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Bundled Payment Models for Coordinated Cardiac and Hip Fracture Care Proposed Rule

OVERVIEW

On July 25th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to establish new bundled payment models for high-quality, coordinated cardiac and hip fracture care. The proposed rule aims to advance care coordination, improve quality of care, and reduce spending through financial accountability. The proposed rule includes policies such as:

- New bundled payment models for cardiac care and an extension of the existing bundled payment model for hip replacements to other hip surgeries;
- A new model to increase cardiac rehabilitation utilization; and
- A proposed pathway for physicians with significant participation in bundled payment models to qualify for payment incentives under the proposed Quality Payment Program.

This document summarizes major provisions of the proposed rule. CMS will accept comments until October 1, 2016. The proposed rule is available here.

PROPOSED PAYMENT MODELS

CMS proposes to implement bundled payment models for episodes of care surrounding an acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment excluding lower extremity joint replacement (SHFFT). Under the proposed rule, CMS proposes to test whether episode payment models for AMI, CABG, and SHFFT episodes of care would reduce Medicare expenditures while preserving or enhancing quality for beneficiaries.

CMS proposes that the episode of care would begin with an inpatient admission to an anchor hospital for a heart attack, bypass surgery, or surgical hip/femur fracture treatment. Participating hospitals would be held responsible for the quality and cost of care associated with each Medicare fee-for-service beneficiary's episode of care.

Episodes would end 90-days after the date of discharge from the anchor hospital. The proposed episode payment models would include the inpatient stays and all related care covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.

CARDIAC BUNDLES

The proposed AMI model would include beneficiaries discharged under the following Medicare Severity-Diagnosis Related Group (MS-DRGs): 280-282 and 246-251.

The proposed CABG model would include beneficiaries discharged under MS-DRGs 231-236.

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Participation

For the cardiac bundles, participants would include all hospitals paid under the IPPS in 98 randomly-selected metropolitan statistical areas (MSAs). Hospitals outside these geographic areas would not participate in the model. There is no application process for these models.

CMS proposes that the AMI and CABG payment models be implemented together in the same MSAs. These participating MSAs may or may not be the same as the SHFFT-participating MSAs.

ORTHOPEDIC BUNDLES

The SHFFT model builds on the framework established for CMS's Comprehensive Care for Joint Replacement (CJR) model, which retrospectively bundles Medicare payments for hip and knee replacements. The CJR model began April 1, 2016. CMS proposes that SHFFT model would include beneficiaries discharged under MS DRGs 480-482.

Participation

Because the SHFFT model builds upon the existing CJR model, CMS proposes that the SHFFT model be implemented in the same 67 MSAs that were selected for the CJR model.

PRICING AND PAYMENT

At the beginning of each performance year, CMS would provide each participating hospital with a set price for an episode, referred to as the target price. The target price would be set based on a mix of hospital-specific and regional-historical data on total costs related to the episode of care for Medicare fee-for-service beneficiaries admitted for heart attacks, bypass surgery, or surgical hip/femur fracture treatment. Target prices would also be adjusted based on complexity. CMS proposes that the blend of hospital-specific and regional-historical data would be adjusted over the duration of the payment model:

- **July1, 2017-December 31, 2018 (performance year 1 and 2):** Two-thirds participant specific data and one-third regional data;
- **2019 (performance year 3):** One-third participant-specific data and two-thirds regional data; and
- **2020-2021 (performance year 4-5):** Only regional data.

At the end of each performance year, actual spending for the episode would be compared to Medicare's target price. Hospitals that meet quality standards and spend less than the target price would earn the difference between actual spending and their target. Hospitals with costs exceeding the quality-adjusted target price would be required to repay Medicare.

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CARDIAC REHABILITATION INCENTIVE PAYMENTS

CMS proposes a model that will test the effects of payments that encourage the use of cardiac rehabilitation services. The cardiac rehabilitation incentive payment model would test the impact of providing an incentive payment to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery. The incentive payments would be based on beneficiary utilization of cardiac rehabilitation services in the 90-day care period following hospital discharge. Hospitals may use this incentive payment to coordinate rehabilitation and support beneficiary adherence to the cardiac rehabilitation treatment plan to improve cardiovascular fitness.

Participation

Participants would include hospitals in 45 geographic areas that were not selected for the cardiac care bundled payment models and 45 geographic areas that were selected for the cardiac care bundled payment models.

This test would be implemented over the same five-year period as the cardiac care bundled payment models. Standard Medicare payments for cardiac rehabilitation services would continue to be made directly to those providers throughout the model.

Payment

The two-part cardiac rehabilitation incentive payment would be paid retrospectively based on the total cardiac rehabilitation use of beneficiaries attributable to participating hospitals.

The initial payment would be $25 per cardiac rehabilitation service for each of the first 11 services paid for by Medicare during the care period for a heart attack or bypass surgery. After the first 11 services, the payment would increase to $175 per service.

Based on Medicare coverage, the number of cardiac rehabilitation program sessions would be limited to a maximum of two one-hour sessions per day for up to 36 sessions over the course of 36 weeks. There would be an option for an additional 36 sessions over an extended period of time, if approved by the Medicare Administrative Contractor. Intensive cardiac rehabilitation program sessions would be limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

PAYMENTS FOR HIGHER-QUALITY CARE

Under the proposed rule, hospitals that deliver higher-quality care would be eligible to be paid a higher amount of savings than those with lower quality performance. Hospitals' quality-adjusted target price would be based on a 1.5 to 3 percent discount rate relative to historical spending. Hospitals providing the highest-quality care would receive the lowest discount percentage.

Hospitals would be assessed based on quality metrics appropriate for each episode payment model. Quality measures include, but are not limited to:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization (NQF #0230);
- Excess Days in Acute Care after Hospitalization for AMI;

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- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery (NQF #2558);
- HCAHPS Survey (NQF #0166); and
- Hip/femur fractures (same measures as the existing CJR model).

TIMELINE

CMS proposes to test the payment models for five performance years, beginning on July 1, 2017.

CMS recognizes that hospitals will need time to adapt to the new models and proposes to gradually phase in risk on the following timeline:

Downside risk (possible repayment to Medicare):

- **July 2017-March 2018 (performance year 1 and the first quarter of performance year 2):** No repayment;
- **April 2018- December 2018 (quarters 2 through 4 of performance year 2):** Capped at 5 percent;
- **2019 (performance year 3):** Capped at 10 percent;
- **2020-2021 (performance years 4 and 5):** Capped at 20 percent.

Gains (payments from Medicare to hospitals):

- **July 2017-December 2018 (performance year 1 and 2):** Capped at 5 percent
- **2019 (performance year 3):** Capped at 10 percent;
- **2020-2021 (performance years 4 and 5):** Capped at 20 percent.

ADVANCE ALTERNATIVE PAYMENT MODELS (APMS)

The AMI, CAGB, CJR, and SHFFT models could qualify as Advanced APMs beginning in 2018. Specifically, the proposed rule would create a track in each model to potentially qualify under the criteria proposed in the Quality Payment Program proposed rule for Advanced APMs beginning in January (CJR) or April (AMI, CABG, SHFFT) of 2018. In addition, CMS announced that it intends to build upon the Bundled Payments for Care Improvement initiative with a new voluntary bundled payment model to begin in CY 2018. This model would also potentially qualify under the proposed criteria for advanced APMs.