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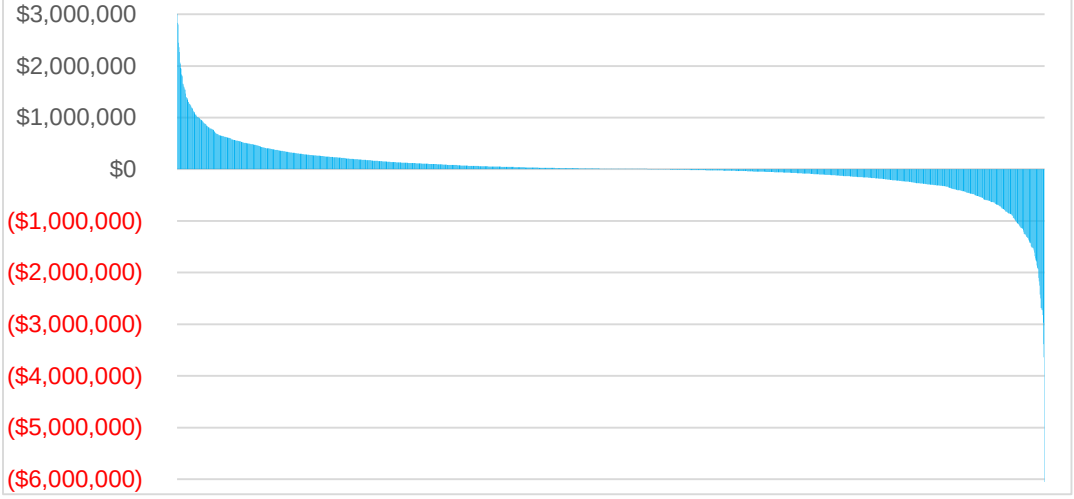
NEW CARDIAC BUNDLES COULD PRODUCE SOME BIG WINNERS AND LOSERS

Avalere experts say that the impact for most hospitals will be modest

A new analysis from Avalere reveals that 85 percent of hospitals that may be required to participate in the new Medicare cardiac bundled payment models would not experience gains or losses that exceed $500,000 per year, based on their current spending patterns. The Centers for Medicare & Medicaid Innovation (CMMI) announced the new bundled payment arrangements for Medicare patients admitted for heart attack and cardiac bypass surgery. A bundled payment reimburses a 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.

Figure 1 shows the distribution of hospitals' historical spending compared to their regional average for cardiac episodes to demonstrate the potential annual impact of the payment system assuming no changes in care patterns.

Figure 1. Differences Between Hospital Episode Spending and the Regional Average for Cardiac Episodes



While hospitals are distributed relatively evenly between potential winners and losers under the proposed program, some institutions could face significant penalties because their spending far exceeds the average spending for their region. One reason these hospitals have higher spending could be that they are treating sicker patients, many of whom lack the necessary support systems to prevent them from bouncing back to the hospital for costly follow-up care.

"We've hit a tipping point. Healthcare executives recognize that CMS is moving beyond the experimental phase with value-based payment," said Josh Seidman, senior vice president at

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Avalere. “Many hospitals will now need to develop the data analysis infrastructure, cost management discipline and care coordination capabilities required to deliver efficient cardiac care.”

CMMI intends to implement the mandatory cardiovascular bundled payment models in 98 randomly selected markets for hospitals that admit Medicare fee-for-service patients receiving three types of cardiac care, including:

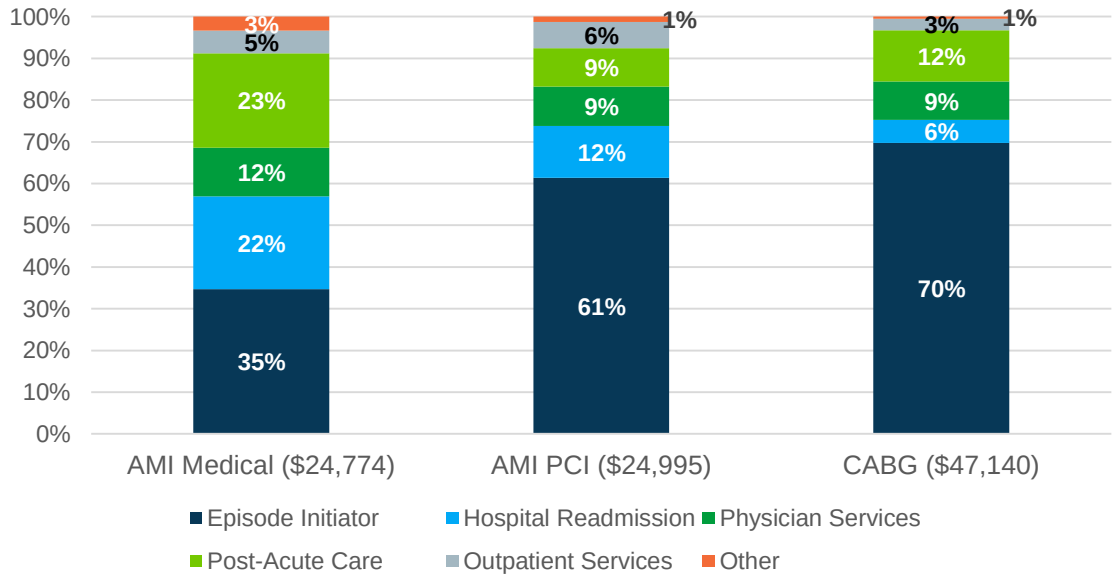
- Patients receiving coronary artery bypass surgery (CABG).
- Heart attack patients who are medically managed, meaning they are treated with drugs and other non-interventional therapies.
- Heart attack patients receiving percutaneous coronary intervention (PCI), including stents, angioplasty, or other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

The new cardiac bundled payments are set to be phased in starting July 1, 2017.

Hospitals Could Achieve Savings by Targeting Device Spending and Care Management for Surgical and Medically-Managed Patients, Respectively

Avalere’s analysis also finds significant differences in the distribution of spending across the 90-day episode between patients who undergo a surgical intervention (CABG) and those who do not (Figure 2). Sixty to 70 percent of spending for CABG and PCI episodes are incurred during the initial hospital stay. In contrast, only 35 percent of spending for heart attack patients who are managed with drugs are related to the inpatient stay. Avalere’s analysis indicates that 47 percent of spending on these medically-managed heart attack patients is linked to *post-discharge* care, including post-acute services and readmissions to acute care settings.

Figure 2. Average Medicare Payments by Care Setting
(Average Payment Per Episode)



“Given the array of new cardiac bundles, there is no magic bullet to achieving savings. Instead, participating hospitals will need to pull multiple levers to drive down costs,” noted Fred Bentley, vice president at Avalere. “They will be working more closely than ever with their physicians to streamline care and promote adherence to clinical guidelines. And they will accelerate the development of high-performance post-acute networks to cut readmissions and achieve efficiencies for their medically-managed heart attack episodes.”

To support the alignment of incentives on cost and quality, CMMI provided hospitals with greater flexibility to create gainsharing agreements with physicians and other provider organizations. The arrangements allow providers to share in the bonus payments that hospitals receive (as well as the penalties) if they succeed in keeping spending per episode below the target price. By giving surgeons and proceduralists “more skin in the game” through gainsharing, hospitals have been able to standardize on medical devices and negotiate more favorable rates.

Recognizing the downward pressure this will put on prices, according to Avalere, many medical device manufacturers are reorienting their business around providing comprehensive solutions to support more efficient, coordinated care. While hospitals are still intent on driving down device costs, they may be open to additional support that device suppliers can provide.

“Medical device manufacturers and life sciences companies are re-thinking supply chain and hospital contracting to focus on paying for value over an episode of care,” said Mary Ann Clark, vice president at Avalere.

Expanding Value-Based Payments in Medicare Accelerates Move Away from Fee-For-Service

This newest cardiac care bundle builds on the Comprehensive Care for Joint Replacement (CJR) model that took effect in April 2016. CMS also intends to extend the orthopedics-focused bundles beyond CJR to include surgical hip and femur fracture treatment (SHFFT) episodes. The new round of mandatory models underscores CMS’ commitment to migrating Medicare to a value-based environment and away from the fee-for-service paradigm.

CMS is currently accepting comments through October 3, 2016. Avalere experts anticipate that the final rule on the new cardiovascular and orthopedic bundles will be issued later this year, and CMS may propose additional mandatory bundles to accelerate Medicare’s migration to a value-based environment in the near future.

Methodology

Avalere analyzed 2013 and 2014 Medicare Part A 100% Standard Analytic Files. The analysis includes 90-day episodes for all hospitals located in the 294 EPM-eligible MSAs between October 1, 2013 and September 30, 2014. Physician and Durable Medical Equipment (DME) Medicare Part B payments are not included in the data for the first figure above, while spending on these services was included for the cost breakdowns shown in the second figure. The “Other” category in the second figure includes DME and additional Part B services.

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