

## CMS EXPANDS MANDATORY BUNDLED-PAYMENT MODEL TO CARDIAC CARE

In July 2016, the Centers for Medicare & Medicaid Services (CMS) announced a proposal for a new bundled-payment model for Medicare patients admitted for heart attack and cardiac bypass surgery. This cardiovascular bundled-payment model is to be tested in a five-year demonstration that takes effect July 1, 2017. Hospitals will be chosen from 98 randomly-selected metropolitan statistical areas (MSAs) for the cardiac bundling program. Hospitals outside of these selected areas will not participate in the cardiac bundles. There is no application process for hospitals for these models.

Via the July announcement, CMS also proposed to expand its first and mandatory bundled-payment model for total hip and knee replacements, i.e., the Comprehensive Care for Joint Replacement (CJR) model which took effect in April 2016, to include covering surgeries repairing hip and femur fractures. The hip/femur fracture bundles will be tested in the 67 MSAs already selected for the CJR model.

This new course of mandatory models reinforces CMS' commitment to migrating Medicare away from fee-for-service (FFS) payments and toward a value-based environment to create a healthcare system that provides better care, spends healthcare dollars more wisely, and makes people healthier. Shifting Medicare to quality incentives uses payment systems that reward hospitals, physicians, and other providers for quality over quantity of care. The Department of Health and Human Services aims to have half of traditional Medicare payments go through alternative payment models by 2018.

### PROPOSAL SUMMARY

The cardiac bundles proposal was published in the [Federal Register](#) on August 2, 2016. Titled "Medicare Program: Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model", the proposal contains three new, significant policies:

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

Research shows that bundled payments can support providers – hospitals, physicians, post-acute care providers, and other clinicians – in working closely together to provide better care at lower cost. As part of implementing the new payment models, CMS will provide hospitals with tools to help them improve care coordination and deliver higher-quality care. Proposed activities include providing participants with relevant spending and utilization data, and facilitating the sharing of best practices between participants through a learning and diffusion program.

Another proposed activity to improve care coordination and increase program flexibility is to waive certain Medicare requirements to facilitate development of novel approaches to the delivery of care. CMS proposes adopting a waiver to the definition of a physician to include a nonphysician practitioner – defined for the purposes of this waiver as a **clinical nurse specialist** (CNS), physician assistant (PA), or nurse practitioner (NP) – as a means of increasing the availability CR and intensive cardiac rehabilitation

(ICR) services furnished to EPM beneficiaries in Acute Myocardial Infarction (AMI) and Coronary Artery Bypass Graft (CABG) episodes. This waiver will allow a physician, a nonphysician practitioner to perform the functions of a supervisory physician. Those supervisory functions include prescribing exercise, and establishing, reviewing, and signing an individualized treatment plan for a provider or supplier of CR and ICR services furnished to an EPM beneficiary during an AMI or CABG episode. Excluded from this proposed waiver is the medical director function, which at this time only may be performed by a physician.

### **BUNDLED PAYMENT**

A bundled payment reimburses the provider a fixed fee amount for an episode of care, including an initial hospital stay and 90 days of post-discharge care. The bundled payments will be based on historical spending levels on a hospital-by-hospital basis, but in time will transition to average regional spending levels. CMS intends to implement the mandatory cardiovascular bundled payment models for participating hospitals that admit Medicare FFS patients receiving three types of cardiac care, including:

- Patients receiving CABG
- Heart attack patients who are medically managed, i.e., are treated with drugs and other non-interventional therapies
- Heart attack patients receiving percutaneous coronary intervention (PCI), including stents, angioplasty, or other interventions.

The bundle makes hospitals accountable for the cost and quality of care provided during the inpatient stay and for 90 days after discharge. Hospitals will be paid a fixed target price for each episode of care, and those that hit higher quality targets will qualify for a higher target price. At the end of each performance year, hospitals have an additional opportunity to earn shared savings based on how they performed in terms of their target price.

### **GAINSHARING AGREEMENTS SUPPORTING COLLABORATION**

To support the alignment of incentives on cost and quality, CMS will provide hospitals with greater flexibility to create gainsharing agreements with physicians and other provider organizations. One of the major goals of bundled payments is to encourage coordination among all providers involved in a patient's care. As in the CJR model, hospitals participating in the cardiac care demonstration will be allowed to enter into financial arrangements with other types of providers (e.g., skilled nursing facilities, physicians), as well as with Medicare Shared Savings Program Accountable Care Organizations (ACOs). Those arrangements will allow hospital participants to share reconciliation payments, internal cost savings, and the responsibility for repayment to Medicare with other providers and entities that choose to enter into these arrangements, subject to the limitations outlined in the proposed rule.

### **CARDIAC REHABILITATION INCENTIVE PAYMENTS DEMONSTRATION TEST**

As previously noted, this CMS proposal also announced a model that will test the effects of payments that encourage the use of CR and ICR services. The cardiac rehabilitation incentive payment model will test the impact of providing an incentive payment to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery, which would be based on beneficiary utilization of CR and ICR services in

the 90-day care period following hospital discharge. Hospitals may use this incentive payment to coordinate CR and support beneficiary adherence to the CR treatment plan to improve cardiovascular fitness. These payments would be available to hospital participants in 45 geographic areas that were not selected for the cardiac care bundled payment models, as well as 45 geographic areas that were selected. This test will cover the same five-year period as the cardiac care bundled payment models.

Also as previously mentioned, this provision of the CMS proposal, seeks to adopt a waiver for furnishing CR and ICR services to allow a CNS, NP, or PA, in addition to a physician, to perform specific physician functions. This type of Medicare rule waiver was tested under the CJR model where CMS waived certain program rules regarding the direct supervision requirement for certain post-discharge home visits, telehealth services, and the skilled nursing facility 3-day rule. CMS finalized these waivers to offer providers more flexibility so that they may increase coordination of care and management of beneficiaries in model episodes.

CMS suggests that adopting the CJR waivers for the proposed EPMs requires further examination to determine if such adoption would increase financial vulnerability to the Medicare program or would create inappropriate incentives to reduce the quality of beneficiary care. For an EPM beneficiary in an AMI or CABG episode, this proposed waiver will apply to any provider or supplier who furnishes CR and ICR services to that beneficiary. CMS anticipates monitoring outcomes of care for EPM beneficiaries that receive CR and ICR services under this proposed waiver during an AMI or CABG episode. The monitoring may involve an analysis of all or a sample of claims, medical records, or other clinical data for AMI and CABG EPM CMS-5519-P 523 beneficiaries and providers or suppliers of CR and ICR services.

For this proposal, CMS states that it also reviewed other program requirements, such as waiving beneficiary cost sharing, allowing home nursing visits/home monitoring, and allowing telehealth visits in the home under the AMI and CABG models. However, CMS states at this time it did not find clinical data and literature that it believed sufficient to support proposing any additional waivers – other than the nonphysician practitioner – to the CR/ICR program requirements in this proposed rule.

### **PATHWAY FOR BUNDLED PAYMENT MODELS TO QUALIFY AS ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)**

The proposed rule also describes new pathways for physicians who participate in bundled payment models to qualify for financial rewards through the proposed Quality Payment Program, which implements the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). MACRA introduced financial incentives for physicians participating in Advanced APMs that align incentives for high quality, cost-effective care. The cardiac care bundled payment models and the CJR model, could qualify as Advanced Alternative Payment Models beginning in 2018, including for physicians who collaborate with hospitals participating in the models. This is the more lucrative track under MACRA, which determines physicians' Medicare payment adjustments in place of the sustainable growth rate formula.

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 because these tracks would:

- Require participants to bear risk for monetary losses that meets the proposed nominal risk criteria
- Use quality measures that meet the proposed measure requirements to base payments, and

- Allow participants to opt into a track that requires use of Certified Electronic Health Record Technology

Finally, the proposed rule indicates that CMS plans to build on its Bundled Payments for Care Improvement Initiative. This includes a new voluntary bundled payment program that would begin in 2018, and could also potentially qualify as an Advanced APM under MACRA. CMS is yet to determine the details of a voluntary bundled payment program; however, the voluntary hospitals will be those that have contractual relationships with physician groups, ACOs, and other eligible providers.

#### FOR MORE INFORMATION:

- [Cardiac Bundled Payment Models](#)
- [Cardiac Rehabilitation Incentive Payment Model](#)
- [Comprehensive Care for Joint Replacement Model](#)