What You Need to Know About CMS’s Expansion of Mandatory Bundled Payments

Examining CMS’s Proposed Hip/Femur and Cardiac Bundles

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Today’s Presentation

Part I of Our Coverage on CMS’s Proposal

I. What You Need to Know About CMS’s Expansion of Mandatory Bundled Payments

A comprehensive overview of CMS’s proposed expansion of bundled payments. Includes an analysis of the transition away from FFS to value-based payments, a discussion of key provisions of the proposal and the impact for hospital CEOs and service line administrators.

II. Unpacking the New Mandatory Cardiac Bundled Payment Proposal

August 29, 2016 at 1p.m.

An in-depth review of the technical and operational details in CMS’s proposal for cardiac bundled payments. Includes information on how the proposed bundles would be structured and what cardiovascular administrators and post-acute providers can do to prepare for a final ruling.
The Accelerating Shift Toward Value-Based Payments

1. Overview of the Proposal

2. Assessing the Impact and Next Steps
Executive Summary

- On July 25, 2016, CMS released a proposed rule for three new episodic payment models (EPMs) for hip, heart attack and bypass surgery. This marks both an expansion of the Comprehensive Care for Joint Replacement (CJR) program as well as the first mandatory cardiovascular bundled payment program.

- Under this proposal, hospitals already participating in CJR markets for eligible lower extremity joint replacement procedures (LEJRs) would also be required to assume financial responsibility for eligible surgical hip/femur fracture treatment (SHFFT) cases.

- Hospitals in 98 yet-to-be-determined markets would be required to take financial responsibility for eligible coronary artery bypass (CABG) and acute myocardial infarction (AMI) episodes, including AMIs treated via percutaneous coronary intervention (PCI).

- CMS will receive comments on the proposed rule until October 3, 2016 at 5p.m. EDT.

- As proposed, the program would run for five years starting on July 1, 2017 until December 31, 2021.

1) MS-DRGs 480-482.
2) MS-DRGs 231-236.
3) MS-DRGs 280-282.
4) MS-DRGs 246-251.

Source: CMS, Advisory Board analysis.
Doubling Down on Bundled Payments

CMS Proposal the Latest Move Away from Volume towards Value

CMS’s Aggressive Targets for Transition to Risk

Percent of Medicare Payments Tied to Risk Models

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>30%</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

Major Recent CMS Risk Model Initiatives

- **July 2015**: CMS announces CJR, a mandatory orthopedic bundle
- **July 25, 2016**: CMS proposes three new EPM bundles for hip and cardiac episodes
- **April 2016**: CJR begins in 67 markets across the country

We’ve often talked about a **tipping point in the movement from fee-for-service to alternative payment models**, and I believe today is the day.

*Dr. Susan Nedza, former Chief Medical Officer at CMS*

Putting the EPMs in Context

Just One of Many Avenues for CMS to Pursue Reform

Continuum of Medicare Risk Models

Pay-for-Performance
- Hospital VBP Program
- Hospital Readmissions Reduction Program
- HAC Reduction Program
- Merit-Based Incentive Payment System

Bundled Payments
- Bundled Payments for Care Improvement Initiative (BPCI)
- Comprehensive Care for Joint Replacement (CJR)
- EPMs for SHFFT, AMI and CABG

Shared Savings
- MSSP Track 1 (50% sharing)

Shared Risk
- MSSP Track 2 (60% sharing)
- MSSP Track 3 (up to 75% sharing)
- Next Generation ACO Model (80-85% shared savings option)

Full Risk
- Next Generation ACO Model (full risk option)
- Medicare Advantage (provider-sponsored)

Source: CMS, Advisory Board analysis.
MACRA the Latest Push to Risk

Two New Payment Tracks For Provider Groups

**Merit-Based Incentive Payment System (MIPS)**
- Consolidates existing P4P\(^1\) programs including Meaningful Use, Physician Quality Reporting System (PQRS), and Value-Based Payment Modifier (VBPM)
- Gives providers performance score based on four categories: quality, resource use, clinical practice improvement, and EHR\(^2\) use
- Adjustments start in 2019 and reach -9% / +27% by 2022

**Advanced Alternative Payment Model (APM) Track**
- Provides financial incentives (5% annual bonus in 2019-2024, 0.75% annual payment increase from 2026 on) and exemption from MIPS
- Requires that physicians meet increasing targets for revenue at risk
- Qualifying APMs must involve some degree of downside risk, quality measurement that is comparable to the MIPS, and EHR use requirements

For more information about MACRA—including details on the MIPS and APM tracks—visit [www.advisory.com/macra](http://www.advisory.com/macra).

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1) Pay-for-Performance.
2) Electronic Health Record.

Source: H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board Company interviews and analysis.
# Heavy Bias Toward Downside Risk

## Under Current Structure, Bundles Not Eligible APMs

<table>
<thead>
<tr>
<th>APMs</th>
<th>Medicare Advanced APMs</th>
<th>Other Advanced APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Affect MIPS payments; do not contribute to Advanced APM track eligibility)</td>
<td>(contribute to Advanced APM track eligibility)</td>
<td>(contribute to “Other Payer” Advanced APM track eligibility in 2021)</td>
</tr>
<tr>
<td><strong>Qualifying Models</strong></td>
<td><strong>Qualifying Models</strong></td>
<td><strong>Qualifying Models</strong></td>
</tr>
<tr>
<td>Medicare Shared Savings Program Track 1</td>
<td>MSSP Tracks 2, 3</td>
<td>Commercial contracts with sufficient downside risk</td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement</td>
<td>Next Generation ACO</td>
<td>Medicare Advantage</td>
</tr>
<tr>
<td>Comprehensive Care for Joint Replacement</td>
<td>Comprehensive Primary Care Plus (CPC+)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comprehensive ESRD Care Model¹</td>
<td></td>
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<tr>
<td></td>
<td>Oncology Care Model Two-Sided Risk²</td>
<td></td>
</tr>
</tbody>
</table>

### Requirements for Advanced APMs:
- Maximum possible loss must be at least 4% of spending target
- Threshold to trigger losses must be no greater than 4% above target
- Loss sharing rate must be at least 30%
- EHR use, quality requirements

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1) Large Dialysis Organization arrangement
2) Available in 2018.

Source: CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.
Proposal Would Create Path for APM Qualification

Would Introduce Two-Track Approach Within Mandatory Bundles

How CJR Currently Stacks Up Against Advanced APM Criteria

- Threshold to trigger losses no greater than 4%
- Loss sharing at least 30%
- Maximum possible loss at least 4% of spending target
- Quality requirements comparable to MIPS
- Certified EHR use

CMS Proposes Changes to Enable Mandatory Bundles to Satisfy Criteria

Beginning in 2018, hospitals participating in mandatory bundled payments would be able to choose one of two tracks:

1. **Track 1** would require use of certified EHR
   - Eligible advanced APM
2. **Track 2** would not require use of certified EHR
   - Not eligible advanced APM

1) End-stage renal disease.
2) Large dialysis organization.
3) Comprehensive Primary Care Plus.
4) Notice of intent to apply.
5) Letter of intent.

1. The Accelerating Shift Toward Value-Based Payments

2. Overview of the Proposal

3. Assessing the Impact and Next Steps
## Central Elements of Mandatory Bundles

### EPMs Largely Follow the Overall Structure of CJR Model Design

<table>
<thead>
<tr>
<th>Definition</th>
<th>Why It’s Important</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode of Care</strong></td>
<td>All care related to selected MS-DRGs during anchor hospitalization and 90 days post-discharge (all Medicare Part A and B)</td>
</tr>
<tr>
<td><strong>Target Price</strong></td>
<td>CMS spending goal for an episode of care; a target that is up to 3% lower (discounted) than historical/regional spending performance</td>
</tr>
<tr>
<td><strong>Reconciliation Process</strong></td>
<td>Process used to determine difference between hospital performance (actual episode spend) and target price</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Specific measures that CMS has defined as important indicators of quality for EPM episodes of care</td>
</tr>
</tbody>
</table>

The program holds hospitals accountable for financial responsibility for spending across the entire episode of care for eligible episodes. This is the benchmark that your episodic spending will be judged against. This is the process CMS uses to determine if it will make a reconciliation payment to you, or if you will owe a repayment. Quality performance determines the discount required and whether your organization is eligible to receive a reconciliation payment.
Participating Markets Would Be Selected Randomly

Cardiac EPM Eligibility Criteria Based on AMI Volumes

Key Elements of Cardiac EPM Market Selection

- 98 markets would be chosen randomly from 284 eligible MSAs across the country
- Eligible MSAs would be those with more than 75 AMIs per year, those with more than 75 non-BPCI AMIs per year, and those with at least 50% of non-BPCI AMIs per year
- MSAs where there is no CABG would still be eligible for inclusion
- The AMI and CABG episodes would be implemented together in selected markets
As Proposed, Program Would Start July 1, 2017

SHFFT and Cardiac EPM Performance Periods

2016

Year 1 starts, July 1, 2017

2017

6 Months

We are here, August 5, 2016

Year 2 starts, Jan 1, 2018

Downside risk commences on April 1, 2018

2018

12 Months

Year 3 starts, Jan 1, 2019

2019

12 Months

Year 4 starts, Jan 1, 2020

2020

12 Months

Year 5 starts, Jan 1, 2021

2021

12 Months

Source: CMS, Advisory Board analysis.
CMS Expands CJR and Launches Two New Models

1. **Expansion of CJR to include hip/femur repair**
   - The proposed rule would add financial responsibility for SHFFT episodes to hospitals in existing CJR markets.

2. **First mandatory bundles for cardiac episodes**
   - Hospitals would be financially responsible for cost and outcomes for heart attack and bypass episodes.

3. **Cardiac rehab incentive payment system**
   - CMS proposes a two-tiered incentive payment system to increase utilization of cardiac rehab services.

Source: CMS, Advisory Board analysis.
CJR Markets Assume Additional Responsibility

Hospitals Would Take Financial Ownership for Hip/Femur Repair Episode

**Current CJR Program**

- Hospitals within 67 geographically defined MSAs

Medicare enrollees with parts A and B, discharged with LEJR (DRG 469 or 470)

**CJR Expansion by the Numbers**

<table>
<thead>
<tr>
<th>109,000</th>
<th>$308M</th>
<th>$130M</th>
</tr>
</thead>
</table>
| Estimated annual number of potentially eligible SHFFT procedures | Revised estimated episodic cost savings under CJR | Estimated additional episodic cost savings from the SHFFT EPM

1) Metropolitan Statistical Area.
2) In the proposed rule, CMS revised its original estimated costs savings for CJR.

Source: CMS, Advisory Board analysis.
Understanding CMS’s Rationale

CMS Signals an Interest in Patients with Chronic Conditions

Three Key Reasons for Selecting SHFFT

Cost: CMS spends an average of $4.7B annually for 90-day SHFFT episodes

Volumes: Hip fractures are common in the Medicare patient population

Patient population: Beneficiaries typically have chronic conditions that commonly contribute to the initiation of the episode

Hip Fractures by the Numbers

258,000
People aged 65 years or older admitted to the hospital in 2010

8th
Most common principle discharge diagnosis for Medicare FFS beneficiaries in 2013

$20B
Estimated lifetime cost for all hip fractures in the U.S. in one year

33%
Mortality rate associated with hip fractures at one year

Source: CMS, Advisory Board analysis.
A Focus on PAC Critical for SHFFT Episodes

Post-Acute a Major Cost Driver for Hip/Femur Repair

**SHFFT 90-Day Episodic Costs**

*Medicare, 2014*

- **Hospital Outpatient**: $500
- **Physician**: $2K
- **Readmissions**: $3K
- **Index Admission**: $13K
- **Post-Acute Care**: $17K

PAC drives nearly half of total episodic costs.
Introducing CABG and AMI Episode Payment Models

Bypass and Heart Attack Would Be First Mandatory Cardiac Bundles

Cardiac EPMs

CABG
- MS-DRGs 231-232
- All care during index hospitalization through to 90-days post-discharge
- Hospital would be financially responsible for cost, quality of the episode

AMI
- MS-DRGs 280-282; 246-251
- All care during index hospitalization through to 90-days post-discharge
- Hospital would be financially responsible for cost, quality of the episode

$40M  Estimate of cost savings to CMS over five years for both cardiac EPMs

Source: CMS, Advisory Board analysis.
How Did We Get Here?

CMS Has Been Building to Mandatory Cardiac Bundles for Years

**Medicare Participating Heart Bypass Demo**
- 1991-1996
- Seven hospitals
- Tested bundled Part A and B payments for two CABG DRGs

**Bundled Payment for Care Improvement (BPCI)**
- 2013 – ongoing
- 4 Models, includes medical and surgical cardiac episodes
- First year preliminary results available

**CMS Evolution to Cardiac Bundling**

**Acute Care Episode (ACE) Demo**
- 2009-2012
- 3-years, 5 participants
- Bundled Part A and B payments for nine cardiac DRGs

**Cardiovascular a Familiar Target for Quality Measures**
- Readmissions Reduction Program includes AMI, HF
- Hospital-based VBP includes AMI, HF 30-day mortality rates
- AMI, HF 30-Day payment reporting
- AMI, HF excess days metric

Source: CMS, Advisory Board analysis.
PCI Included in the AMI EPM

Bundle Would Encompass Both Medical and Surgical MS-DRGs

AMI EPM

- Would encompass both medical treatment of AMI as well as revascularization via PCI
- Medical episodes likely to be slightly more than half of the EPM
- Excludes intracardiac procedures

The AMI model is the first Innovation Center episode payment model that includes substantially different clinical care pathways (medical management and PCI) for a single clinical condition in one episode in a model and, as such, represents an important next step in testing episode payment models for clinical conditions which involve a variety of different approaches to treatment and management.

“-CMS

AMI by the Numbers

2.9%
Of all beneficiaries discharged with AMI as principle diagnosis in 2013

$4.1B
Total annual Medicare spending on AMI episodes

Source: CMS, Advisory Board analysis.
Assessing Costs At 90 Days After Admission

Cardiac and AMI EPMs Would Require Tailored Strategies

Percentage of Total Costs Attributed to Each Setting at 90 Days

Medicare, 2014

1) Post-acute care.
2) Medical treatment of AMI.

Source: Advisory Board analysis.
A Familiar Challenge

Readmissions a Major Source of Costs Across Time

**Total Costs Attributed to Subsequent Admissions**  
*Medicare, 2014*

<table>
<thead>
<tr>
<th>Procedure</th>
<th>30 Days</th>
<th>60 Days</th>
<th>90 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CABG</strong></td>
<td>$3.40K</td>
<td>$4.89K</td>
<td>$5.73K</td>
</tr>
<tr>
<td><strong>PCI</strong></td>
<td>$2.16K</td>
<td>$3.77K</td>
<td>$4.98K</td>
</tr>
<tr>
<td><strong>AMI</strong></td>
<td>$4.01K</td>
<td>$4.10K</td>
<td>$6.81K</td>
</tr>
</tbody>
</table>

Source: Advisory Board analysis.

**Readmissions Reduction Toolkit**

Best practices, tools, and strategies from across the Advisory Board to help walk you through a stepwise process to isolate and correct patient and systemic issues and lower readmission rates.
A Two-Tiered Incentive for Cardiac Rehab

CMS Proposal Would Reward Significant Cardiac Rehab Utilization

Cardiac Rehab Incentive Payment System

- Normal FFS Payment
- + incentive payments

First 11 sessions:
- $25/session

Subsequent sessions, up to a total of 36:
- $175/session

Total available incentive payments: $4,625

12-Session Threshold
Chosen by CMS based on evidence that beneficiaries who complete 12-23 cardiac rehab sessions have lower mortality rates

An Uncertain Financial Impact

+27M to -32M
Range of CMS’s estimate of the impact of the proposal: it could result in additional spend or significant savings

1) Proposed cardiac rehab HCPCS codes for inclusion: G0422, 93797, 93798 and G0423.
2) Proposal includes an option to extend.
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## No End in Sight

### CMS Seeking Comments on Future Bundled Payment Programs

#### New Voluntary Payment Model
- Currently, BPCI does not qualify as an APM
- CMS intends to implement **a new, voluntary bundled payment model** for CY 2018
- The new voluntary payment model would meet APM criteria

#### Health Information Technology
- Assess how non-hospital providers, such as post-acute care providers, can prepare to take on risk
- CMS interested in increasing readiness of non-hospital providers through increased investments in health IT

#### Condition-Based EPMs
- Focus on an acute event or long-term care management, rather than a procedure
- Emphasize outpatient care
- May provide **a transition to physician accountability** for episode quality and costs

#### Event-Based EPMs
- Encompass a wider variety of procedures, including **outpatient-based procedures**
- Include **elective procedures and a broader range of clinical conditions** that may overlap or interact

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**Key Areas of CMS Inquiry**

<table>
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<th>Category</th>
<th>Description</th>
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Source: CMS, Advisory Board analysis.
New Proposal Strong Signal of Support for Bundles

Five Implications of the Proposed Rule for the Future Direction of Payment Reform

1. Value-based incentives rolling forward even in “traditional” fee-for-service Medicare program

2. Use of mandatory episodic payment models will continue to grow in Medicare

3. Expanded bundled payments may be the best opportunity for specialists to qualify for APM track

4. MACRA framework likely to guide development of payment models moving forward

5. Administration trying to build sufficient momentum for payment reform to ensure continuation through change in administrations

Source: Advisory Board interviews and analysis.
Proposal Poses Strategic Challenges for CEOs

Four Implications of the Proposed Rule for Hospital CEOs

1. Expect nation-wide rollout of mandatory episodic payment reform in the future.

2. Engaging cardiac specialists in the EPM will be crucial for both the bundle and MACRA more broadly.

3. Developing a cohesive, organization-wide strategy for post-acute care will be necessary for both the orthopedic and cardiac bundled payments.

4. Consider expanding cost and quality initiatives to the entire continuum of patient care, including community-based settings.

Source: Advisory Board interviews and analysis.
A Shockwave for CV Service Line Leaders

Five Implications of the Proposed Rule for CV Leaders

1. Service line leaders will be tasked with understanding episodic costs and opportunities for savings in both cardiac EPMs.

2. Successfully navigating cardiac bundled payments will require collaboration within the service line as well as across the care continuum.

3. Specialist engagement with episodic cost management initiatives will be crucial.

4. CV leaders will need to consider post-acute costs and develop or refine a strategy for post-acute collaboration.

5. Even in markets that ultimately aren’t chosen for participation, CV leaders should consider this proposal to be a signal that future bundling or episodic payment reform is likely to occur.

Source: Advisory Board interviews and analysis.
I.

What You Need to Know About CMS’s Expansion of Mandatory Bundled Payments

*Today’s Presentation*

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II.

Unpacking the New Mandatory Cardiac Bundled Payment Proposal

*August 29, 2016 at 1 p.m.*

An in-depth review of the technical and operational details in CMS’s proposal for cardiac bundled payments. Includes information on how the proposed bundles would be structured and what cardiovascular administrators and post-acute providers can do to prepare for a final ruling.
How Can We Help You Prepare?

Key Advisory Board Resources

**Executive Education**
Stay tuned for future webinars, publications, and best practice guides on EPM payments

**Data and Analytics**
Request a tailored discussion with our team, where we can use our analytics to identify opportunities

**Consulting Services**
We have decades of experience in managing costs and utilization to help you win under EPM

**Technologies**
Our Dedicated Advisors will help you harness and optimize the value of your current technologies

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**Spotlight:**
**Cardiovascular Roundtable**
Membership program dedicated to your CV strategic and operational priorities

New Best Practice Resources:
- The Playbook for Episodic Costs
- Reducing Procedural Readmissions

To set up time with our experts or for more information, please complete the survey question at the end of this section or email cardiovascular@advisory.com

Source: Advisory Board analysis.
Analytical Resources Available

- **The Hospital Benchmark Generator**
- **Episodic Cost Profiler**
- **Care Transitions Mapping Tool**
- **Episode Pathway Profiler**

- Organization-specific data relative to national benchmarks for orthopedic and cardiac complications, readmissions and HCAHPS
- National and Customized Episodes available for MS-DRGs.
  - Episodes include average index hospitalization, post acute care spending, physician and outpatient care over 30, 60 and 90 days
- Examine Medicare patient transitions from acute care to PAC setting for EPM patients
  - View comparative raw readmissions rates between PAC types and providers
- View episodic spending allocation at specific locations and time intervals following anchor discharge
  - Modify view in intervals of 5 days (up to 90) following anchor hospitalization

Source: Advisory Board analysis.
Additional Tools and Services for Support

ABC Capabilities Span Analytics, Strategy and Execution Partnership

**Decision support tools**

- **Identification of largest cost and quality opportunities**
  - Variation in device cost, test utilization, LOS by physician
- **Identification of revenue risks and opportunities**
  - Physician referral patterns
  - Splitter analysis and leakage

**Strategy and execution support services**

- **Areas of consulting expertise**
  - Bundled payment implementation
  - Physician alignment strategies
  - Standardizing care pathways
- **Subscription based strategic advisory services, including**
  - Discharge and utilization recommendations
  - Facility and market specific data
- **Integrated workflow platform**
  Enables coordinated, proactive and efficient care management across settings

Source: Advisory Board analysis.