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## New Cardiac and Orthopedic Payment Models

On January 3, 2017, the *Centers for Medicare and Medicaid Services* (CMS) published a final rule creating new bundled payment models for services provided during three (3) care episodes: (1) *acute myocardial infarction* (AMI); (2) *coronary artery bypass graft* (CABG); and, (3) surgical hip/femur fracture.[1] Under the final rule, CMS will conduct a five-year test, starting on July 1, 2017, as to whether these *episode payment models* (EPMs), which combine payments to all providers across the continuum of care involved in the treatment of the patient for a particular condition, "*improve the quality of care provided to [Medicare] beneficiaries in an applicable episode while reducing episode spending through financial accountability*."[2] Additionally, the final rule creates an incentive program related to cardiac rehabilitation treatments, and modifies certain provisions of the *Comprehensive Care for Joint Replacement* (CJR) Model. Together, the final rule expands the scope of CMS bundled payment initiatives to the context of cardiovascular care, and reflect CMS's emphasis on using EPMs to drive the shift from *fee-for-service* (FFS) payment to *value-based reimbursement* (VBR).[3] This *Health Capital Topics* article will discuss the provisions of this final rule, and how the rule continues the shift toward VBR in healthcare delivery.

The January 3, 2017 final rule reflects a continuation of the series of bundled payment initiatives set forth by CMS since the passage of the *Patient Protection and Affordable Care Act* (ACA) in March 2010. Section 3021 of the ACA established the *Center for Medicare and Medicaid Innovation* (CMMI), an agency within CMS with the specific purpose of "*…test*[ing] *innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals…*"[4] CMMI has utilized its authority under the ACA to institute a variety of bundled payment models, including the *Bundled Payment for Care Improvement Initiative* (BPCI) for a variety of inpatient care episodes (discussed in the November 2011 *Health Capital Topics* issue, entitled "*CMS Bundled Payments Initiative: Four Models for Coordinated Care*"), and the CJR model.

CMS bundled payment models have evolved from flat payments to providers (e.g., BPCI),[5] to explicit links between quality metric scores and the ultimate amount of the bundled payment received by providers (e.g., CJR).[6] The BPCI included four approaches: (1) three retrospective payment system models that set a target cost for an established episode of care; and, (2) one single prospective payment model for all services provided during a patient's single inpatient stay.[7] The four BPCI models were designed to incentivize care coordination and the reduction of costs, although the size of the bundled payment is not explicitly tied to the satisfaction of various quality metrics.[8] In contrast, the CJR model considers quality of care in determining the size of the bundled payment, specifically by requiring hospitals performing hip and knee replacement surgeries to earn sufficiently high composite quality scores, which are calculated using quality metrics related to both patient satisfaction and complications in hip and knee replacement surgeries, in order to receive *reconciliation payments* for reducing expenditures.[9] Additionally, while participation in BPCI is voluntary for hospitals, these enterprises are required to participate in CJR if they are located in one of the 67 *metropolitan statistical areas* (MSA) designated by CMS to test the payment model.[10]

By finalizing three (3) new EPMs, CMS continues both the increasing trend of bundled payments, as well as linking the amount of the bundled payment to quality performance. Under the final rule, CMS will test whether the three new EPMs will reduce Medicare expenditures while also improving the quality of care for AMI, CABG, and surgical hip/femur fracture treatment, excluding lower extremity joint replacement.[11] The proposed EPM tests will be conducted over a five-year period, starting on July 1, 2017, and ending on December 31, 2021, and will hold hospitals accountable for the cost and quality of care provided to Medicare FFS beneficiaries during both the inpatient stay and post-acute care.[12] The costs associated with these procedures would be compared to a fixed target price, and hospitals that deliver care for less than the quality-adjusted price would receive payment for the savings achieved (reconciliation payment), while those hospitals whose costs exceed the target price would be required to repay Medicare.[13] For the AMI and CABG EPMs, the hospitals required to participate will be located in 98 randomly selected MSAs, while the hospitals required to participate in the surgical hip/femur fracture treatment EPM will be located in the 67 MSAs currently participating in the CJR model.[14]

In addition to the new EPMs, CMS's January 3, 2017 final rule also created the *Cardiac Rehabilitation Incentive Program*, a reimbursement model designed to


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improve cardiac fitness by assessing the impact of providing incentive payments to hospitals where Medicare recipients are hospitalized for heart attacks or bypass surgeries, and basing payments to those hospitals on the utilization of cardiac rehabilitation services for the 90-day period following hospital discharge.[15] Four codes listed in the *healthcare common procedure coding system* (HCPCS) qualify for incentive payments under the program, with the codes covering either the provision of cardiac rehabilitation services or the accompanying physician care:

(1) 93797 – Physician services for outpatient cardiac rehabilitation; without continuous *electrocardiogram* (ECG) monitoring (per session);

(2) 93798 – Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session);

(3) G0422 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring; with exercise (per session); and,

(4) G0423 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise (per session).[16]

Payment under the *cardiac rehabilitation incentive program* is based on a two-tiered incentive system based on the number of cardiac rehabilitation services performed:

(1) An extra payment of $25 to hospitals per cardiac rehabilitation service for each of the first 11 services provided to a particular patient and reimbursed by Medicare during the care period; and,

(2) After 11 covered cardiac rehabilitation services, the extra hospital payment per applicable service would increase to $175 during the care period.[17]

The program would then sum the applicable payment across all applicable beneficiaries to determine the overall incentive payment to the hospital.[18] The *cardiac rehabilitation incentive model* participants would include 90 MSAs, 45 of which are included in the AMI and CABG bundling programs and 45 MSAs not included in those models.[19]

As the new EPMs are set to begin on July 1, 2017, healthcare providers may find it prudent to closely monitor the implementation of the new EPMs by CMS. Richard Chazal, MD, FACC, president of the *American College of Cardiology* (ACC) , described the new EPMs as "*a challenging step*" for cardiologists, but stated that the ACC hopes that "*the end result [of the programs] will be opportunities for coordinated care and improvement in quality, while also decreasing costs for patients*."[20] However, it is yet unknown whether the implementation of these programs, as part of the overall shift away from FFS and toward VBR, will be impacted by the incoming Trump administration, as the President-elect's nominee for Secretary of the U.S. Department of Health and Human Services, Rep. Tom Price, has been a vocal critic of VBR programs, in particular bundled payment programs originating from the CMMI.[21]

1 "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 (CJR)" Federal Register Vol. 82, No. 1 (January 3, 2017) p. 180.
2 *Ibid* p. 184.
3 *Ibid.*
4 "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, § 3021, 124 Stat. 119, 389 (March 23, 2010).
5 "Bundled Payments for Care Improvement Initiative (BPCI)" Centers for Medicare & Medicaid Services, April 18, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-18.html (Accessed 4/28/2016).
6 "Introduction to Comprehensive Care for Joint Replacement (CJR) Model" Centers for Medicare & Medicaid Services (Accessed 12/1/2015), p. 8.
7 *Ibid.*
8 *Ibid.*
9 Centers for Medicare & Medicaid Services, (Accessed 12/1/2015)
10 Federal Register Vol. 82, No. 1 (January 3, 2017) p. 185.
11 *Ibid.* p. 184.
12 *Ibid.* p. 185.
13 *Ibid.* p. 191.
14 *Ibid.* p. 596.
15 *Ibid.* p. 185-186.
16 *Ibid.* p. 574.
17 *Ibid.* p. 580.
18 *Ibid.*
19 "Cardiac Rehabilitation (CR) Incentive Payment Model" Centers for Medicare & Medicaid Services, Department of Health & Human Services, January 17, 2017, https://innovation.cms.gov/initiatives/cardiac-rehabilitation/ (Accessed 1/18/17).
20 "ACC President on Final Rule on Bundled Care Models for Cardiac Care" American College of Cardiology, December 21, 2016, http://www.acc.org/about-acc/press-releases/2016/12/21/09/06/acc-president-on-final-rule-on-bundled-care-models-for-cardiac-care?w_nav=S (Accessed 1/16/17).
21 "As Trump's HHS Secretary, Tom Price Could Slow Shift To Value-Based Care" By Bruce Jaspen, Forbes, November 29, 2016, http://www.forbes.com/sites/brucejapsen/2016/11/29/as-trumps-hhs-secretary-tom-price-could-slow-shift-to-value-based-care/#2fdb94ef96f1 (Accessed 1/16/17); "Obamacare's Test Kitchen for Payment Experiments Faces an Uncertain Future" By Julie Appleby, National Public Radio, November 30, 2016, http://www.npr.org/sections/health-shots/2016/11/30/503863311/health-law-s-test-kitchen-for-payment-changes-could-offer-tool-for-gop-ideas (Accessed 1/18/17).


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