DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9916 **Related Change Request (CR) #: CR 9916**

Related CR Release Date: February 17, 2017 **Effective Date: July 1, 2017**

Related CR Transmittal #: R169DEMO **Implementation Date: July 3, 2017**

Episode Payment Model Operations

Provider Types Affected

This MLN Matters® is intended for physicians and acute care hospitals that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

In August 2016, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule that planned to implement an additional set of models that share many design features of the Comprehensive Care for Joint Replacement (CJR) model, but focus on three different clinical conditions. The new Episode Payment Models (EPMs) will focus on Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), and Surgical Hip and Femur Fracture Treatment (SHFFT), most frequently hip pinning. These models will begin in 2017 and run for 5 years.

Change Request (CR) 9916 is intended to prepare Medicare's claims processing systems for implementation of Episode Payment Models (EPMs). CR9916 directs the MACs to conduct beneficiary eligibility checks, including for overall eligibility for the EPMs as well as for additional related services such as post-discharge home visits Under EPM, CMS will allow a beneficiary in certain EPM episodes to receive Skilled Nursing Facility (SNF) services without having to meet the three-day requirement in performance years 2 through 5 of the model. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

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Background

The Social Security Act (Section 1115A) authorizes CMS to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. CMS has previously used its legislative authority to create payment models, such as the Bundled Payments for Care Improvement (**BPCI**) initiative, to test bundled payments.

In April 2016, CMS began testing a new bundled payment model called the Comprehensive Care for Joint Replacement (**CJR**) Model. The CJR Model requires that hospitals test bundled payments for Lower Extremity Joint Replacement (LEJR) episodes in multiple geographic areas. The CJR Model is designed to promote quality and financial accountability for episodes of care surrounding a LEJR and test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

In December 2016, CMS published a final rule that implements an additional set of models that share many design features of the CJR Model, but focus on three different clinical conditions, namely:

- Acute Myocardial Infarction (AMI),
- Coronary Artery Bypass Graft (CABG), and
- Surgical Hip and Femur Fracture Treatment (SHFFT), most frequently hip pinning.

These models will begin in 2017 and run for 5 Performance Years (PY).

- PY1: July 1, 2017 – December 31, 2017
- PY2: January 1, 2018 - December 31, 2018
- PY3: January 1, 2019 - December 31, 2019
- PY4: January 1, 2020 - December 31, 2020
- PY5: January 1, 2021 - December 31, 2021

Under the EPMs, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for AMI, CABG, and/or SHFFT episodes. All related care within 90 days of hospital discharge will be included in the episode of care.

The final rule also finalized the concurrent implementation of a Cardiac Rehabilitation Incentive Payment (**CR**) Model. The CR Model will provide incentive payments to hospitals that discharge patients following an AMI or CABG with referral to cardiac rehabilitation/intensive cardiac rehabilitation, an underutilized but effective treatment for patients recovering from an acute cardiac event. Incentive payments will be tied to the number of cardiac rehabilitation/intensive cardiac rehabilitation visits that the patient completes. The CR Model will be implemented in two separate cohorts in order to test its

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efficacy, one in the same regions as the AMI and CABG models, and one in purely Fee-For-Service (FFS) regions.

EPM Episodes of Care

Medicare currently pays for AMI, CABG, and SHFFT procedures under the Inpatient Prospective Payment System (IPPS) through Medicare Severity Diagnosis Related Groups (MS-DRGs). Under the EPMs, episodes would begin with admission to an acute care hospital when a claim is assigned to an MS-DRG included in one of the EPMs upon beneficiary discharge and paid under the IPPS, and would end 90 days after the date of discharge from the acute care hospital. The episode would include the inpatient procedure, inpatient stay, and all related care as defined under the model that is covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.

EPM Participants

Participants would be acute care hospitals, who would be the episode initiators (that is, the entity where the episode begins) and bear quality and episode payment accountability under the EPMs. CMS will require all hospitals paid under the IPPS and located in selected geographic areas to participate in the EPMs, with limited exceptions for those hospitals currently participating in BPCI **Model 2** or **Model 4** for the same clinical episodes. The care for eligible beneficiaries who receive care at these hospitals will automatically be included in the model.

EPM Model Beneficiary Inclusion Criteria

The defined population of Medicare beneficiaries whose care will be included in the EPMs must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode.
- The beneficiary's eligibility for Medicare is not on the basis of the End Stage Renal Disease (ESRD) benefit.
- The beneficiary is not prospectively assigned to an Accountable Care Organization (ACO) in the Next Generation ACO model, an ACO in a track of the Comprehensive ESRD Care Model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3.
- The beneficiary is not enrolled in any managed care plan.
- The beneficiary is not covered under a United Mine Workers of America health plan.
- Medicare is the primary payer.

EPM Episode Reconciliation Activities

CMS will continue paying hospitals and other providers according to the conventional Medicare FFS rules during all Performance Years. After each Performance Year, the Medicare payments for services included in the episode for an EPM beneficiary will be aggregated to calculate an actual episode payment. The actual episode payment will then be

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compared against an established EPM target price that reflects a discount over expected episode spending based on a blend of hospital-specific and regional historical episode data. Based on this comparison and taking into consideration episode quality performance based on the composite quality score calculated for each hospital each performance year, CMS will determine whether reconciliation payment to (applicable for PYs 1-5) or recoupment from (applicable for some hospitals PYs 3-5 and other hospitals PYs 2-5) the hospital will be conducted. In addition, in order to be eligible for a reconciliation payment, the hospital must meet the applicable minimum composite quality score. Calculation of these reconciliation or recoupment amounts will be conducted by a specialty contractor annually and paid or recouped beginning in 2018.

Identifying EPM Claims

To validate the retroactive identification of EPM episodes, CMS is associating the Demonstration Code 79 with the EPM initiative. This code will be used to operationalize the waiver of the 3-day stay requirement for covered SNF services. This waiver will be effective in conjunction with the introduction of downside risk to the AMI episodes ending on or after January 1, 2019 (and beginning on or after 10/4/2018) and it will allow for the payment of SNF Claims for beneficiaries who have not met the 3-day hospital stay requirement for claims containing the Demonstration code 79.3

SNF 3-Day Waiver

In order to provide more comprehensive care across the post-acute spectrum and support the ability of participant hospitals to coordinate the care of beneficiaries, CMS will conditionally waive the 3-day stay requirement for beneficiaries for covered SNF services in AMI EPM episodes, effective with AMI EPM episodes that start on or after payment year 3 of the model (January 1, 2019).

Under Medicare rules, in order for Medicare to pay for SNF services, a beneficiary must have a qualifying hospital stay of at least 3 consecutive days (counting the day of hospital admission but not the day of discharge). Additional information regarding the SNF benefit is available in the "Medicare Benefit Manual," (**Pub 100–02, Chapter 8, Skilled Nursing Facility Services**).

As of October 4, 2018, CR9916 allows for payment of SNF claims without a 3-day hospital stay (that is, CMS will waive the 3-day hospital stay requirement when all of the following conditions are met:

- The hospitalization does not meet the prerequisite hospital stay of at least 3 consecutive days for Part A coverage of extended care services in a SNF. If the hospital stay would lead to covered SNF services in the absence of the waiver, then the waiver is not necessary for the stay.
- The discharge is from a hospital participating in an EPM. Participants can be confirmed by a posted file on the CMS website and will be shared with MACs on a monthly basis.

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- The beneficiary must have been discharged from the EPM hospital for one of the specified MS–DRGs (231-236, 246-251, 280-282) within 30 days prior to the initiation of SNF services. (Note that this list of MS-DRGs may need to be updated prior to October 4, 2018 if annual changes to the IPPS MS-DRGs add, combine or delete any of these DRGs.)
- The beneficiary meets the criteria for inclusion in an EPM at the time of SNF admission: That is, he or she is enrolled in Part A and Part B, eligibility is not on the basis of ESRD, is not enrolled in any managed care plan, is not covered under a United Mine Workers of American health plan, is not prospectively assigned to an ACO in the Next Generation ACO model, an ACO in a track of the Comprehensive ESRD Care Model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3, and Medicare is the primary payer.
- The waiver will apply if the SNF is qualified to admit EPM beneficiaries under the waiver. A list of qualified SNFs will be communicated to MACs and CMS Shared Systems Maintainers via a quarterly list, developed by CMS and posted to the CMS website on a quarterly basis. The list will contain those SNFs with an overall star rating of three stars or better for at least 7 of the preceding 12 months of the rolling data used to create the quarterly list.
- The SNF must include Demonstration Code 79 in the Treatment Authorization field on claims that qualify for the SNF waiver under the EPM. Note: The waiver is not valid for swing bed (TOB 18X) stays.
- Other requirements. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

Post-Discharge Home Visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be “homebound” and in need of skilled care (skilled nursing, physical therapy or speech-language pathology services). Additional information regarding the home health benefit is available in the Medicare Benefit Manual (**Pub 100–02, Chapter 7, Home Health Services**.)

Medicare policy allows physicians and Non-Physician Practitioners (NPPs) to furnish and bill for visits to any beneficiary’s home or place of residence under the Physician Fee Schedule (PFS). Medicare policy also allows licensed clinical staff to furnish services “incident to” the physician or NPP visit at a beneficiary’s home when such services are provided under the direct supervision of the physician or NPP. Licensed clinical staff may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform ordered services. Additional information regarding the “incident to” requirements is available in the Medicare Benefit Manual (**Pub 100–02, Chapter 15, Covered Medical and Other Health Services, Sections 60-60.4.1**).

For those EPM beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and

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improving adherence with treatment but who are not homebound or otherwise eligible for the Medicare home health benefit, CMS will waive the "incident to" direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence anytime during the episode, subject to the following conditions:

- Licensed clinical staff will furnish the service under the general supervision of a physician or NPP, who may be either an employee or a contractor of the participant hospital.
- Services will be billed under the PFS by the supervising physician or NPP or by the hospital to which the supervising physician has reassigned his or her billing rights. Up to 9 post discharge home visits can be billed and paid per beneficiary during each 90-day post-anchor hospitalization EPM episode.
- The service will be billed with HCPCS G-code 9863, which is specific to the AMI, CABG, or SHFFT model home visits for patient assessment. These visits must be performed by clinical staff for an individual not considered homebound, and may include but not necessarily be limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. The HCPCS G-code is approved for use only in the Medicare approved AMI, CABG, or SHFFT models and may not be billed for a 30-day period covered by a transitional care management code and paid under the PFS.
- The service cannot be furnished to an EPM beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.

As described in the "Medicare Claims Processing Manual" (**Pub 100-04, Chapter 12, Sections 40-40.4**), Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for the EPMs, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the July 2017 release of the Medicare Physician Fee Schedule (MPFS) Recurring Update.

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Billing and Payment for Telehealth Services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the "Medicare Benefit Policy Manual" (**Pub 100-02, Chapter 15, Section 270**) and the Medicare Claims Processing Manual (**Pub 100-04, Chapter 12, Section 190**).

Under EPM, CMS will allow a beneficiary in an EPM episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in an EPM episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the EPM model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the EPM model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the proposed EPM episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the EPM model that reflect the home setting.
- For level 4 and 5 EPM telehealth home visits, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.
- The facility fee paid by Medicare to an originating site for a telehealth service would be waived if the service was originated in the beneficiary's home.

Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the July 2017 release of the MPFS Recurring Update.

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Cardiac Rehabilitation (CR) Incentive Payment Model Billing and Payment
CR services are covered by Medicare and have been shown by research to improve health outcomes. However, these cardiac rehabilitation services have been historically under-utilized by Medicare beneficiaries. The CR Incentive Payment model is designed to provide participant hospitals in 90 different Metropolitan Statistical Areas with incentive payments to encourage the use of cardiac rehabilitation services for beneficiaries in certain MS-DRGs. Providers and suppliers will continue to be paid under the usual Medicare payment system rules and procedures. Following the end of a model performance year, depending on beneficiaries' utilization of CR/Intensive CR services, participant hospitals may receive an additional incentive payment from Medicare. CMS has provided a waiver of the definition of a physician to include a physician or NPP (defined for the purposes of this waiver as a physician assistant, nurse practitioner, or clinical nurse specialist) in performing specific physician functions in conjunction with the delivery of CR services to EPM-CR and FFS-CR beneficiaries during AMI care periods and CABG care periods.

Additional Information

The official instruction, CR9916, issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R169DEMO.pdf**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.

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