



FACT SHEET

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Notice of Proposed Rulemaking for Bundled Payment Models for High-Quality, Coordinated Cardiac and Hip Fracture Care

On July 25, 2016, the Department of Health & Human Services (HHS) proposed new models that continue the Administration's [progress](#) to shift Medicare payments from quantity to quality by creating strong incentives for hospitals to deliver better care at a lower cost. These models would reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions, and speed recovery.

Today's proposal contains three new significant policies:

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

The proposed bundled payment models for cardiac care includes medical as well as surgical services, which will offer new information on how these models affect quality and costs. Together, this cardiac care model, the cardiac rehabilitation proposal, and the [Million Heart awards](#) announced last week – to support risk assessment and prevention of cardiovascular disease – offer the opportunity to improve prevention and treatment of the top cause of death and disability in this nation. Heart attacks and strokes cause one in three deaths and result in over \$300 billion of health care costs each year.

Stakeholder input is vital for the success of these proposals, and HHS welcomes feedback on today's proposed rule.

Background: Promising Evidence on Bundled Payments for Cardiac and Orthopedic Care

By structuring payment around a patient's total experience of care, in and out of the hospital, bundled payments support better care coordination and ultimately better outcomes for patients.

HHS is proposing new bundled payment models to improve the quality of care and reduce costs for beneficiaries who have a heart attack or undergo bypass surgery. HHS is also proposing to extend its innovative hip and knee bundled payment model to include other surgical treatments for hip and femur fractures beyond hip replacement. These new models support the [Administration's goal](#) to have 50 percent of traditional Medicare payments flowing through alternative payment models by 2018 (already, 30 percent of Medicare payments go through alternative models).

Research has shown 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. For example:

- The [Medicare Acute Care Episode demonstration](#) tested bundled payments for cardiovascular and orthopedic care. Participating hospitals and physicians achieved savings for Medicare while at least maintaining quality of care.
- In the 1990s, Medicare tested bundled payments for bypass surgery through the [Medicare Participating Heart Bypass Center Demonstration](#). The evaluation concluded that the bundles successfully incentivized physicians and hospitals to work together to provide services more efficiently, improve quality, and reduce costs.
- In a [bundled payment program at a private hospital system](#), bundled payments for bypass surgery led to reduced readmissions, shorter hospital stays, reduced in-hospital mortality, and lower costs.
- States are also experimenting with bundled payment approaches. For example, [Arkansas](#) has adopted bundled payments within its Medicaid program and is finding reductions in readmission rates.
- Thousands of providers have participated or are participating in the Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement initiative, including thousands of physicians participating in cardiac and orthopedic bundles. While only [preliminary results](#) are available, they add to the evidence that bundled payments in these areas encourage care coordination and can reduce costs.

Summary of Major Provisions

How the Proposed Payment Models Will Work

Under the proposed episode payment models, the hospital in which a patient is admitted for care for a heart attack,¹ bypass surgery,² or surgical hip/femur fracture treatment³ would be accountable for the cost and quality of care provided to Medicare fee-for-service beneficiaries during the inpatient stay and for 90 days after discharge. Specifically, once the models are fully in effect, participating hospitals would be paid a fixed target price for each care episode, with hospitals that deliver higher-quality care receiving a higher target price.

At the end of a model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) would be compared to the target price that reflects episode quality for the responsible hospital. Hospitals that work with physicians and other providers to deliver the needed care for less than the quality-adjusted target price, while meeting or exceeding quality standards, would be paid the savings achieved. Hospitals with costs exceeding the quality-adjusted target price would be required to repay Medicare.

Setting Target Prices for Specific Conditions

Each year, CMS would set target prices for different episodes based on historical data on total costs related to the episode of care for Medicare fee-for-service beneficiaries admitted for heart attacks, bypass surgery, or surgical hip/femur fracture treatment, beginning with the hospitalization and extending 90 days following discharge. Target prices would be adjusted based on the complexity of treating a heart attack or providing bypass surgery. For example, CMS proposes to adjust prices upwards for those heart attack patients who need to be transferred to a different hospital during their care to reflect the most resource-intensive cardiac care provided during the hospitalization. For heart attack patients, target prices would also differ depending on whether the patient was treated with surgery or medical management.

Target prices would be based on a blend of hospital-specific data and regional historical data:

- July 1, 2017 – December 31, 2018 (performance years 1 and 2): Two-thirds participant-specific data and one-third regional data;
- 2019 (performance year 3): One-third participant-specific data and two-thirds regional data; and
- 2020 – 2021 (performance years 4 and 5): Only regional data.

Paying More for Higher-Quality Care

Under the proposed bundled payment models, hospitals that delivered higher-quality care would be eligible to be paid a higher amount of savings than those with lower quality performance. Specifically, an individual hospital's quality-adjusted target price would be based on a 1.5 to 3 percent discount rate relative to historical spending, with the lowest discount percentage for

¹ Acute myocardial infarction (AMI) model episodes would be initiated by claims for AMI MS-DRGs 280-282 or claims for PCI MS-DRGs 246-251 with an AMI International Classification of Diseases (ICD)-Clinical Modification (CM) diagnosis code in the principal or secondary diagnosis code position.

² Coronary artery bypass graft (CABG) model episodes would be initiated by claims for CABG MS-DRGs 231-236.

³ Surgical hip/femur fracture treatment (SHFFT) model episodes would be initiated by claims for hip and femur procedures, except major joint, MS-DRGs 480-482.

those hospitals providing the highest-quality care. Payments would be based on a quality-first principle: only hospitals meeting quality standards would be paid the savings from providing care for less than the quality-adjusted target price.

Hospitals would be assessed based on quality metrics appropriate to each episode, using performance and improvement on required measures that are already used in other CMS programs and submission of voluntary data for other quality measures in development or implementation testing:

- Heart attacks:
 - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0230)
 - Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
 - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)
 - Voluntary Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality eMeasure (NQF #2473) data submission

- Bypass surgery:
 - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558)
 - HCAHPS Survey (NQF #0166)

- Hip/femur fractures (same measures as in the existing Comprehensive Care for Joint Replacement (CJR) model):
 - Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
 - HCAHPS Survey (#0166)
 - Voluntary Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Patient-Reported Outcome (PRO) and Limited Risk Variable data submission

As part of implementing the new models, CMS would 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, waiving certain Medicare requirements to facilitate development of novel approaches to the delivery of care, and facilitating the sharing of best practices between participants through a learning and diffusion program.

Phased Implementation

Recognizing that hospitals will need time to adapt to the new models and establish processes to coordinate care, the proposed rule includes a number of measures to ease the transition, including gradually phasing-in risk.

Downside risk (possible repayments to Medicare) would be phased in:

- July 2017 – March 2018 (performance year 1 and quarter 1 of performance year 2): No repayment;
- April 2018 – December 2018 (quarters 2 through 4 of performance year 2): Capped at 5 percent;
- 2019 (performance year 3): Capped at 10 percent; and
- 2020 – 2021 (performance years 4 and 5): Capped at 20 percent.

Gains (payments from Medicare to hospitals) would be phased in:

- July 2017 – December 2018 (performance years 1 and 2): Capped at 5 percent;
- 2019 (performance year 3): Capped at 10 percent; and
- 2020 – 2021 (performance years 4 and 5): Capped at 20 percent.

The first performance period would run from July 1, 2017 to December 31, 2017. The second through fifth performance periods would align with calendar years 2018 through 2021.

How the Bundled Payments Would Work: An Example

Consider hospitals in model years 4 and 5 in a region where Medicare historically spent an average of \$50,000 for each coronary bypass surgery patient, taking into account the costs of surgery as well as all related care provided in the 90 days after hospital discharge. Target prices would reflect the average historical pricing minus the discount rate based on quality performance and improvement.

- Hospital A is performing at the highest overall level on quality measures and its discount rate is 1.5 percent for the episode. As a result, its quality-adjusted target price for bypass surgery is \$49,250 (or \$50,000 minus the discount of \$750). By taking measures to avoid readmissions and other unnecessary costs, Hospital A is able to reduce average total hospitalization and related 90-day post-discharge costs for bypass surgery patients to \$48,000. Hospital A would be paid average savings of \$1,250 per patient.
- Hospital B in the same region also reduces its average costs to \$48,000 per patient. However, it achieves only acceptable overall performance on quality measures. Its discount rate is 3 percent and its quality-adjusted target price is \$48,500 (or \$50,000 minus the discount of \$1,500). Hospital B would be paid average savings of \$500 per patient.
- Hospital C also only achieves acceptable performance on quality measures (discount rate of 3 percent) and has a quality-adjusted target price of \$48,500. However, Hospital C has average costs of \$50,000 per patient. If Hospital C is unable to improve its cost and/or quality performance, it would have to repay Medicare an average of \$1,500 per patient.

Participants in the New Bundles

For the new cardiac bundles, participants would be hospitals in 98 randomly-selected metropolitan statistical areas (MSAs). Hospitals outside these geographic areas would not participate in the model. There is no application process for hospitals for these models.

Because the hip/femur fracture surgeries model builds upon the existing CJR model, CMS proposes to test these bundled payments in the same 67 MSAs that were selected for that model.

Rural counties are excluded from the models. In addition, CMS proposes to limit financial risk for the remaining rural hospitals that are located in participating MSAs, such as sole community hospitals, Medicare-dependent hospitals, and rural referral centers. Specifically, these hospitals' total losses are limited to 3 percent for the second through fourth quarters of 2018 and 5 percent for 2019 through 2021.

Collaboration with Other Providers

One of the major goals of bundled payments is to encourage coordination among all providers involved in a patient's care: for example, collaboration between hospitals and physicians and skilled nursing facilities. Therefore, as in the CJR model, CMS is proposing to allow hospital participants to enter into financial arrangements with other types of providers (for example, skilled nursing facilities and physicians), as well as with Medicare Shared Savings Program Accountable Care Organizations (ACOs). Those arrangements would allow hospital participants to share reconciliation payments, internal cost savings, and the responsibility for repayment to Medicare with other providers and entities who choose to enter into these arrangements, subject to the limitations outlined in the proposed rule.

Evaluation

As noted above, preliminary results from other tests of bundled payments for cardiac and orthopedic care suggest that these models have strong potential to improve patient care while reducing costs. Because they will include a wide range of hospitals around the country, the models announced today will allow CMS to test the impact of bundles on quality and cost when implemented at scale and across all types of providers and patients.

CMS's evaluation of the models will examine quality during the episode period, after the episode ends, and for longer durations such as one-year mortality rates. CMS will examine outcomes and patient experience measures such as mortality, readmissions, complications, and other clinically relevant outcomes. The evaluation will include both quantitative and qualitative data and will use a variety of methods and measures in assessing quality. The outcomes examined will include: claims-based measures such as hospital readmission rates, emergency room visits rates, and the amount of care deferred beyond the 90-day post-hospital discharge episode duration; HCAHPS satisfaction and care experience measures; and functional performance change scores from the patient assessment instruments in home health agencies and skilled nursing facilities. In addition, CMS plans for the evaluation to include a beneficiary survey that will be used to assess the impact of the model on beneficiary perceptions of access, satisfaction, mobility, and other relevant functional performance measures.

In addition to the formal evaluation, CMS is proposing continuous monitoring of arrangements between participants and collaborators and auditing of patients' medical records to allow early detection of and intervention in any quality concerns.

Additional Changes in the Proposed Rule

Cardiac Rehabilitation Incentive Payments

CMS is also announcing a model that will test the effects of payments that encourage the use of cardiac rehabilitation services. [Clinical studies](#) have found completing a rehabilitation program can lower a patient's risk of heart attack or death. Increasing the use of cardiac rehabilitation services has the potential to improve patient outcomes and help keep patients healthy and out of the hospital.

The cardiac rehabilitation incentive payment model would 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 cardiac rehabilitation and intensive cardiac rehabilitation services in the 90-day care period following hospital discharge. Hospitals may use this incentive payment to coordinate cardiac rehabilitation and support beneficiary adherence to the cardiac rehabilitation 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 for the cardiac care bundled payment models. This test will cover the same five-year period as the cardiac care bundled payment models. Standard Medicare payments for cardiac rehabilitation services to all providers of these services for model beneficiaries would continue to be made directly to those providers throughout the model.

CMS proposes establishing a two-part cardiac rehabilitation incentive payment that would be paid retrospectively based on the total cardiac rehabilitation use of beneficiaries attributable to participant hospitals:

1. The initial payment would be \$25 per cardiac rehabilitation service for each of the first 11 services paid for by Medicare during the care period for a heart attack or bypass surgery.
2. After 11 services are paid for by Medicare for a beneficiary, the payment would increase to \$175 per service paid for by Medicare during the care period for a heart attack or bypass surgery.

Based on Medicare coverage, the number of cardiac rehabilitation program sessions would be limited to a maximum of two one-hour sessions per day for up to 36 sessions over up to 36 weeks, with the option for an additional 36 sessions over an extended period of time if approved by the Medicare Administrative Contractor. Intensive cardiac rehabilitation program sessions would be limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

Pathway for Bundled Payment Models to Qualify as Advanced Alternative Payment Models (APMs)

In addition to proposing new bundled payment models for hospitals, today's 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). The legislation introduced financial incentives for physicians participating in Advanced APMs that align incentives for high-quality, cost-effective care. The bundled payment models proposed in today's rule – as well as the CJR model which began this year – could qualify as Advanced Alternative Payment Models beginning in 2018, including for physicians who collaborate with hospitals participating in the models.

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 beginning in January (CJR) or April (heart attacks and bypass surgery) of 2018 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.

In addition, the rule announces CMS's intent to build upon the Bundled Payments for Care Improvement initiative with a new voluntary bundled payment model to begin in calendar year 2018 that would also potentially qualify under the proposed criteria for Advanced APMs.

The models announced today, including the proposed policies that would allow the new bundled payment models and the CJR model to potentially qualify as Advanced APMs under MACRA, further the Administration's commitment to create a health care system that provides better care, spends health care dollars more wisely, and makes people healthier.

Today's proposal incorporates input received to date, but it is only a first step in an iterative process for implementing the new models. HHS welcomes additional feedback from patients, caregivers, clinicians, health care professionals, Congress, and others on how to best achieve these goals.

The proposed rule can be viewed at <https://innovation.cms.gov/Files/x/advancing-care-coordination-nprm.pdf> and is anticipated to display at <https://www.federalregister.gov/public-inspection> on July 26, 2016. CMS looks forward to feedback on the proposals and comments are due 60 days after the proposed rule publishes in the Federal Register.

For more information on the Cardiac Bundled Payment Models:

<https://innovation.cms.gov/initiatives/epm/>

For more information on the Cardiac Rehabilitation Incentive Payment Model, visit:

<https://innovation.cms.gov/initiatives/cardiac-rehabilitation/>

For more information on the Comprehensive Care for Joint Replacement Model, visit:
<https://innovation.cms.gov/initiatives/cjr>

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