The Journey to Episode-Based Care: A Bumpy Ride or a Roller Coaster?

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Nothing to Disclose
Outline

1. The best road?
   AMI/CABG Episode Payment Model
2. Where the rubber meets the road!
   Cardiac Rehab Incentive Payment Model
3. The recommended route =
   Roadmap to Reform
Regulatory Terms

• EPM or “Episode”: episode payment model
• 90-day episode (or care period): from hospital admission to 90 days after hospital discharge
• Participant: hospital in MSA selected for EPM
• AMI or CABG EPM: participant & beneficiaries in the episode
• FFS: Fee-for-Service
• CMMI: Centers for Medicare & Medicaid Innovation Office @ CMS
Regulatory Terms (cont)

- EPM-CR participant: hospital in EPM and in CR incentive model = “90-day EPM”
- FFS-CR participant: hospital in CR incentive, but not in EPM model = “90-day care period”
- EPM-CR beneficiary or FFS-CR beneficiary: patient

*Cited pg #s refer to CMS final regulation in Federal Register, Vol. 82, No. 1, January 3, 2017*
Resource Links

- Medicare Program - Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; Federal Register - 1-3-2017
- Episode Payment Model (EPM)-Selected MSAs with Institutions (CMS web site); 12-2016
- CR Incentive Payment Model-Selected Institutions (CMS web site); 12-2016
North Carolina: Are you in or are you out?

- 32 institutions in AMI/CABG episode payment model (EPM)
- 18 institutions in cardiac rehabilitation incentive payment model
- EPM-CR group: In AMI/CABG EPM & in CR inc pay model
- FFS-CR group: In CR inc pay model, not in EPM — “AMI or CABG care period”
AMI/CABG Episode Payment Model

EPM Overview

CMS CMMI Episode Model Goals

• Higher-quality & more efficient service delivery
• Coordination across in-pt & post-acute services
• Adherence to treatment & med regimens
• Management of chronic disease
• Reduced readmissions & complications
• Coordination between providers & suppliers
• Choosing most appropriate post-acute settings

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AMI/CABG Episode Payment Model
EPM Design

• Episode is 90 days
  – Initiated at hosp admission to 90 days post-DC
  – Day of hospital discharge is day 1 of 90 days

• EPMs are hospital-based
  – MD services separately billed by MDs, but are included in EPM costs

• Model covers 5 performance years (PY)
  – Begins 7/1/17
    • PY 1: 7/1/17-12/31/17
    • PY 2: 1/1/18-12/31/18
AMI/CABG Episode Payment Model

Eligible Diagnoses

• Primary & secondary diagnoses (MS-DRGs) at discharge initiate episode (270-71)
  *Final regulation differs from proposed

• Initiation & attribution of AMI & CABG episodes will vary, based on scenario
  – If patient is hospitalized for AMI and has CABG during anchor hospitalization (not transferred), discharge diagnosis (MS-DRG) would initiate a CABG episode (not AMI episode)
  – Episode attributed to final hospital (after transfer) based on discharge MS-DRG (AMI or CABG)
Transfer-Initiation of EPM

1. *If* patient is discharged from anchor (1st) hospitalization (MS-DRG initiates either AMI or CABG episode) & is re-admitted to anchor or other hospital,

   *Then* patient remains under anchor hospital for initial episode

2. *If* patient transfers *during initial* hospitalization,

   *Then* episode initiation is based on MS-DRG for final transfer admission
Transfer-Initiation of EPM

7 scenarios that determine if/which institution initiates episode:

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

Federal Register / Vol. 82, No. 1 / Tuesday, January 3, 2017 / Rules and Regulation, pg 282
Episode Payment Model-Payment

• Services continue to be paid according to FFS
• EPM is *retrospective payment methodology*
• At end of performance year, Medicare payment from submitted claims for **all services furnished in the episode** are combined to calculate an actual episode payment
Episode Payment Model-Payment

• Actual payment is reconciled against quality-adjusted target price, *for example*:
  – Medicare pays participant if actual cost is less than target with acceptable or higher quality score
  – Hospital re-pays Medicare if actual payment exceeds target and quality score is not acceptable

• Quality-adjusted target price calculated from historical data of hospital-specific to blend in regional to fully regional data
Quality-Adjusted Target Price

Services included over 90-day episode related to treating episode are: (updated q.o. year)

- MD services
- In-pt services
- In-pt rehab facility
- SNF
- Long-term care
- Home Health
- Out-pt services (CR, PT, labs, DME, Part B drugs)
- Hospice
Quality-Adjusted Target Price

- Financial risk begins at end of performance year 3
- Hospitals with post-episode spending 30 days after end of episode that exceeds 3 standard deviations of average regional spending will repay
  - Why is that?
EPM Quality Measures

AMI
• Hospital 30-day all-cause mortality (NQF #0230)
• Excess days in acute care
• HCAHPS Survey (NQF # 0166)
• Voluntary hybrid 30-day all-cause mortality (NQF #2473)

CABG
• Hospital 30-day all-cause mortality (NQF #0230)
• HCAHPS Survey (NQF # 0166)
• Voluntary STS composite measure (NQF #0696) (354-56)
EPM Rules

• Beneficiary engagement incentives (483)
• Collaborators & financial sharing arrangements (435+)
• Beneficiary notification of model (416-24)
• Patient choice (410-15)
  – May not opt out of EPM (rule for geographic area)
  – Do maintain choice of provider
  – Participant may provide recommended and must provide complete list of post-acute care providers in geographic area
CR Incentive Payment Model
Overview

CMS Goals

- CR/ICR achieves significant improvements in long-term patient outcomes (thanks to CR Collaborative)
  - Cardiovascular mortality
  - Improved health-related QOL
  - Reduced risk of hospital admission
- CR is underutilized
- CR helps in long-term care management & care coordination for AMI/CABG
- *CR has dose-dependent effect on mortality*
- *Timely referral & early enrollment post-dc improve utilization* (578)
CR incentive Payment Model

• CR/ICR programs may be hospital owned (out-pt dept) or physician-based (MD-owned)

• Beneficiary has choice of which CR/ICR program he/she attends
CR incentive Payment Model

• No financial or sharing arrangements (593)
  – Differs from EPM
  – “No financial arrangements beyond ..permitted under existing law…”
  – “Financial relationships will be narrowly focused...related to plan to advance goals of model.”

• Utilization data analysis, beneficiary outreach, care coordination, management for CR referral & adherence to treatment plan
CR Incentive Payment

• “CR incentive payment is not a payment for CR/ICR services...it is for CR participant work to coordinate & increase utilization of beneficiary’s participation...” (579)

• CR inc pay is separate & distinct from reconciliation payments & repayments for EPM-CR participants

• CR inc pay is separate from reimbursement based on submitted claims data
CR Incentive Payment

• CR inc pay is unrelated to comparison of actual EPM episode payment to quality-adjusted target price
• CR inc pay is outside quality-adjusted target price
• Reimbursement for CR services is included in episode costs
CR Incentive Payment

• “At least 12 CR/ICR services provides a strong incentive for CR participants to expand CR referrals and to increase likelihood that beneficiaries complete a clinically meaningful # of CR services.” (Hammill et al)

• Incentive amounts:
  – #1-11=additional $25/session
  – #12-36=additional $175/session
CR Incentive Payment

• Programs in CR inc pay model will want to consider strategies that increase CR sessions within that window of time
• Incentive payments stop at end of 90 days
• FFS reimbursement for CR/ICR continue per statute:
  – Up to 36 CR sessions within 36 wks
  – Up to 72 ICR sessions within 18 wks

(576-80)
CR Incentive Payment

• Designed to reward CR participant efforts to coordinate and increase utilization of beneficiary’s participation in CR services

• *Incentive $ is only for participants in CR inc pay model*
  – *Doesn’t matter where* beneficiary receives CR sessions
CR Incentive Payment

What about CAHs & rural CR programs?

• Hospitals paid under “reasonable cost methodology” (CAHs) are excluded from EPM & CR inc pay models

What should those programs do?

• Expect and prepare for increased referrals
• Implement R2R strategies – huh?
• Market your CR program to referring “participants”
Waiver of Physician Definition for EPM-CR & FFS-CR Participants

Only for beneficiaries in EPM or care period (not other CR pts)

• Qualified NPP (NP, PA, CNS) may:
  – Serve as daily supervising MD/NPP only for beneficiaries in EPM or care period
  – Prescribe exercise
  – Establish, sign, review ITPs

• Qualified NPP (NP, PA, CNS) may not:
  – Independently order CR (MD must co-sign)
  – Serve in medical director role
Waiver of Physician Definition for EPM-CR & FFS-CR Participants

• Participant CR program could extend hours for EPM-CR or FFS-CR beneficiaries with NPP immediately available

• This flexibility does NOT extend to non-participant CR programs
  – EPM-CR or FFS-CR beneficiary referred to local rural CR program must follow MD supervision requirements in Medicare CR regulation, 42 CFR 410.49
Beneficiary Engagement Incentives for EPM-CR & FFS-CR Participants

Must be:

• Provided directly by FFS-CR or EPM participant
• Reasonably connected to medical care
• A preventive care item/service or item/service that advances a clinical goal, such as:
  – Adherence to drug regimens, to care plan
  – Reduction of readmissions & complications
  – Management of chronic diseases affected by AMI/CABG tx

(592)
Beneficiary Engagement Incentives for EPM-CR & FFS-CR Participants (cont)

- Home based CR is not included (not billable)
- Not tied to receipt of item/service outside EPM or care period
- Not tied to particular provider or supplier (i.e., ICR site)
- Not advertised or promoted beyond beneficiary being made aware
- Documentation of items/services that exceed $25
Beneficiary Engagement Incentives for EPM-CR & FFS-CR Participants

Technology:

• Not to exceed $1000/beneficiary per EPM/care period
• Must be minimum necessary to advance goal
• Exceeding $100 must:
  – Remain property of EPM/FFS participant
  – Be returned at end of EPM/care period
Beneficiary Engagement Incentives for EPM-CR & FFS-CR Participants

Transportation must be:

• Provided directly by & under control of FFS-CR or EPM-CR participant
• Not tied to receipt of items/services other than CR/ICR during 90-day period
• Not tied to particular program (i.e., provider or supplier)
• Not advertised or promoted other than beneficiary made aware of availability
• Document date, beneficiary, & cost amount exceeding $25/bene

(588)
Slide courtesy of Dr. Rich Josephson
Your Roadmap

Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative

Philip A. Ades, MD; Steven J. Keteyian, PhD; Janet S. Wright, MD; Larry F. Hamm, PhD; Karen Lui, RN, MS; Kimberly Newlin, ANP; Donald S. Shepard, PhD; & Randal J. Thomas, MD, MS

Road map to 70% CR participation

**Cardiac rehabilitation adherence**
- Set 36 CR sessions as goal
- Home-based CR option
- Flexible CR hours
- Work to minimize CR co-pays

**Cardiac rehabilitation enrollment**
- CR staff liaison
- Early appointment at CR
- CR enrollment as performance measure
- Work to minimize co-pays

**Cardiac rehabilitation referral**
- EMR-based referral
- CR staff liaison
- CR referral as performance measure
Table 1
• Strategies that influence referral & enrollment to CR

Table 2
• Strategies that influence adherence in patients enrolled

AACVPR R2R Web Site
• http://www.aacvpr.org/R2R
Best Practice Strategies

- Establish a Philanthropic Fund
- CR Referral Performance Measures in a Quality Improvement System
- Use of Text Messaging and Mobile Apps
- Use of Video
- 12-Month Cardiovascular Condition Episode (Bundle)
- ECG Monitoring Based on Clinical Need
- Accelerated Use of CR
- Safe Start Self-Pay
- Open Gym
- Group Screening
- Inpatient Liaison for Outpatient CR
Step 1 – Hospital Assessment

What is your admin’s perspective & experience re EPM & CR?

Is your institution:

• In EPM & CR inc pay?
  – Incentivized to provide more CR
    • maybe

• In CR inc pay only?
  – Incentivized to provide more CR
Step 1 – Hospital Assessment

Is your institution:

• In EPM but not CR inc pay?
  – Admin incentivized to be cost-efficient
  – Varied strategies may be an option

• In neither model?
  – May depend on institution’s philosophy
  – Is CR a service that adds value to institution or is it a cost center?
Step 2 – Program Assessment

- What is your average discharge to enrollment wait time?
- What is your referral (of eligible) %?
- What is your referral to enrollment %?
- What is the average # of sessions completed?
- Is your program break even or profitable?
Step 3 – Best Practice Strategies

What are your program barriers to utilization?

• Delayed wait times from discharge to enrollment
• Poor adherence
• Capacity limitations
  – Hours, space, staff, equipment, MD availability, # of ECG monitors, etc
Best Practice Strategies

• **ECG Monitoring Based on Clinical Need**
  Self-efficacy improves adherence

• **Accelerated Use of CR** [sample schedule]
  More CR in shorter time period

• **Open Gym** [sample schedule]
  Accommodate more patients/day

• **Group Screening**
  Reduce discharge to start time
Thank-you