New Payment Models: What Does This Mean for Cardiology

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New York-Presbyterian • Columbia • Weill Cornell
Anyone who isn’t really confused doesn’t understand the situation.

- Edward R. Murrow
Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.

- APMs can apply to
  - Care episode (PCMH)
  - Specific clinical condition (episode/bundled payment)
  - Population (ACO)

Advanced APMs are a Subset of APMs
Fragmentation Of Care

Primary Care  
Specialty Care  
In-patient & Out-patient Hospital  
Hospice  
Post-acute Care  
Home Health

Lack of Communication and Appropriate Follow-up  
Diagnostic Errors  
Hospital Readmission  
Adverse Drug Events
Established by HHS—

- to accelerate the health care system’s transition to alternative payment models
- capture best practices, disseminate information, and apply lessons learned
National Quality Strategy

Better Care
Move from current fee-for-service payment to a model that pays clinicians for quality care and improved health.

Smarter Spending
Shift payment structure to pay for quality of care rather than individual services.

Healthier People
Requires the participation of the entire health care community.
Better Care, Smarter Spending, Healthier People

Goals for U.S. Health Care

2016
30%
At least 30% of U.S. health care payments are linked to quality and value through APMs.

2018
50%
At least 50% of U.S. health care payments are so linked.

Adoption of Alternative Payment Models (APMs)

2016
50%
2018
30%
# APM Framework

## Population-Based Accountability

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Fee for Service — No Link to Quality &amp; Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foundational Payments for Infrastructure &amp; Operations</td>
</tr>
<tr>
<td></td>
<td>Pay for Reporting</td>
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<tr>
<td></td>
<td>Rewards for Performance</td>
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<td>Rewards and Penalties for Performance</td>
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</table>

<table>
<thead>
<tr>
<th>Category 2</th>
<th>Fee for Service — Link to Quality &amp; Value</th>
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<tbody>
<tr>
<td>A</td>
<td>APMs with Upside Gainsharing</td>
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<tr>
<td>B</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
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<table>
<thead>
<tr>
<th>Category 3</th>
<th>APMs Built on Fee-for-Service Architecture</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>APMs with Upside Gainsharing</td>
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<tr>
<th>Category 4</th>
<th>Population-Based Payment</th>
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<tbody>
<tr>
<td>A</td>
<td>Condition-Specific Population-Based Payment</td>
</tr>
<tr>
<td>B</td>
<td>Comprehensive Population-Based Payment</td>
</tr>
</tbody>
</table>
APM Goals
For Payment Reform

Current State

Category 1
Fee for Service
No Link to Quality & Value

Category 2
Fee for Service
Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

Future State

Category 1
Fee for Service
No Link to Quality & Value

Category 2
Fee for Service
Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment
# CMS Charting a Path Toward Greater Risk

Cardiac EPM, MSSP Track 3, and Next-Gen ACO Filling Out the Continuum

## Continuum of Medicare Risk Models

<table>
<thead>
<tr>
<th>Pay-for-Performance</th>
<th>Bundled Payments</th>
<th>Shared Savings</th>
<th>Shared Risk</th>
<th>Full Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Merit-Based Incentive Payment System</td>
<td>• Bundled Payments for Care Improvement Initiative (BPCI)</td>
<td>• MSSP Track 1 (50% sharing)</td>
<td>• MSSP Track 2 (60% sharing)</td>
<td>• Next Generation ACO Model (full risk option)</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive Care for Joint Replacement (CJR) Model</td>
<td></td>
<td>• MSSP Track 3 (up to 75% sharing)</td>
<td>• Medicare Advantage (provider-sponsored)</td>
</tr>
<tr>
<td></td>
<td>• Cardiac Episode Payment Models</td>
<td></td>
<td>• Next Generation ACO Model (80-85% shared savings option)</td>
<td></td>
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ACO GROWTH

Overall Trajectory

Number of ACOs and Number of Lives Covered ( Millions)

Source: Leavitt Partners Center for Accountable Care Intelligence
ACOs by Contract Type in the US
CONSISTENT WITH PAST YEARS, 2015 RESULTS INDICATE...

Quality ≠ Cost

The Benchmark Matters
Average benchmark per beneficiary & total expenditures per beneficiary by shared savings achievement

Physician-Led & Integrated ACOs Tend to Do Better

Shared Savings Rate

Hospital System  | Physician Group  | Integrated

$12,000  |  | $9,500
$5,000  |  | $5,000
$3,000  |  | $3,000
$0      |  | $0
Providers need time to develop the competencies for success.
Bundled Payments Savings Potential

- ACOs: $5.3B
- Bundled Payments: $19B

$47B

2013 CBO estimate of 10-year savings associated with bundle payments, 2014-2023
BPCI Cardiac Episodes

- Acute Myocardial Infarction
- Percutaneous Coronary Intervention
- Coronary Artery Bypass Graft
- Cardiac Arrhythmia
- Cardiac Defibrillator
- Cardiac Valve

- Congestive Heart Failure
- Chest pain
- Major Cardiovascular Procedure
- Pacemaker
- Pacemaker device replacement or revision
- AICD generator or lead revision
### Bundled Payment for Care Improvement (BPCI) Model

<table>
<thead>
<tr>
<th></th>
<th>3 Days Pre-Acute ¹</th>
<th>Hospital Inpatient Stay</th>
<th>Inpatient MD Services</th>
<th>Post-Acute Facility Services</th>
<th>Post-Acute MD Services</th>
<th>Related Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td></td>
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<td>Model 2</td>
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<td>Model 3</td>
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<tr>
<td>Model 4</td>
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</table>

¹ 3 Days Pre-Acute refers to the period before the hospital inpatient stay.
Where Are Bundled Payments Happening?
Medicare, Medicaid, Commercial, and Employer Participants

- **Medicare** Bundled Payments for Care Improvement ("BPCI")

- **Medicaid** Bundled Payment Programs
  - Arkansas
  - Ohio
  - Tennessee

- **Employer** Bundled Payment Programs

- **Commercial** Bundled Payment Programs
Advanced APMs in 2017

- Next Generation ACO Model
  - Shared Savings Program Track 2 and 3 ACO
- Oncology Care Model
  - (Two-sided Risk Arrangement)

- Comprehensive Primary Care Plus (OPC+)
- Comprehensive ESRD Care Model

Future Advanced APM Opportunities

- Advancing Care Coordination through Episode Payment Models
- New Voluntary Bundled Payment Model
- Acute Myocardial Infarction (AMI)
- Comprehensive Care for Joint Replacement (CJR) Payment Model
- Coronary Artery Bypass Surgery (CABG)
- ACO Track 1+
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

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, CABG
• Hospital-based VBP includes AMI, HF 30-day mortality rates
• AMI, HF 30-Day payment reporting
• AMI, HF excess days metric

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Cardiac Episode Payment Models

Understanding Key Components of the New Cardiac EPM Proposal

- Composition of the cardiac EPM episode
- Transfer rules
- Retrospective payment model mechanics
- Quality requirements
- Gainsharing opportunities
- Regulatory waivers
Central Elements of Cardiac EPM Bundles

Episode of Care
All care (Part A & B) related to anchor hospitalization (AMI & CABG) and 90 days post-discharge

Target Price
Episode target - up to a 3% discount off of historical/regional spending performance

Reconciliation Process
Calculate difference between episode spend and target price

Quality
Specific measures that CMS has defined as important indicators of quality for cardiac EPMs
Participating Markets Randomly Selected

Eligibility Criteria Based on AMI Volumes

Key Elements of Cardiac EPM Market Selection

- 98 markets would be chosen randomly from 284 eligible Metropolitan Statistical Areas (MSAs)
- Eligible MSAs:
  - >75 AMIs per year
- The AMI and CABG episodes would be implemented together in selected markets
Taking a Long View of Patient Care

EPMs Would Track Costs, Outcomes Up to 90 Days Post-Discharge

EPM Proposed Episode and Included Services

Anchor Hospitalization

Select Services Included in EPM Proposal

- Inpatient services
- Post-acute care (LTACH, IRF, SNF, home health)
- Related readmissions
- Clinical lab services
- Independent outpatient therapy
- Outpatient services
- Physician services
- Other part A and B covered services (DME, part B drugs, hospice, etc.)

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No Immediate Change in Billing

CMS Would Use Retrospective Reconciliation to Adjust Hospital Payments

Proposed Hospital Payment Process Under Cardiac EPM

1. Fee-for-Service Billing
   - Hospital bills FFS, receive payment as usual; CMS tracks claims

2. Comparison to Target
   - Total costs compared to target price based on historic claims

3. Payment Reconciliation
   - If over target hospital repays CMS; if under, receives reconciliation

Incorporates Blend of Regional and Facility Historic Claims Data

- Target price based on 3 years of historic claims
- Hospital & regional claims define target price
- In 2020 and 2021, only regional data used

Phases in Upside and Downside Financial Risk

- Partial upside risk in year 1
  Phased to 20% by year 4
- Partial downside risk in year 2 & 3
  Full risk (20%) in years 4 & 5
Reconciliation to be Based on Payment and Quality

Two Factors Would Determine Whether You Pay CMS, or CMS Pays You

1. Medicare Payment Below Target

EPM episode payments must be below CMS’ target

2. Meet Quality Standards

Hospital performance on EPM quality composite determines discount target and reconciliation payment eligibility

Reconciliation payment eligibility dependent on minimum quality standard

If hospital comes in below target price but does not achieve at least “Acceptable” rating, they will not be eligible for reconciliation payment.
Individual Performance Would be Phased Out from Target Price by Year 5

Model Years
1-2
1/3 Regional CY2013-2015
2/3 Individual CY2013-2017

Model Years
3-4
1/3 Individual CY2015-2017
2/3 Regional CY2015-2017

Model Year
5
3/3 Regional CY2017-2019

Target Price Updates
Hospitals will receive updated target prices twice per year (January and October) to account rate updates across various payment systems

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<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Definition</th>
<th>Weight in Composite</th>
<th>Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day Mortality</td>
<td>30-day, all cause, risk-standardized mortality rate following a hospitalization for AMI</td>
<td>50%</td>
<td>Claims-based per Inpatient Quality Reporting (IQR) (NQF #0230)</td>
</tr>
<tr>
<td>AMI Excess Days</td>
<td>Excess days in acute care (ER, observation, and readmission days following a hospitalization for AMI)</td>
<td>20%</td>
<td>Claims-based per IQR</td>
</tr>
<tr>
<td>HCAHPS Survey</td>
<td>Patient experience (not specific to DRGs). Communication, pain management, cleanliness, quietness etc.</td>
<td>20%</td>
<td>Patient Survey (NQF #0166)</td>
</tr>
<tr>
<td>Hybrid AMI Mortality Voluntary Data</td>
<td>30-day, risk-standardized AMI mortality rate, using a combination of claims data and EHR data submitted by hospitals</td>
<td>10%</td>
<td>Voluntary submission (NQF #2473)</td>
</tr>
</tbody>
</table>
Hybrid AMI Mortality to Measure Clinical Status

A Potential Replacement for the Current 30-Day Mortality Measure

Hybrid AMI Mortality Measure

Claims Data

30-Day AMI Mortality Measure (NQF #0230)
- Same measure cohort and outcome

EHR Data

Five core clinical data elements:
- Age
- Heart rate
- Systolic blood pressure
- Troponin
- Creatinine

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### CMS Proposes Options for Gainsharing

**Risk-Sharing Restrictions**

- Hospital may only share funds from internal savings or final reconciliation/repayment.
- Maximum physician gainshare is 50% of Part B physician fee schedule.
- Gainsharing payments must be partly based on quality metrics set by the hospital (not referrals/patient volumes).
- If sharing downside risk, the hospital must retain 50% of repayment risk.
- Maximum repayment amount for one partner is 25%.

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Proposed Cardiac EPM Program Waivers

Skilled Nursing Facility Three-Day Rule
CMS will waive the SNF 3-day rule only for the AMI EPM if a patient is discharged to a SNF with at least a three star quality rating (starting in performance year 2).

Waiver of “Incident To” Direct Supervision Requirement for post discharge home visits
Non-physician and clinical staff can provide home visits (physician doesn’t have to be present) - for patients not eligible for home health services. 13 visits for AMI and 9 visits for CABG EPM.

Telehealth Services
Waive the geographic site requirement for telehealth, allowing patients to receive telehealth services no matter where they are located. Also would waive the originating site requirement.
Hospital Transfers a Concern

Understanding the Issues, Defining the Terms

Key Questions Regarding Transfers

Before Going Further, Define Your Terms

- Participant: Hospital in selected MSA for EPMs
- Nonparticipant: Hospital not in selected MSA for EPMs
- Inpatient to inpatient transfer: Patient admitted at initial hospital, then transferred to different hospital
- Outpatient to inpatient transfer: Patient not admitted at initial hospital then transferred to different hospital (e.g., seen in ER and immediately transferred)

If an AMI patient starts at one hospital and then is sent elsewhere for care, who is financially responsible?

If the DRG at the initial hospital is different than the DRG at the transfer hospital (e.g., if AMI patient had a CABG), how is the episode target price set?
# CMS Proposes Rules for AMI, CABG Episode Attribution

## Inpatient to Inpatient Transfers

<table>
<thead>
<tr>
<th>Situation</th>
<th>Initiation, Attribution</th>
<th>Takeaway</th>
</tr>
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<tr>
<td><strong>1</strong> Inpatient to Inpatient Transfer: Nonparticipant to Participant</td>
<td>Initiate episode based on DRG at transfer (i.e., receiving) hospital. Attribute episode to transfer hospital.</td>
<td>Transfer hospital determines DRG. Transfer hospital financially responsible for episode.</td>
</tr>
<tr>
<td><strong>2</strong> Inpatient to Inpatient Transfer: Participant to Participant or Nonparticipant</td>
<td>Initiate episode based on DRG at initial hospital. Attribute episode to initial hospital.</td>
<td>Initial hospital determines DRG. Initial hospital financially responsible for episode.</td>
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### CMS Proposes Rules for AMI, CABG Episode Attribution

#### Outpatient to Inpatient Transfers

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<tr>
<td>3 Outpatient to Inpatient Transfer: Nonparticipant or participant to Participant</td>
<td>Initiate episode based on DRG at transfer (i.e., receiving) hospital Attribute episode to transfer hospital</td>
<td>Transfer hospital determines DRG Transfer hospital financially responsible for episode</td>
</tr>
<tr>
<td>4 Outpatient to Inpatient Transfer: Participant to Nonparticipant</td>
<td>No AMI or CABG model initiated</td>
<td>No episode initiated</td>
</tr>
</tbody>
</table>
Preparing for Cardiac Episode Payment Models

Responding to the Proposed Rule for Cardiac EPMs

1. **Understand the sources of costs in episodes; identify high areas of episodic cost and evaluate internal efficiencies and local PAC provider outcomes.**

2. **Patient engagement; evaluate care management program, access to care, communication tools including EMR patient portal.**

3. **Physician leadership; engage and educate cardiovascular specialists and team members on the cardiac EPM program, develop coherent strategy and organizational structure.**

Even if not chosen for participation, cardiologists should consider this proposal to be a signal that future bundling or episodic payment reform is likely to occur.
Assessing Costs At 90 Days After Admission

Understanding Costs a Crucial Step to Developing an EPM Strategy

Percentage of Total Costs Attributed to Each Setting
Medicare, 2014

Index admission remains a large source of costs at 90 days for CABG
PAC an important contributor to total episodic costs
Over a quarter of total costs for AMI attributed to readmissions

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ACC Key Comment Areas:
Proposed Rule for Cardiac EPMs

- **Clinical homogeneity** in the AMI model
- AMI model **quality measures**
- **Advanced APMs**
- Special policies for **hospital transfers** of beneficiaries with AMI
- **Risk sharing and financial arrangements** under EPMs
- **Additional care coordination considerations**
Clinical Homogeneity

CMS proposes to include beneficiaries who are discharged under AMI (MS-DRGs 280-282) and PCI (MS-DRGs 246-251) with an AMI ICD-10 CM diagnosis code in the principal or secondary diagnosis position.

ACC strongly recommends limiting the AMI model to STEMI patients discharged with AMI code only in the principal diagnosis position.
Proposed AMI Quality Measures

4 measures: 3 required, 1 voluntary

Measure                                       Weight
• MORT-30-AMI (NQF #0230)                     50%
• AMI Excess Days                             20%
• HCAHPS Survey (NQF #0166)                   20%
• Hybrid AMI Mortality (NQF #2473)            10%

Voluntary Data
AMI Quality Measures and Role of NCDR

- The ACC recommends reducing the weighting for the MORT-30-AMI measure to no more than 30% of the composite quality performance score.

- The ACC recommends reallocating the remaining 20% of the weight to the Core Quality Measure Collaborative (CQMC) cardiovascular measures set and measures reported through NCDR.
Transfer Policy

• The ACC strongly recommends attributing patients to the hospital where revascularization procedures are performed rather than the anchor hospital.

• The admitting hospital that transfers the patient for treatment has little or no control over the rest of the episode and thus should not be held accountable.
Other Positions

Risk Sharing and Financial Arrangements under EPMs

- The ACC recommends including both Part A and Part B services in gainsharing arrangements to achieve truly meaningful risk sharing.

Additional Care Coordination Considerations

- The ACC urges CMS to make resources for care coordination strategies available to support advancing care coordination.
Bundled Payment Model: Opportunities

• Represents continued movement towards a value-based payment system that focuses on improved quality and value – key elements of ACC’s strategic plan.

• Reflects CMS’ continued efforts to find new ways for specialists to be rewarded for delivering quality care.

• May qualify as an Advanced Alternative Payment Model (APM) under MACRA.

• Opportunity to extend the value of NCOR (ACTION, Cath-PCI) and ACC quality programs.
Bundled Payment Model: Challenges

• Different from previous CMS bundles payment models:
  – Higher-risk patients
  – Surgeries are not elective (Physicians have less control over timing/planning)
• Those without experience with bundles will have little time to adapt or plan in advance.
• Changes in payment structures must be driven by clinical practices that improve patient outcomes.
• Potential for unintended consequences
Program Would Start July 1, 2017

Cardiac EPM Performance Periods

- Year 1 starts, July 1, 2017
- Year 2 starts, Jan 1, 2018
- Year 3 starts, Jan 1, 2019
- Year 4 starts, Jan 1, 2020
- Year 5 starts, Jan 1, 2021

We are here, November 17, 2016
Downside risk commences on April 1, 2018

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Physician-Focused Payment Model Technical Advisory Committee

- MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

- The PTAC is a federal advisory committee that provides independent advice to the Secretary. The PTAC is supported by HHS Office of the Assistant Secretary for Planning and Evaluation.

- This committee provides a unique opportunity for stakeholders to participate in the development of new models and to help determine priorities for the physician community.
PFPM Technical Advisory Committee (PTAC)

PFPM = Physician-Focused Payment Model

Goal to encourage new APM options for Medicare clinicians

- Submission of model proposals by Stakeholders
- 11 appointed care delivery experts that review proposals, submit recommendations to HHS Secretary
- Secretary comments on CMS website, CMS considers testing proposed models
- Models with favorable response go to CMS Innovation Center