Bundles aka Episode Payment Models

Getting ready for 2017

Cathleen Biga
President/CEO Cardiovascular Management of Illinois
Cathleen Biga, MSN, RN: Disclosures:

- Co-chair: ACC CV Administrator Work Group
- Member: Cardiovascular Management Council
- Member: Health Affairs Committee
- Member: BOT Work Group on Medical and Professional Liability Insurance
- Member: CQC AUC Implementation & Evaluation
- Member: CQC FOCUS Committee
- Member: Partners in Quality Committee
- Member: Task Force on MACRA
- Ownership Interest/Partnership/Principal: Cardiovascular Management of Illinois
- Consultant Fees/Honoraria: Medaxiom
- Organizational (Non-Commercial): Cardiology Advocacy Alliance
- Organizational (Non-Commercial): Medaxiom Advisory Board
Our national healthcare crisis is strongly related to our aging population.

- **EACH 8 SECONDS A BOOMER ENTERS MEDICARE**
- **65+ MORE LIKELY TO PRESENT CHRONIC DISEASES**
- **45% ARE NONCOMPLIANT WITH THEIR CARE PLANS**

20% of the population is responsible for 85% of healthcare costs.
The bundles are coming!!
The bundles are coming!!
FRIDAY, MARCH 04, 2016

Medicare Reaches Value-Based Payment Goal a Year Ahead of Schedule

Medicare’s march toward payment systems that are tied to value and not volume has been moving along at a faster-than-expected clip, according to the Department of Health and Human Services (HHS), which says that Medicare has reached its goal to tie 30% of all payments to value-based systems nearly 1 year ahead of schedule.

According to an HHS announcement, growth of alternative payment models, including accountable care organizations (ACOs) and patient-centered medical homes, have allowed Medicare to shift $117 billion out of a system relying on fee-for-service payments. HHS says that this is expected to lead to greater savings, including $411 million savings in the latest reporting period.

CMS Announces Bundled Payments for Oncology

Cheryl Clark, February 16, 2015

The Oncology Care Model, to be implemented in January 2016, incentivizes cancer doctors to reduce pharmacy costs, in part through better coordination.

A radical cancer payment model introduced by Medicare officials Thursday will pay qualifying oncologists $100,000 for six months for each beneficiary receiving chemotherapy or radiotherapy.

In exchange, qualifying providers must run round-the-clock outpatient clinics to manage common drug therapy side effects that might otherwise send their patients to the hospital. Many centers are now staffing up with nurse practitioners.

“If this after-hours care, there’s a way to treat [side effects such as] nausea or vomiting... or dehydration without the patient going to the ED and being hospitalized,” Patrick Conway, CMS Acting Principal Deputy Administrator and Chief Medical Officer, said in an interview Friday. “The largest savings from this program will come from reducing unnecessary care.”

The Oncology Care Model, or OCM, will launch in 2016, and could result in substantial savings in avoided hospital and pharmacy costs for many of the 1.6 million U.S. patients.
Episodes of care - historical

• 1990’s Bundled payments CABG
  – Successful in reducing cost, improved quality, and provided services more efficiently

• ACE project: tested bundled payments in early 2000’s
  – Cardiac and ortho
  – Ortho widely successful
  – Medicare savings while maintaining quality

• BPCI: CMMI project

• Ortho Mandated bundle
Episodes in 2016

- Component of the s-QRUR - 64 episodes
  - Condition episodes
  - Procedural episodes
  - 10 of these will transfer to MIPs cost category
    - Just CABG and Valve made it to the final rule
- LAN –
  - Maternity
  - Ortho bundle
  - CAD bundle with nested procedures
- CMS mandated bundles
  - 4/1/16 – ortho (CJR in 67 Metropolitan Statistical Areas)
  - 7/25/16 – MI/PCI, CABG, expansion of ortho (SHFFT)
And the lucky MSA’s......

<table>
<thead>
<tr>
<th>HSA Code</th>
<th>Hospital Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>140063</td>
<td>RUSH OAK PARK HOSPITAL</td>
<td>520 S MAPLE AVE</td>
<td>OAK PARK</td>
<td>Illinois</td>
</tr>
<tr>
<td>140065</td>
<td>ADVENTIST LA GRANGE MEMORIAL HOSPITAL</td>
<td>5101 S WILLOW SPRINGS RD</td>
<td>LA GRANGE</td>
<td>Illinois</td>
</tr>
<tr>
<td>140068</td>
<td>ROSELAND COMMUNITY HOSPITAL</td>
<td>45 W 111TH STREET</td>
<td>CHICAGO</td>
<td>Illinois</td>
</tr>
<tr>
<td>140080</td>
<td>PRESENCE SAINT FRANCIS HOSPITAL</td>
<td>355 RIDGE AVE</td>
<td>EVANSTON</td>
<td>Illinois</td>
</tr>
<tr>
<td>140082</td>
<td>LOUIS A WEISS MEMORIAL HOSPITAL</td>
<td>4646 N MARINE DRIVE</td>
<td>CHICAGO</td>
<td>Illinois</td>
</tr>
<tr>
<td>140083</td>
<td>LORETTO HOSPITAL</td>
<td>645 SOUTH CENTRAL AVE</td>
<td>CHICAGO</td>
<td>Illinois</td>
</tr>
<tr>
<td>140084</td>
<td>VISTA MEDICAL CENTER EAST</td>
<td>1324 NORTH SHERIDAN ROAD</td>
<td>WAUKEGAN</td>
<td>Illinois</td>
</tr>
<tr>
<td>140088</td>
<td>CENTER</td>
<td>5841 SOUTH MARYLAND</td>
<td>CHICAGO</td>
<td>Illinois</td>
</tr>
<tr>
<td>140095</td>
<td>SAINT ANTHONY HOSPITAL</td>
<td>2875 WEST 19TH STREET</td>
<td>CHICAGO</td>
<td>Illinois</td>
</tr>
</tbody>
</table>

1,120 hospitals in AMI and CABG
1,320 hospitals in the Cardiac Rehab incentive
Fairly evenly distributed???
Basic episode

- **Trigger Event** (Step 1)
- **Clinically Relevant Service** Grouped to Episode (Step 2)
- **Service Not Grouped to Episode**

---

**Episode Start**

**Episode Window**

**Episode End**

**Time**
From a service to an episode.....

Full cost is associated with ALL episodes
Anatomy of an Episode

• Structured payment around a patient's TOTAL experience of care
  – Quality – outcome
  – Cost
  – Experience

• Pre and post hospital
  – Often 3 days pre and usually 90 days post
  – Note the CMS bundles begin on admission

• Better coordination of care

• Ultimately better patient outcome
Goals of episode payment

Episode Payment Can:

- Create incentives to break down existing siloes of care
- Promote communication and coordination among care providers
- Improve care transitions
- Respond to data and feedback on the entire course of illness or treatment
The final rule:

• 1600 page document
• Episodes begins with admission and goes 90 days post-discharge
• Program is for 5 years: 7/1/2017-12/31/2021
• All costs in Medicare Part A and B
• Hospital is financially accountable for cost and quality
• Also announced the MSSP Track 1+
  – Limited downside risk
  – Targeted smaller practices
The MS-DRG’s

• **AMI** (AMI MS-DRGs: 280-282 & PCI MS-DRGs: 246-251 with AMI ICD-CM diagnosis code)
  – IPPS admissions for AMI treated medically or with revascularization via percutaneous coronary intervention (PCI)
• **CABG** (MS-DRGs: 231-236)
  – IPPS admissions for surgical coronary revascularization irrespective of AMI diagnosis

Remember to run your ICD codes with your PCI DRG’s

N-STEMI remained in the final rule
Phewww we don’t have a lot of AMI’s

- 😊 you are still included
- If fewer than 75 AMI episodes over 3 yrs.
  - Use 100% of regional historical
- If fewer than 125 AMI/PCI episodes over 3 yrs.
  - Use 100% of regional historical
- If fewer than 50 CABG episodes over 3 yrs.
  - Use 100% of regional historical
- If you are in Next Gen ACO, MSSP Track 3, or BPCI you are excluded
Attribution

- Changed from proposed rule
- Cancels the initial AMI episode if there is an inpatient to inpatient transfer
- “Receiving” hospital will be attributed the case
- “Solved” the post acute care attribution
The services:

- **Included services**
  - Physicians' services
  - Inpatient hospitalization (including readmissions)
  - Inpatient Psychiatric Facility (IPF)
  - Long-term care hospital (LTCH)
  - Inpatient rehabilitation facility (IRF)
  - Skilled nursing facility (SNF)
  - Home health agency (HHA)
  - Hospital outpatient services
  - Independent outpatient therapy
  - Clinical laboratory
  - Durable medical equipment (DME)
  - Part B drugs
  - Hospice

- **Excluded services**
  - Acute disease diagnoses unrelated to a condition resulting from or likely to have been affected care during the EPM episode
  - Certain chronic disease diagnoses, depending on whether the condition was likely to have been affected by care during the EPM episode or whether substantial services were likely to be provided for the chronic condition during the EPM episode
Target pricing will include

• Hospital specific + regional historical costs for index admission + 90 days post acute care
• Complexities of the patient condition
• All services
• The target price is discounted based on quality performance (i.e., low quality results in a higher discount percentage, which effectively lowers the target price and makes it more difficult to come in “under” cost).
What data are they using

• For years 1 & 2 = expenditures from 2013-2015
• For years 3 & 4 = 2015 through 2017
• For year 5 = 2017 through 2019
• The quality adjusted target price:
  – Years 1 & 2 = 2/3 of your data + 1/3 regional
  – Year 3 = 1/3 of your data + 2/3 regional
  – Year 4 & 5 = all regional 😊
Please define Regional

• Who is in my region?? 9 regions in the country
Costs

• Hospitals carry the risk
  – They can engage “collaborators”
• This is a retrospective program
• All providers and suppliers continue to bill and be paid
  – All your services will count in the hospitals total cost
• Historical costs
• Regional costs
The money: $$$

- Participant hospitals that spend below the target price and have a composite quality score above the acceptable limit:
  - 5% of the target price in years 1-3
  - 10% in year 4
  - 20% in year 5

- CMS removed the downside risk for Years 1 & 2 however if collaborators wish to gain Advanced APM status - they can in yr. 2
<table>
<thead>
<tr>
<th>Model</th>
<th>Episode Volume</th>
<th>Average Hospital Payments</th>
<th>Target</th>
<th>Total Hospital Payments</th>
<th>Total Target</th>
<th>Estimated Performance</th>
<th>% of Target</th>
<th>Stop Gain Limit</th>
<th>Estimated Impact After Stop Gain*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction (AMI)/Percutaneous Coronary Intervention (PCI)</td>
<td>58</td>
<td>$27,287</td>
<td>$23,715</td>
<td>$1,590,558</td>
<td>$1,382,354</td>
<td>$(208,204)</td>
<td>-15.1%</td>
<td>5.0%</td>
<td>$0</td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft (CABG)</td>
<td>43</td>
<td>$54,506</td>
<td>$49,645</td>
<td>$2,336,132</td>
<td>$2,127,805</td>
<td>$(208,327)</td>
<td>-9.8%</td>
<td>5.0%</td>
<td>$0</td>
</tr>
</tbody>
</table>
### Table 12: Details

#### Downside Risk for All Participants—DR effective for episodes ending on or after 1/1/2019 (anchor discharges occurring on or after 10/4/2018)

<table>
<thead>
<tr>
<th></th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
<th>PY4</th>
<th>PY5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop-loss threshold</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop loss threshold for certain hospitals*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discount percentage (range) for Repayment, Depending on Quality Category</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n/a as no downside risk in PY1 and PY2 without election of voluntary downside risk for PY2</td>
<td>5%</td>
<td>10%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

#### Voluntary Downside Risk – DR effective for episodes ending on or after 1/1/2018 (anchor discharges occurring on or after 10/4/2017)

<table>
<thead>
<tr>
<th></th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
<th>PY4</th>
<th>PY5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop-loss threshold</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop loss threshold for certain hospitals*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>
List of Collaborators

- Physicians and nonphysician practitioners
- Home health agencies
- Skilled nursing facilities
- Long term care hospitals
- Physician group practices
- Inpatient rehabilitation facilities
- Providers of outpatient therapy services
- Hospitals
- Critical access hospitals
- Accountable care organizations (ACO) that participate in the Medicare Shared Savings Program
Financial Service Arrangements

- Allows arrangements to facilitate coordination
  - Physicians, SNF’s, ECF’s, home care
  - Tightly regulated to protect beneficiaries
- Limited to 50%
  - And no more than 25% to anyone collaborator
- Limited to Part B – stayed in final rule
- Payment based on quality and services in the EPM
- Must notify pt. if participating
- Fraud and abuse waivers not a “given”
  - But will be considered
  - Notices will be published
Flow of Funds

EPM Collaborator

Collaboration Agreement

Collaboration Agent (i.e., physician in physician group)

Gainsharing Payment

Alignment Payment

EPM Participant

Reconciliation Payment

Repayment Amount

Medicare
Quality

• QUALITY FIRST
• Based on 3 yrs. historical data
• Quality score + improvement score (composite quality score)
• AMI data:
  – 30 day mortality (NQF #0230) – scored at 50% of total
  – Excess days post MI
  – HCAHPS (NQF #0166)
  – Hybrid AMI mortality (NQF #2473) – voluntary measure
    • Uses 5 measures from EHR’s within 2 hrs. of presentation
• CABG
  – 30 day mortality – currently at 75%
  – HCAHPS
  – Final rule added a voluntary CABG measure
    • STS measures
DOC VADER

ON PATIENT SATISFACTION
Is readmission really an issue

CABG (Avg cost $47,000)

AMI (Avg cost $24,000)

PCI*

*Avg cost varies due to number of stents and drug treatment.

Source: CMS 2014
Calculating quality

• Points are assigned based on performance
• Reconciliation Payments require an acceptable or better score
• Discounts for establishing the quality adjusted target price:
  – 3% - unacceptable or acceptable
  – 2% - good
  – 1.5% - excellent
## Associated Performance weights

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Weight in Composite Quality Score</th>
<th>Quality Domain/Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI (NQF #0230)</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>AMI Excess Days</td>
<td>20%</td>
<td>Outcome/80%</td>
</tr>
<tr>
<td>Hybrid AMI Mortality (NQF #2473) Voluntary Data</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>HCAHPS Survey (NQF #0166)</td>
<td>20%</td>
<td>Patient Experience/20%</td>
</tr>
</tbody>
</table>

* Composite weight based on quality metric.

Source: CMS NPRM, July 25, 2016
Quality and impact on payment

• If unacceptable quality – not eligible for reconciliation payment
  – And will see a 3% discount

• If acceptable, good, or excellent – eligible for reconciliation payment + an effective discount of 3%, 2%, or 1.5% respectively
  – Better quality = greater financial opportunity
How will they score this?

<table>
<thead>
<tr>
<th>Performance Percentile</th>
<th>MORT-30-AMI (Points)</th>
<th>AMI Excess Days (Points)</th>
<th>HCAHPS Survey (Points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥90th</td>
<td>10.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>≥80th and &lt;90th</td>
<td>9.25</td>
<td>3.70</td>
<td>3.70</td>
</tr>
<tr>
<td>≥70th and &lt;80th</td>
<td>8.50</td>
<td>3.40</td>
<td>3.40</td>
</tr>
<tr>
<td>≥60th and &lt;70th</td>
<td>7.75</td>
<td>3.10</td>
<td>3.10</td>
</tr>
<tr>
<td>≥50th and &lt;60th</td>
<td>7.00</td>
<td>2.80</td>
<td>2.80</td>
</tr>
<tr>
<td>≥40th and &lt;50th</td>
<td>6.25</td>
<td>2.50</td>
<td>2.50</td>
</tr>
<tr>
<td>≥30th and &lt;40th</td>
<td>5.50</td>
<td>2.20</td>
<td>2.20</td>
</tr>
<tr>
<td>&lt;30th</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Measures and Associated Performance Weights in CABG Model Composite Quality Score:

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Weight in Composite Quality Score</th>
<th>Quality Domain / Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-CABG (NQF #2558)</td>
<td>75%</td>
<td>Outcome/75%</td>
</tr>
<tr>
<td>HCAHPS Survey (NQF #0166)</td>
<td>15%</td>
<td>Patient Experience/15%</td>
</tr>
<tr>
<td>Voluntary STS Measure</td>
<td>10%</td>
<td>Outcomes/10%</td>
</tr>
</tbody>
</table>
Key success factors

• Care coordination
• Timely access
• Improve communication
• Adherence to treatment
• Team based care
• Best practices
• Reduction in variation of care
• Collaboration between hospitals, physicians, home care, SNF, ECF
Some interesting facts

• If you are readmitted for a CABG during an AMI episode:
  – Target pricing = AMI/PCI + CABG anchor benchmark
    • Note the CABG would NOT include post-discharge CABG services
      – Goal is to not “double dip”

• < 3% of AMI pts have a PCI 2-90 days post discharge
Cardiac Rehab Incentive

- Additional program
  - 45 of the 98 randomly selected +
  - 45 selected MSA’s that are not part of the EPM
- Cardiac rehab and intensive rehab programs
- $25 per visit from 1-11
- $175 per visit from 12-36
- Can’t be included in FSA
- Won’t be counted in reconciliation payments
- Can provide transportation
- Use of APP’s
And so…..

• Ensure coding is accurate
• Understand current quality thresholds
• Understand staged multi-vessel procedures & post AMI ICD implants
• Understand your scope/exposure
  – DRG analysis
• Establish data analytics and information sharing
• Reduce variation in care across the System
• Create the infrastructure and expertise to coordinate care transitions and manage post-acute services
Just the Basics *please*

- For the episodes in MIPS/cost
  - Find your s-QRUR
  - Focus your review

- For the CMS Bundles
  - Know your exposure (find the numbers)
  - Prepare to design care pathways
  - Find your current quality benchmarks
  - Identify your collaborators
  - S-QRUR data should be reviewed with hospital data
Do EPM’s count as an A-APM?

• Not till year 3 when there is down side
  – There is a “voluntary” option for 1/1/18

• Initial criteria is still in play
  – 20% of patients
  – 25% revenue