Circulation

CARDIOLOGY NEWS

Shifting Landscape for Bundled Payments for Heart Conditions

Bridget M. Kuehn

Hospitals will have a choice in whether they wish to participate in the Centers for Medicare & Medicaid Service's (CMS) bundled payment programs for heart conditions under a new proposal released in January 2018. The new proposal is the latest twist in the shift away from fee-for-service payments toward value-based payments in American health care.

The proposal followed the November 2017 cancellation of a CMS mandatory bundled payment program for acute myocardial infarction (AMI) slated to roll out at hospitals in 98 randomly selected metropolitan areas in early 2018. The shift toward a voluntary program suggests the Trump administration plans to take a different approach to value-based payments.

"While CMS continues to believe that bundled payment models offer opportunities to improve quality and care coordination while lowering spending, we believe that focusing on developing different bundled payment models and engaging more providers is the best way to drive health system change while minimizing burden and maintaining access to care," wrote CMS Administrator Seema Verma in a statement about the cancellation.

New Centers for Medicare & Medicaid Services bundled payment policies, which are designed to promote cost savings and value in cardiac care, will be voluntary.

EVOLVING BUNDLES

Many hospitals had already made preparations for the mandatory AMI bundles by creating the necessary data infrastructure and establishing partnerships with outpatient centers to help them track and improve patients' postacute care. But the cancellation put many plans on hold.

"At that point, a lot of work nationally had been put into getting ready for cardiac bundles," said Jason Wasfy, MD, a cardiologist and director of outcomes research at the Massachusetts General Hospital Heart Center. "The mandatory bundle of payments would have been a very significant change for hospitals caring for AMI patients in the sense that it would have incentivized hospitals across the country to really focus on costs, care delivery, and the quality of care patients receive even after discharge."

Instead of being paid a la carte for services related to a heart attack, hospitals would have received a bundled payment for all related services for 30, 60, or 90 days after the initial incident. They would receive incentive payments for reducing overall care costs or penalties for failing to do so.

The program also included incentives for hospitals to boost patients' participation in cardiac rehabilitation programs. Wasfy explained that low reimbursement rates have led to underuse of cardiac rehabilitation.

"No matter your opinion about mandatory bundles, it still would have been a really valuable tool to encourage providers to refer more patients to cardiac rehabilitation," he said.

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The cancellation of the mandatory program wasn't a surprise because many leaders in the Trump administration, including Verma, had publicly expressed their opposition to mandatory payment models, explained Karen Joynt Maddox, MD, MPH, a cardiologist and assistant professor of medicine at Washington University School of Medicine in St. Louis.

"This administration has signaled pretty consistently that they were interested in moving away from mandatory models," Maddox explained. "There [was] concern that the mandatory bundles were an overreach, because they're making hospitals responsible for things that happen after discharge."

Another concern was that some necessary patient services might be cut by hospitals trying to reach their incentives, she said.

The new voluntary program unveiled by CMS in January will extend to more heart-related conditions, including AMI, cardiac arrhythmia, cardiac defibrillator, cardiac valve, congestive heart failure, coronary artery bypass graft, pacemaker, percutaneous coronary interventions, and stroke. It offers only a 90-day bundle and just one risk track, instead of giving hospitals options on the level of risk or time periods.

"The program in some ways is simpler than the old one," Maddox said. It's also the first time outpatient procedures have been included, she said.

Shifting to a voluntary approach may make it more difficult to rigorously assess the effects of bundled payments because the participants won't be randomized, Wasfy said. He explained that better hospitals may choose to participate in voluntary care improvement programs, whereas those that are struggling may decide to stay on the sidelines. To date, the data on voluntary bundled payment programs have been mixed, showing reduced costs and, in some cases, reduced length of stay and fewer readmissions or discharges to inpatient facilities. Another potential downside of voluntary programs is that nearly half of the participants in CMS's previous voluntary programs have quit, according to a *JAMA* commentary coauthored by Maddox.

"It's less of a transformational change in the way cardiac care is paid for and delivered [than the mandatory bundles], but I still think it represents an important innovation," Wasfy said.

COST PRESSURE

One incentive for physicians to participate in the voluntary program is that it counts as an alternative payment model (APM) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under MACRA, physicians who participate in an APM can earn a 5% bonus reimbursement and are exempted from the MACRA's Merit-Based Incentive Payment System (MIPS). The MIPS requires physicians to report data to CMS on 6 quality measures, participate in practice-wide quality improvement efforts, and meet certain electronic medical records requirements.

"MIPS seems like sort of a crazy convoluted program, and it's got pretty big upside and downside risk attached to it," Maddox explained. But she noted that for cardiologists who split their time between hospital and outpatient care, it may be difficult to hit the targets necessary to earn incentives through an APM. "It'll be easier for proceduralists or surgeons," she said.

It's unlikely that CMS or private insurers will stop experimenting with bundled payments and other value-focused payment reforms, because it helps them to reduce costs, Maddox said. Given the urgent need to rein in health spending, especially escalating costs associated with cardiology care, Wasfy predicts there will be increasing pressure on the field to shift toward value-based payments. Both agreed it's important for cardiologists to take an active role in payment reform.

"There is no way cardiologists and hospitals will not be on the hook," he said.

"It's important to focus on value and to think hard about the way we all practice and what really helps patients and what may not help patients as much. In some cases, that may mean increasing use of some interventions, for example, cardiac rehabilitation, while decreasing use of others." ■

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