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Episode Payment Models: Ensuring Readiness for Reimbursement Changes

By Kristin Truesdell

Despite a volatile political forum where no one knows for certain what is ahead in the short or long term, the CMS Final Rule for Episode Payment Models (EPM) is here: CMS-5519-F. Over the next five years, most likely beginning July 1, 2017, the Center for Medicare and Medicaid Services will implement and test three ambitious and very extensive new Medicare A and B Episode Payment Models for Acute Myocardial Infarction (AMI) and Coronary Artery Bypass Grafting (CABG), along with the cardiac rehabilitation incentive payment models.

On January 20th, however, President Trump signed into order a 60-day freeze on rules that been published in the Federal Register, but have yet to reach their effective day (i.e., cardiac bundles). In addition, the newly selected Secretary of the Health & Human Services Department has expressed his dislike of mandatory bundled payment programs. Both of these factors potentially threatens the future of the cardiac episode payment models, though for now, no action other than the freeze has been proposed. Even with this uncertainty, Corazon recommends that organizations continue to plan for the July 1st implementation, as bundled payment models have historically proven to decrease costs to Medicare — a statistic that will likely be included in support of the argument to preserve the program.

The CMS mission and goal for this approach is to use EPM to promote payment for **value** and **outcomes** instead of payment for volume through financial alignments and other incentives for hospitals caring for CABG and AMI episodes. This shift is a drastic change to traditional hospital reimbursement, and will no doubt affect the clinical, operational, and financial aspects of the cardiac service line.

Overall, EPM models encourage hospitals to build a collaborative and financial relationship with physicians and other providers, which Corazon believes to be an effective route to reduce both complications and hospital readmissions, and also quicken recovery. This approach seems easy and effective in theory; however, the burden lies with the hospitals. Forming these collective relationships can play a pivotal role in cost reduction and payment distribution. While helping to meet quality metrics, finding a means to success within this new approach can be a daunting task at best. In fact, Corazon recommends hospitals develop a solid cardiovascular strategic plan now that can propel them forward to remain solvent over the next five years.

A Closer Look at EPM

The final rule for EPM gives hospitals the opportunity to redesign care delivery in order to improve quality of care and evaluate cost during the period of the episode. Those Included in the AMI and CABG EPM are 98 randomly selected metropolitan statistical areas (MSAs) where **participation is mandatory.** Participants in these selected MSAs are all acute care hospitals paid under the Inpatient Prospective Payment System (IPPS); however, some exclusions apply.

The EPM is triggered by admissions to an acute care hospital for AMI and CABG MS-DRGs. The following are the MSDRG definitions:

- **AMI Episode:**
  - MS-DRGs: 280-282; or
  - MS-DRGs: 246-251 with an AMI diagnosis code in the primary or secondary position
- **CABG Episode:**
  - MS-DRGs: 231-236

While the hospital and other providers will continue to bill and collect reimbursement as they do currently, the bundle will cover the cost and quality during the inpatient stay, and 90 days after discharge. This puts hospitals at risk for becoming accountable for all the spending during an episode. CMS is giving hospitals a great deal of flexibility as to how to approach this process, but, ultimately the hospitals are expected to build a plan that considers the most appropriate strategies for care reform, while performing quality assessment and evaluation of their own patterns and care delivery processes in regard to the full continuum of care for the entire AMI and CABG episodes.

Hospitals are in the driver's seat. As a result, Corazon believes hospitals need to strategically align themselves with like-minded quality and financially focused partners working toward shared goals and objectives. With the hospital at risk, it behooves the organization to build the framework for quality and financial standards, and guidelines that will meet targeted episode payment. *But how?*

These standards and guidelines, potentially in the form of a contract, must take into account the level of service provided through the care continuum, to ensure fair equitable division of funds based on the partners' own performance indices. From there, it is imperative that the

organization identifies physicians and post-acute care partners who have proven "track records" in quality metrics and reduced readmission rates. Ultimately, these partners need to be held accountable and accept responsibility for their ability to drive performance — the bottom line now depends on it.

Unfortunately, existing relationships between physician groups or post-acute care partners and the hospital may no longer be aligned with the same vision for the necessary quality- and value-driven performance expectations; however, if committed, any track record performance gaps can be overcome through savvy negotiations for education, cost allocation, and performance improvement strategies.

The Basics — How Does It All Work?

The EPM is expected to begin July 1, 2017 and run through December 31, 2021, with the first performance year defined as July 1, 2017 – December 31, 2017. During each performance year, hospitals will receive target prices based upon a blend of regional price and hospital price — see Figure 1 for the timeline.

Figure 1. During each performance year, hospitals will receive target prices based upon a blend of regional price and hospital price.

AMI Quality Measures

1. Hospital 30-Day, All-Cause, Risk- Standardized Mortality Rate following AMI (NQF #0230) (MORT-30-AMI)
2. Excess Days in Acute Care after Hospitalization for AMI (AMI Excess Days)
3. HCAHPS Survey (NQF #0166)

Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following AMI Hospitalization (NQF #2473), which is a blend of claims data and HER data, can voluntarily be submitted as a fourth quality measure that can only benefit the participant.

CABG Quality Measures

1. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following CABG Surgery (NQF #2558) (MORT-30-CABG)
2. HCAHPS Survey (NQF #0166)

Eleven distinct measures from the Society of Thoracic Surgeons (STS) Registry can voluntarily be submitted as a third quality measure that can only benefit the participant.

The above-mentioned quality measures are scored on a weighted point system to determine the Composite Quality Score (CQS). The CQS score in turn determines the quality discount percentage (1.5%, 2% or 3%), which is used to calculate the quality adjusted target payment. Excellent quality is valued with a 1.5% discount and acceptable quality is valued with a 3% discount.

Hospitals that lower cost and meet quality benchmarks can earn additional payments from Medicare — referred to as reconciliation payments — for the difference between the quality-adjusted target price and the actual spending up to a specified cap. Therefore, the lower the discount percentage, the likelier it is that a reconciliation payment will increase. Participants must meet an acceptable level of quality performance in order to be eligible for a possible reconciliation payment. If actual spending exceeds the quality-adjusted target price, then hospitals are required to repay Medicare the difference up to a specified cap. Table 1 illustrates an example of a CABG episode.

To further entice hospitals, cardiac rehabilitation services following hospitalization for AMI and CABG will be implemented in 45 of the 98 cardiac MSAs and 45 non selected MSAs. For each of the first 11 cardiac rehab sessions a patient receives, hospitals will be paid $25 per session; for the next 25 cardiac rehab sessions, hospitals will be paid $175 per session. CMS believes in the ability of long-term rehabilitation utilization to improve outcomes and reduce long-term cost; therefore, these payments incentivize hospitals to use rehab as a means to raise the level of post-acute care, and (hopefully) improve clinical outcomes and functionality.

Strategic planning in this context cannot be taken lightly and is of great importance when creating the path for multiple entities that will join in one shared model. Strategic focus covers the full continuum of care, over some of which a hospital may have little control; however, participating hospitals must ensure goal compliance and meet optimal performance goals in order to be successful. Corazon has been working with hospitals so that the quality composite score can be determined prior to any submission to CMS, allowing facilities to proactively correct any deficiencies.

	RECONCILIATION		REPAYMENT	
	Hospital A	Hospital B	Hospital C	Hospital D
Target Price	$50,000	$50,000	$50,000	$50,000
CMS Quality Discount	1.5%	3%	2%	3%
Quality-Adjusted Target Price	$49,250	$48,500	$49,000	$48,500
Actual Spending	$48,000	$48,000	$50,000	$50,000
Difference Per Patient	$1,250	$500	($1,000)	($1,500)
Volume of Patients	200	200	200	200
Overall Financial Impact	$250,000	$100,000	($200,000)	($300,000)
	Stop-Gain Limit (i.e., cap)		Stop-Loss Limit (i.e., cap)	
Year 1	5%		No repayment	
Year 2	5%		No repayment	
Year 3	5%		5%	
Year 4	10%		10%	
Year 5	20%		20%	
In this scenario, Hospital A will receive a reconciliation payment in Year 1 of $12,500 (5% of $250,000).				

Table 1. An example of a CABG episode.

Quality Improvement as Strategy

Under the new payment model, quality through the care continuum will be driven by clinical and organizational performance. We have found that hospitals often receive outside assistance to develop clear clinical pathways to outline the continuum of care steps for both AMI/CABG. Not only are pathways beneficial visual tools that capture gaps in processes, but they are also cost-effective, and contribute to patient satisfaction while providing a calculated hospital length of stay. A pathway is often instrumental with post-acute care in that it defines patient progress through various services with a targeted endpoint.

Improving & Optimizing the Patient Experience (HCAHPs)

Patient experience will comprise 20- 25% of the composite quality score. CMS continues to highlight the importance of patient experience regarding patient perspective on care, including communication, care transitions, and discharge information. Hospitals must be transparent and engage with staff, physicians, and other care partners regarding the implications for not meeting HCAHP's quality metrics, including time limited performance improvement plans. Ongoing education and reinforcement is a MUST for partners, physicians, and staff.

Reducing Mortality

The hospital 30-day, all-cause, risk standardized mortality rate (RSMR) is the quality domain with the highest percentage value for both AMI and CABG, at 50% and 75%, respectively. Corazon recommends that all mortalities be debriefed and reviewed to evaluate for process improvement. Using this information can then lead to the development of action items that will minimize future acute events.

Reducing Readmissions and Complications

It is not the intent of CMS to penalize for "appropriate" readmission, but rather to help patients and providers understand variation among hospitals in the days that are spent by patients in acute care settings following a discharge for AMI (Observation days, emergency department (ED), visits, and readmissions). This gives opportunity for hospitals to target transition-of-care as a quality improvement activity. CMS is committed to the belief that this measure will reduce readmissions, observation stays, and/or ED visits by encouraging hospitals to further invest in interventions that will improve hospital care by better assessing the readiness of patients for discharge and facilitating quality transitions to outpatient status.

Physician Engagement

Physicians must be engaged participants within the EPM model. Corazon has long advocated for hospital physician partnerships in varied forms — strong and productive partnerships that drive engagement of both parties toward mutual goals to benefit all stakeholders. With EPM, this shared responsibility and reward is ever more important. No doubt, the physician role is instrumental for ensuring the safety of the patient by addressing the most common opportunities and barriers that a physician faces during care.[1] Meanwhile, the hospital must provide the appropriate setting (tools, resources, staff, etc.) for successful care delivery. Working together to improve quality and reduce cost is the hallmark of the EPM approach — and only those hospitals that have a solid foundation of physician support and respect will thrive in the new model of care.

Hospitals cannot hesitate or ignore the movement to a quality-based bundled system in light of CMS commitment to a "quality over quantity" approach. Quality assurance is now and should no doubt remain the ultimate approach, even with the current political uncertainty facing the U.S. healthcare system. Evidence supports EPM as a means to provide safe, efficient, and quality care to today's patients in the hospital environment. Bottom line: forming strategic-minded and quality-driven partnerships with physicians and post-acute partners will strategically position hospitals for the best financial return based on performance. Corazon believes ALL hospitals should start today with considerations about moving to a bundled-payment approach for care — tomorrow may be too late.

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Kristen Truesdell is a Manager at Corazon, Inc., a national leader in strategic program development for the heart, vascular, neuroscience, spine, and orthopedic specialties. Corazon offers a full continuum of consulting, software solution, recruitment, and interim management services for hospitals, health systems, and practices of all sizes across the country and in Canada. To learn more, visit www.corazoninc.com or call 412-364-8200. To reach the author, email ktruesdell@corazoninc.com.