Leveraging CDI to Improve Performance Under Alternative Payment Model (APM) Methodology

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Discuss the concept of "bundled/episodic payments" as a mandatory program under CMS alternative payment methodology
  - Describe the concept of "revenue at risk"
  - Explain the methodology used to risk-adjust the mandatory episode payment models and the role of CDI efforts
  - Recognize the importance of incorporating CDI review strategies impacting measures associated with the CMS mandatory episode payment models/bundles

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CMS Plans to Transform Healthcare

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

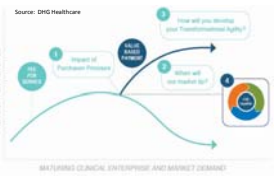
Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. HHS will intensify its work with states and private payers to support adoption of alternative payments models through their own aligned work, sometimes even exceeding the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

Source: DHG Healthcare



http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html

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The CMS Shift From Fee-For-Service

- Many are familiar with the value-based reimbursement models, which includes the mandatory programs of
  - Hospital Value Based Purchasing (HVBP)
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital-Acquired Condition Reduction Program (HACRP)
- But CMS is also implementing Alternative Payment Models (APMs)
  - The timeline includes 50% of payments by the end of 2018

http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html

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Alternative Payment Models (APMs)

- In total, as of January 1, 2016, CMS has identified 10 APMs:
  - Medicare Shared Savings Program (MSSP)
  - Pioneer ACOs
  - Next Generation ACOs
  - Comprehensive End Stage Renal Disease (ESRD) Care Model
  - Comprehensive Primary Care Model
  - Multi-Payer Advanced Primary Care Practice
  - End-Stage Renal Disease Prospective Payment System
  - Maryland All-Payer Model
  - Medicare Care Choices Model
  - Bundled Payment Care Improvement (BPCI)

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03.html

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Bundled/Episode (of Care) Payments

- Traditionally, Medicare makes separate payments to providers and suppliers for each service they perform for beneficiaries during a single illness or course of treatment
- CMS states this approach can result in
  - Fragmented care with minimal coordination across providers and healthcare settings
  - Emphasis on the quantity of services offered by providers rather than the quality of care furnished
- According to CMS, research confirms that bundled payments can align incentives for providers—hospitals, postacute care providers, physicians, and other practitioners—allowing them to work closely together across all specialties and settings

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-18.html

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Bundled Payment Care Improvement

- The Bundled Payment Care Improvement (BPCI) is a **voluntary** APM that targets 48 conditions with a single payment for an episode of care, incentivizing providers to take accountability for both cost and quality of care
  - Four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care
  - Organizations enter into payment arrangements that include financial and performance accountability for episodes of care
    - According to CMS, more than 1,700 acute care hospitals, skilled nursing facilities, physician group practices, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, and others have assumed financial risk for episodes of care in the bundle

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03.html
https://innovation.cms.gov/initiatives/bundled-payments

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Steps for Attendees to Answer/View POLLING QUESTIONS

1. Navigate to the event **Agenda** in the main menu
2. Tap the **name of the current session** to view the session details page
3. Tap **Polls**
4. Tap the **name of the poll**
5. Tap your **answer** choice and then tap **Submit**

Polling Question #1

- Is your organization currently participating in a voluntary APM bundled payment model?
  - Yes
  - No
  - I don't know
  - N/A

Revenue At-Risk

- In general, revenue at-risk describes the amount of revenue tied to value-based methodologies
- Revenue is placed "at-risk" because poor performance can lead to penalties, but favorable performance may result in incentive payments
- Many APM participants share their gains with collaborators—those who engage with the hospital to support value-based initiatives like providers, SNFs, etc. as an incentive for their support; however, not all of the "downside" risk can be shared

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Mandatory Bundled/Episode Payments

- Because bundled payments demonstrated promise and voluntary participation levels in BPCI were minimal, CMS expanded testing of bundled payments with the Comprehensive Care for Joint Replacement Model (CJR) on April 1, 2016.
- On December 20, 2016, CMS finalized new policies expanding the conditions subject to mandatory bundled payments with implementation of three Episode-based Payment Models (EPMs). Initially set to begin July 1, 2017, they were delayed until October 1, 2017 with the possibility of further delays.
  - The targeted areas are AMIs, CABG, and surgical hip and femur fracture repair (SHFFT)

https://innovation.cms.gov/initiatives/cjr
https://innovation.cms.gov/Files/fact-sheet/cjr-providerfs-finalrule.pdf

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Orthopedic Models

- Comprehensive Care for Joint Replacement (CJR)
  - Focuses on elective hip and knee joint replacement patients
    - MS-DRGs 469 and 470 (Major Joint Replacement or Reattachment of Lower Extremity with or without an MCC)
- The Surgical Hip and Femur Fracture Treatment (SHFFT) Model was initially set to begin July 1, 2017, but was delayed until October 1, 2017 with the potential for additional delays
  - Supports clinicians in providing care to patients who receive surgery after a hip fracture, other than hip replacement
    - MS-DRGs 480–482 (Hip and Femur Procedures Except Major Joint without a CC/MCC, with a CC, or with an MCC)

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New Cardiac Models

- According to CMS, new mandatory episode payment models will support clinicians in providing care to patients who receive treatment for
  - Heart attacks/AMI
    - MS-DRGs: 280–282 (AMI Discharged Alive without CC or MCC, with CC, or with MCC)
    - PCI MS-DRGs: 246–251 with AMI ICD-CM diagnosis code
  - Heart surgery to bypass blocked coronary arteries (CABG)
    - MS-DRGs: 231–236 irrespective of AMI diagnosis

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

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Timeline

- Each of the mandatory bundle/episode payment models are scheduled to evaluate performance of the model over five years
  - NOTE: The initial year of the model does not consist of a full calendar year (CY)

Model	Start	Year 1	Year 2	Year 3	Year 4	Year 5	End
Bundled Payment (CJR)	4/1/16	Ends 12/31/16	CY 2017	CY 2018	CY 2019	CY 2020	12/31/20
Episode Payments (AMI, CABG, SHFFT)	7/1/17	Ends 12/31/17	CY 2018	CY 2019	CY 2020	CY 2021	12/31/21

https://innovation.cms.gov/initiatives/cjr
https://innovation.cms.gov/Files/fact-sheet/cjr-providerfs-finalrule.pdf
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

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Polling Question #2

- Which of the following types of organizations are required to participate in the Comprehensive Care for Joint Replacement Model?
  - All hospitals paid under IPPS
  - Only academic medical centers
  - Only those facilities who apply to participate
  - Only those facilities located in randomly selected urban areas

Mandatory Participation

- Randomly selected Metropolitan Statistical Areas (MSAs) were used to determine model participants
  - By definition, MSAs are counties associated with a core urban area that has a population of at least 50,000
- CJR and SHFFT models
  - 67 MSAs
  - Over 800 short-term acute care hospitals
- AMI and CABG models
  - 98 MSAs
  - Over 1,100 short-term acute care hospitals

https://innovation.cms.gov/initiatives/cjr
https://innovation.cms.gov/Files/fact-sheet/cjr-providerfs-finalrule.pdf
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

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MSAs Impacted by Cardiac Episode Payments Beginning July 1, 2017

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Mandatory Participation (cont.)

- Hospitals reimbursed under the Medicare inpatient prospective payment system (IPPS) and located in selected MSAs are required to participate in the model
- The following exclusions apply:
  - Geographic areas where all-payer models under the Innovation Center are operating—Maryland and Vermont
  - Concurrently participating in Model 1 or Models 2 or 4 of the BPCI initiative for Lower Extremity Joint Replacement (LEJR) episodes
  - Concurrently participating in Models 2, 3, or 4 of the Innovation Center's Bundled Payment for Care Improvement (BPCI) initiative for AMI, CABG, or SHFFT episodes

https://innovation.cms.gov/initiatives/cjr
https://innovation.cms.gov/Files/fact-sheet/cjr-providerfs-finalrule.pdf

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Defining the Episode of Care

- EPM episodes include:
  - Hospitalization and 90 days post-discharge
  - All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode
    - Acute disease diagnoses unrelated to a condition resulting from or likely to have been affected by 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

https://innovation.cms.gov/Files/slides/acc-cardiac-cjr-overviewslides.pdf

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Episode of Care: CJR Example

- An episode of care in the CJR model
  - Begins with an admission to an acute care hospital (the anchor hospitalization) paid under MS-DRG 469 or MS-DRG 470
  - The model performance period ends 90 days after discharge from the acute care hospital in which the anchor hospitalization took place
  - Includes disease-related diagnoses, such as osteoarthritis of the hip or knee and body system–related diagnoses

https://innovation.cms.gov/Files/slides/acc-cardiac-cjr-overviewslides.pdf

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Mandatory Bundled/Episode Payments

- Includes a retrospective reimbursement mechanism that occurs following the completion of the performance year (December 31 of each year)
  - All providers and suppliers will continue to bill and be paid as usual under the applicable Medicare payment system (i.e., Medicare Part A or Medicare Part B)
  - CMS will establish Medicare episode quality-adjusted target prices for each participant hospital and for each MS-DRG
- The EPMs use two-sided risk approach
  - Downside risk = repayment is required
  - Upside risk = bonus (i.e., reconciliation payment) is earned

https://innovation.cms.gov/Files/x/cjr-faq.pdf
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

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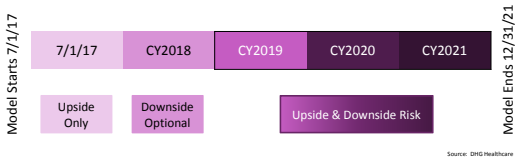
New Episode Payment Two-Sided Risk Example

- Upside gains (reconciliation payments) are available throughout all phases of AMI, CABG, and SHFFT
- Downside risk (repayment) can be deferred until January 1, 2019



Source: DHG Healthcare

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Polling Question #3

- Mandatory bundle/episode payment model affects reimbursement in which of the following ways?
  - Reduces the base rate for all Medicare cases by up to 5% during the applicable performance year
  - Reduces the MS-DRG payment by 3% for the applicable MS-DRG (i.e., MS-DRG 469/470, 280–282, etc.)
  - Can result in an incentive payment or repayment for the applicable MS-DRGs
  - Creates a new type of payment model that isn't based on MS-DRG assignment

Comparing Episodic Payment Models (EPM) to Other Programs

Source: DHG Healthcare

$830m
Net Medicare savings from mandatory value-based programs in FY 17 (1 year)

Net Medicare savings from **CJR + SHFFT models** (annualized) — $100m

Net Medicare savings from **AMI + CABG models** (annualized) — $12m

Why the Disparity?	
Mandatory Value-Based Programs	**Mandatory Episode Payment Models**
Impact 3,600 IPPS hospitals	Each impacts 800–1,100 hospitals
Bonus/penalty applied to all Medicare discharges during the FY	Reconciliation payments affect only specified MS-DRGs
Fully implemented	Phased approach currently testing the concept with a broader sample

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EPM Methodology

- There are two components to performance
  - Quality
    - Participants will earn a composite quality score (CQS) that will be largely based on an organization's quality performance in comparison to that of other hospitals
    - Participants with relatively high-quality performance have an increased opportunity for financial incentives
  - Episode spending
    - Following the end of a model performance year, actual spending for all episodes (total expenditures for related services under Medicare Parts A and B) will be aggregated and compared to the aggregate quality-adjusted target price for the participant hospital

https://innovation.cms.gov/Files/x/cjr-faq.pdf
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

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EPM Methodology

- All of the EPMs adopt a **quality-first principle** where hospitals must achieve a minimum level of episode quality before receiving reconciliation payments when episode spending is below the target price
  - To be eligible to earn a reconciliation payment for the difference between the target price and actual episode spending, up to a specified cap, participant hospitals must:
    - Achieve actual episode spending below the target price
    - Achieve an acceptable or better CQS

https://innovation.cms.gov/Files/x/cjr-faq.pdf
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

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The Impact of Quality Performance CJR Example

Composite Quality Score	Eligible for Reconciliation Payment	Eligible for Quality Incentive Payment	Effective Discount Percentage for Reconciliation Payment (Medicare Savings)	Effective Discount Percentage for Repayment Payment		
				Year 1	Year 2	Years 3-5
Below Acceptable	No	No	3.0%	N/A	2.0%	3.0%
Acceptable	Yes	No	3.0%	N/A	2.0%	3.0%
Good	Yes	Yes	2.0%	N/A	1.0%	2.0%
Excellent	Yes	Yes	1.5%	N/A	0.5%	1.5%

- CMS is still finalizing the policy for downside risk in the new EPMs, but the upside is proposed to be similar to CJR

https://innovation.cms.gov/Files/slides/cjr-proposedchanges-slides.pdf
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html

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Quality Component: CJR Example

CJR Quality Measure	Weight in Composite Quality Score
Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (NQF #1550)	50%
HCAHPS patient experience survey measure (NQF #0166)	40%
THA/TKA voluntary PRO and limited risk variable data submission	10%

https://innovation.cms.gov/Files/x/cjr-faq.pdf

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Quality Component: AMI Example

AMI Quality Measure	Weight in Composite Quality Score
Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (NQF #0230)	50%
Excess days in acute care after hospitalization for AMI	20%
Hybrid AMI mortality (NQF #2473) voluntary data	10%
HCAHPS patient experience survey measure (NQF #0166)	20%

https://www.federalregister.gov/documents/2017/01/03/2016-30746/medicare-program-advancing-care-coordination-through-episode-payment-models-epms-cardiac

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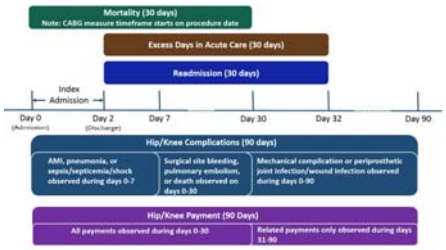
The Role of CDI

- Understand data collection time frames



CMS FAQ FY 2017 IQR Risk Standardized Outcome and Payment Measures, April 2016

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How CDI Can Impact EPM Performance

- Understand the importance of present on admission (POA) accuracy
  - CJR example: Complications that are coded as present on admission (POA) during the index admission are not regarded as complications in the measure outcome because they were present at the time of admission for the THA/TKA procedure

CMS FAQ FY 2017 IQR Risk Standardized Outcome and Payment Measures, April 2016

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How CDI Can Impact EPM Performance

- Understand inclusion and exclusion criteria associated with quality components
- Validate the coding of procedures when applicable (i.e., revisions, resurfacing, etc.)
- Validate mechanical complications are appropriately identified and coded when applicable
- Educate providers to document appropriately when a patient leaves against medical advice rather than expediting the discharge

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How CDI Can Impact EPM Performance

- Understand inclusion and exclusion criteria associated with quality components
  - Validate the coding of procedures when applicable (i.e., revisions, resurfacing, etc.)
  - Validate mechanical complications are appropriately identified and coded when applicable
- Understand clinical risk factors with each EPM population

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Risk-Adjustment Variables

- In order to account for differences in patient mix among hospitals, the measures adjust for variables that are clinically relevant and have relationships with the outcome
  - Age
  - Comorbid diseases
  - Indicators of patient frailty
- For each patient, risk adjustment variables are obtained from inpatient, outpatient, and physician Medicare administrative claims data extending 12 months prior to, and including, the index admission

file:///Users/cherylericson/Downloads/2016_Condtn_Spec_Mort_Rpt.pdf

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Risk-Adjustment Variables

- The measures adjust for case mix differences among hospitals based on the clinical status of the patient at the time of the index admission
- Accordingly, only comorbidities that convey information about the patient at that time or in the 12 months prior, and not complications that arise during the course of the hospitalization, are included in the risk adjustment
  - Verify POA status for chronic conditions

file:///Users/cherylericson/Downloads/2016_Condtn_Spec_Mort_Rpt.pdf

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Importance of Diagnosis Coding Depth

Category	Diagnosis	ICD-10 Code
Amputation Status, Lower Limb	Status amputation, toes, foot, ankle below/above knee	Z89.411–619
Congestive Heart Failure	CHF	I50.9
	Pulmonary heart disease	I27.9
COPD	COPD	J44.9
	Emphysema	J43.9
	Chronic bronchitis	J42
Diabetes	Diabetes, uncontrolled	E11.65
Major Depressive Disorders	Major depression	F32.9
Schizophrenia	Schizophrenia	F20.9
Vascular Diseases	Peripheral vascular disease	I73.9
	Aortic atherosclerosis	I70.0
	Aortic aneurysm	I71.9
	Abdominal aortic aneurysm	I73.9
History of CABG	Presence of coronary bypass graft	Z95.1

Diagnoses having the Greatest Impact on Risk Adjusted Reimbursement (Mortality and Readmissions) that are NOT classified as a CC or MCC under MS-DRG Methodology

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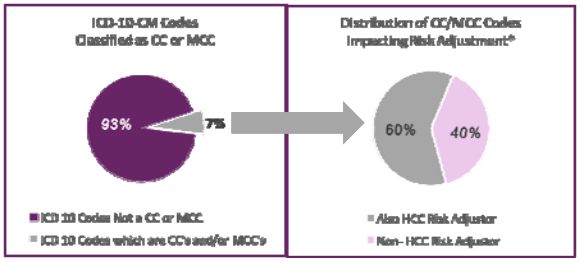
The Risk Adjustment "Blind Spot" Results in Understated Patient Acuity



*Estimates using GEMS Mapping

Source: DMG Healthcare

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Example of Clinical Risk Factors: CJR

- Morbid obesity
- COPD (CC 108)
- Stroke (CC 95, 96)
- Skeletal deformities
- Dementia and senility (CC 49, 50)
- Chronic atherosclerosis (CC 83, 84)
- Protein-calorie malnutrition (CC 21)
- Major psychiatric disorders (CC 54–56)
- Osteoarthritis of hip and knee (CC 40)
- Vascular or circulatory disease (CC 104–106)
- Cardiorespiratory failure and shock (CC 79)
- Diabetes and DM complications (CC 15–20, 119, 120)
- Respiratory/heart/digestive/ urinary/other neoplasms (CC 11–13)
- Osteoporosis and other bone/cartilage disorders (CC 41)
- Rheumatoid arthritis and inflammatory connective tissue disease (CC 38)

NQF #1550 Measure Evaluation 4.1 December 2009

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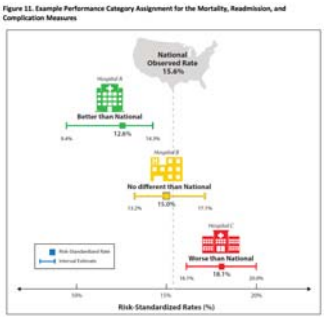
Performance Is Comparative

- CMS estimates each hospital's risk-standardized rate and the corresponding 95% interval to assign the applicable performance category
- Maintaining the status quo is not an option



CMS FAQ FY 2017 IQR Risk Standardized Outcome and Payment Measures, April 2016

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Summary

- There is overlap between the strategies used to support mandatory value-based purchasing efforts and what is required to support performance with mandatory EPMs
- Legacy CDI efforts that focus on CC/MCC capture and increasing the CMI may negatively affect performance on these measures by failing to accurately risk-adjust the episode

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Thank you. Questions?

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