beginning July 1, 2017. The RVUs for this new code will be based upon the same inputs used to determine the payment rate for HCPCS code G9187 (BPCI home visit) and paid at approximately $45 under the PFS. CMS will update values each year.

CMS finalizes its proposal to waive current billing rules to permit separate reporting of post-discharge home visits during surgical global periods so the surgeon or other practitioner may furnish and bill for the post-discharge home visits during surgical global periods.
Billing and Payment for Telehealth Services (§512.605)
CMS finalizes its proposal to waive the geographic site requirements of the Act to permit telehealth services to be furnished to an eligible telehealth individual in his or her home or place of residence. Thus, providers and suppliers will be able to furnish services related to the episode (i.e., AMI, CABG, or SHFFT episode) to EPM beneficiaries via telemedicine for beneficiaries residing in any region. CMS emphasizes that the waiver of the originating site requirement applies only when telehealth services are being furnished in the EPM beneficiary’s home or place of residence during the episode.

Telehealth services include any service on the list of Medicare approved telehealth services and reported on a claim with a principal diagnosis code that is not excluded from the EPM’s episode definition, unless the service’s HCPCS code descriptor precludes delivering the service in the home or place of residence. CMS creates a specific set of HCPCS G-codes to describe the evaluation and management (E/M) services furnished to EPM beneficiaries in their homes via telehealth. CMS believes the services are most similar to services described by the office and other outpatient E/M codes; it structures the new codes similarly to those E/M codes but would adjust them to reflect the location as the beneficiary’s residence and the virtual presence of the practitioner.

CMS finalizes its proposal to create 9 HCPCS G-codes to report home telehealth E/M visits furnished under the EPM waiver (shown in an abbreviated version is shown below). These codes will be payable beginning July 1, 2017, and will be paid under the PFS as equal to the work and MP RVUs established for the comparable office/outpatient visits.

**TABLE 50: HCPCS CODES FOR TELEHEALTH VISITS FOR EPM BENEFICIARIES IN HOME OR PLACE OF RESIDENCE**

<table>
<thead>
<tr>
<th>Code Number</th>
<th>Short Descriptor</th>
<th>Work and MP RVUs Equal to Those of the Corresponding Office/Outpatient E/M Visit CPT Code for Same Calendar Year under the PFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9864</td>
<td>In home E/M new pt 10 mins</td>
<td>99201</td>
</tr>
<tr>
<td>G9865</td>
<td>In home E/M new pt 20 mins</td>
<td>99202</td>
</tr>
<tr>
<td>G9866</td>
<td>In home E/M new pt 30 mins</td>
<td>99203</td>
</tr>
<tr>
<td>G9867</td>
<td>In home E/M new pt 45 mins</td>
<td>99204</td>
</tr>
<tr>
<td>G9868</td>
<td>In home E/M new pt 60 mins</td>
<td>99205</td>
</tr>
<tr>
<td>G9869</td>
<td>In home E/M new est 10 mins</td>
<td>99212</td>
</tr>
<tr>
<td>G9870</td>
<td>In home E/M new est 15 mins</td>
<td>99213</td>
</tr>
<tr>
<td>G9871</td>
<td>In home E/M new est 25 mins</td>
<td>99214</td>
</tr>
<tr>
<td>G9872</td>
<td>In home E/M new est 40 mins</td>
<td>99215</td>
</tr>
</tbody>
</table>
CMS will update the values each year to correspond to final values established under the PFS. CMS does not include PE RVUs for these services, since it does not believe that virtual visits envisioned for this model typically incur the kinds of costs included in the PE RVUs under the PFS.

CMS clarifies that all telehealth services under the waiver must meet Medicare coverage and payment criteria and that no additional payment would be made to cover set-up costs, technology purchases, training and education, or other related costs. CMS also will waive the usual facility fee when the service was originated in the beneficiary’s home or place of residence. Lastly, beneficiaries can only receive telehealth services under the waiver during the EPM episode.

SNF 3-Day Rule (§512.610)

a. Waiver

CMS finalizes its proposal, with modification, to waive the SNF 3-day rule for coverage of a SNF stay following the anchor hospitalization under an EPM where it is clinically appropriate. Consistent with linking the availability of the 3-day waiver to the participant’s downside risk, CMS delays the availability of the 3-day waiver until PY 3 (i.e., anchor hospital discharges beginning on or after October 4, 2018).

CMS also permits use of this waiver only for discharges to a SNF with an overall rating of three stars or better (on the CMS Five-Star Quality Rating System) based on information publicly available at the time of hospital discharge. Specifically, to be qualified, the SNF must be included in the most recent calendar year quarter on the Nursing Home Compare website and be rated an overall 3 stars or better for at least 7 of the 12 months based on a review of the most recent rolling 12 months of overall star ratings. CMS will post on its web site the list of qualified SNFs in advance of each calendar quarter.

CMS will permit the SNF 3-day waiver to apply to the AMI model. However, CMS will not permit the waiver for the CABG model or for the SHFFT model.

To conform with the delay in downside risk for EPM participants until PY 3, CMS is also delaying availability of the 3-day waiver until PY 3.

b. Additional Beneficiary Protections under the SNF 3-Day Stay Rule Waiver

CMS finalizes its proposal to hold the EPM participant hospital financially responsible for misusing the waiver in situations where waiver requirements are not met.

CMS is concerned with the three following scenarios:

- The EPM participant hospital discharges a beneficiary that is in a specific EPM where the SNF 3-day rule waiver does not apply (e.g., the CABG or SHFFT model).
- The EPM participant hospital discharges a beneficiary prior to October 4, 2018, where the SNF 3-day rule waiver does not apply.
• The EPM participant hospital discharges a beneficiary to a SNF that does not meet the 3-star quality rating requirement and does not provide a discharge planning notice to the beneficiary alerting them of potential financial liability.

Where CMS determines the waiver requirements are not met under one or more of the circumstances described above, CMS applies the following rules:

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

However, where the EPM hospital discharges a beneficiary to a SNF that does not meet the 3-star quality rating requirement and a discharge planning notice is provided to the beneficiary alerting him or her of potential financial liability, then the hospital will not be financially liable for the cost of the SNF stay and the normal rules for coverage of SNF services will apply. Essentially, the discharge notice would absolve the hospital of liability.

Waivers of Medicare Program Rules to Allow Reconciliation Payment or Repayment Actions Resulting from the Net Payment Reconciliation Amount (§512.620)
CMS finalizes its proposal to waive requirements of sections 1813 and 1833(a) of the Act (relating to deductibles and coinsurance) for Part A and Part B payment systems only to the extent necessary to make reconciliation payments or receive repayments based on the NPRA that reflect the episode payment methodology under the final payment model for EPM participant hospitals. CMS clarifies that its policies on reconciliation payments or repayments would not change beneficiary cost-sharing from the regular Medicare program cost-sharing for the related Part A and Part B services that were paid for beneficiaries and aggregated to determine actual episode spending in the calculation of the NPRA.

New Waiver for Providers and Suppliers of Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services Furnished to EPM Beneficiaries during an AMI or CABG Episode (§512.630)
A cardiac rehabilitation (CR) program is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment, and an intensive cardiac rehabilitation (ICR) program is a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients’ cardiovascular disease through specific outcome measurements described in §410.49(c). CMS notes that CR and ICR programs may be furnished to EPM beneficiaries during AMI and CABG episodes, and finalizes in this rule to make a payment adjustment under the AMI and CABG models to account for and possibly incentivize the provision of CR and ICR services beyond what has historically been provided during AMI and CABG episodes.

CMS will waive the definition of physician to permit certain nonphysician practitioners to perform the functions of the supervisory physician, prescribe exercise, and establish, review, and
sign an individualized treatment plan for a provider or supplier of CR and ICR services furnished to an EPM beneficiary during an AMI or CABG episode. However, CMS will not permit a nonphysician practitioner to act in the capacity of a medical director under the waiver.

For an EPM beneficiary in an AMI or CABG episode, this waiver will apply to any provider or supplier that furnishes CR and ICR services to that beneficiary.

K. Data Sharing (§512.350)

CMS finalizes its proposal to provide EPM participants in the proposed AMI, CABG, and SHFFT models with beneficiary-level claims data for the historical period used to calculate their episode benchmark and quality-adjusted target prices as well as with ongoing quarterly beneficiary-identifiable claims data in response to their request for such data in accordance with regulations

1. Beneficiary Claims Data

CMS will make beneficiary claims information for AMI, CABG, and SHFFT episodes available upon request through two formats:

- **Summary claims data** that will encompass the total expenditures for episodes under the proposed AMI, CABG, and SHFFT models in which an EPM is participating including the procedure, inpatient stay, and all related care covered under Parts A and B within the 90-day period after discharge in the following categories: Inpatient, Outpatient, SNF, Home Health, Hospice, Carrier/Part-B, and DME. The data would provide summary spending data (e.g., total average spending for each episode and a breakdown of the episode counts and spending averages by each of the most common categories).
- **Beneficiary-level raw claims** for all of the categories listed for each EPM episode. The data will include episode summaries, indicators for excluded episodes, diagnosis and procedure codes, and enrollment and dual eligibility information for beneficiaries that initiate AMI, CABG, and SHFFT episodes.

Data will be provided both for the baseline period and on an ongoing basis during participation in the model, in accordance with applicable privacy and security laws and established privacy and security protections.

2. Aggregate Regional Data

CMS will provide an EPM participant, upon request, aggregate expenditure data available for all claims associated with AMI, CABG, and SHFFT episodes for the U.S. Census Division in which the EPM participant is located.

3. Timing and Period of Baseline Data

CMS will make three years of baseline historical data (both beneficiary and summary level) available to EPM participants upon request and prior to the start of the first episode payment
model performance year. It will be available for episodes that began January 1, 2013 through December 31, 2015.

4. Frequency and Period of Claims Data Updates for Sharing Beneficiary-Identifiable Claims Data During the Performance Period

For the first year of the models (2017), CMS will provide claims data from July 1, 2017 to June 30, 2018 at least as frequently as quarterly. Participants during the first year will receive data for up to the current quarter and all of the previous quarters going back to July 1, 2017. CMS intends to eventually make these data available more frequently.

EPM participants will only need to make a single initial request to receive data on episode spending rather than multiple periodic requests for data; CMS will make data available to EPM participants for the duration of their participation or until they notify CMS that they no longer wish to receive these data.

5. Legal Permission to Share Beneficiary-Identifiable Data

CMS will make available the minimum information necessary for the participant hospital to understand spending patterns during the episode to appropriately coordinate care, and to target care strategies toward individual beneficiaries. CMS further indicated:

- Under the HIPAA Privacy Rule, covered entities may use, or disclose to another covered entity, protected health information (PHI) for health care operations.
- When using or disclosing PHI, or when requesting this information from another covered entity, covered entities must make reasonable efforts to limit the information that is used, disclosed or requested to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
- It is limiting disclosure of the data only to the hospitals that bear financial risk for an AMI, CABG, or SHFFT episode.