Clinical and financial impact of treating heart failure patients with finerenone in hospitals with Medicare alternative payment models

Poster number 40

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Background

- Heart failure (HF) is associated with high burden of illness and disproportionately affects Medicare-eligible populations[1,2]
  - Heart failure with mildly reduced or preserved ejection fraction, which includes HF with left ventricular ejection fraction (LVEF) >40%, has emerged as a key area of unmet need with fewer treatment options than HF with reduced ejection fraction[3]
  - Over half of patients with HF have LVEF >40%[4]
- The Centers for Medicare and Medicaid Services (CMS) have developed alternative payment models (APMs), which may incentivize hospitals to reduce readmissions and improve outcomes compared to traditional fee-for-service (FFS). These include[5-7]
  - The Medicare Shared Savings Program (MSSP),
  - The Hospital Readmissions Reduction Program (HRRP), and
  - The Bundled Payments for Care Initiative Advanced (BPCI-A) Model
- Finerenone (Kerendia®) is approved by the Food and Drug Administration (FDA) for the treatment of adults with HF and LVEF ≥40% based on the FINEARTS HF study, which showed reductions in total HF hospitalizations or urgent visits for HF, and cardiovascular death[8,9]

Objectives

- To estimate the clinical and financial impact to hospitals of adding finerenone as a treatment for Medicare patients hospitalized for HF with LVEF ≥40% under CMS APM strategies

Methods

- A model was developed to estimate annual clinical events and financial margins for an average US community hospital with vs without adoption of finerenone for treatment of Medicare patients hospitalized for HF with LVEF ≥40% (**Table 1**)
- Financial margins were calculated based on finerenone drug cost, gross margin for hospital encounters (HF hospitalizations and ED visits), and CMS APM payments and penalties
- The probability of HF readmissions and ED visits for HF within 90 days of an initial HF hospitalization was informed by a subgroup analysis of FINEARTS-HF subjects randomized during or within 7 days of HF hospitalization[10] (**Table 2**)

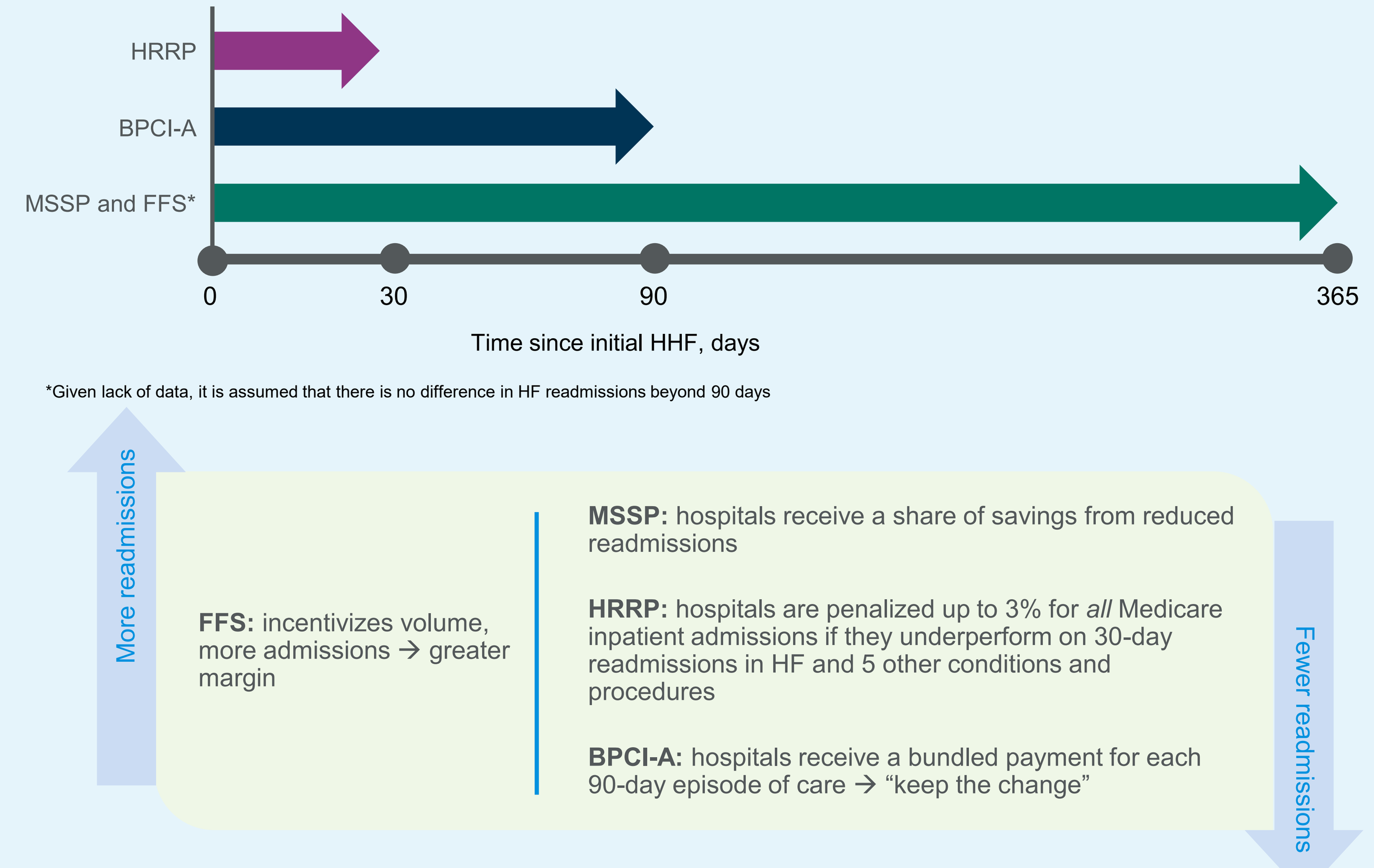
Table 1. Model Inputs

Parameter	Value	Source
Total admissions per year	6,330	AHA 2025[11]
Share of admissions due to HF	4.5%	CMS 2025[12]
Number of unique patients	77.2%	Bozkurt 2024[13]
Share of LVEF ≥40%*	74.0%	Racine 2024[14]
Share of HF patients with Medicare	75.6%	Agarwal 2021[15]
Finerenone, cost per day	22.89	RED BOOK, Kerendia PI[16,17]
Finerenone days of treatment per HF admission	2	Shafrin 2024[18]
Reimbursed amount per HF readmission	$9,340	DRG 291-293: CMS 2025[19]
Reimbursed amount per all-cause hospitalization	$14,833	CMS 2025[19]
Reimbursed amount per ED visit for HF	$1,348	Lam 2021[20]
Gross margin per encounter	5%	Ly 2018[21]
Share of readmissions or ED visits to same hospital	78.7%	Lahewala 2018[22]
Capacity constraint	75.3%	Leuchter 2025[23]
MSSP participation	29.4%	CMS 2025[5]; AHA 2025[11]
HRRP participation	58.3%	CMS 2025[12]; AHA 2025[11]
BPCI-A participation	1.1%	CMS 2025[24]; AHA 2025[11]
Shared savings amount (MSSP)	75%	Shafrin 2024[18]
Share of all-cause admissions under Medicare (HRRP)	40.6%	AHRQ 2025[25]
Neutrality modifier (HRRP)	0.9652	CMS 2025[12]
Share of HRRP DRG payments due to HF	27%	CMS 2025[12]
HRRP penalty without finerenone	0.32%	CMS 2025[12]

*An approximation based on the share of LVEF >40%
AHA, American Hospital Association; AHRQ, Agency for Healthcare Research and Quality; APM, alternative payment model; BPCI-A, Bundled Payments for Care Initiative Advanced Program; CMS, Centers for Medicare and Medicaid Services; DRG, diagnosis-related group; ED, emergency department; FFS, fee-for-service; HF, heart failure; HRRP, Hospital Readmissions Reduction Program; LVEF, left ventricular ejection fraction; MSSP, Medicare Shared Savings Program; PI, prescribing information; WAC, wholesale acquisition cost.

- APM payments or penalties were calculated based on HF readmissions (**Figure 1**)
  - MSSP, HRRP, and BPCI-A consider slightly different timeframes (ie, 30-day, 90-day, or 1-year readmissions)
  - This analysis considered an upside-only risk for MSSP: shared savings without risk of penalty
  - Though HRRP penalty is based on seven different readmission types, non-HF readmissions were not explicitly modeled
- Key assumptions:
  - No treatment discontinuation
  - No difference in clinical outcomes beyond 90 days
  - Reduced HF readmissions would increase non-HF admissions
- One-way sensitivity analysis (OWSA) was conducted to assess the effect of uncertainty
  - Input values were varied by 95% confidence intervals (CI), where available, or ±20% of the base case value
- Scenario analyses include:
  - Setting HRRP reduction for SoC alone to 0% or 1%
  - Readmission risk (SoC alone) based on real-world evidence[10] (**Table 2**)

Figure 1. Overview of Payment Models



BPCI-A, Bundled Payments for Care Initiative Advanced Program; FFS, fee-for-service; HHF, hospitalization for heart failure; HRRP, Hospital Readmissions Reduction Program; MSSP, Medicare Shared Savings Program.

Table 2. Risk of Clinical Events

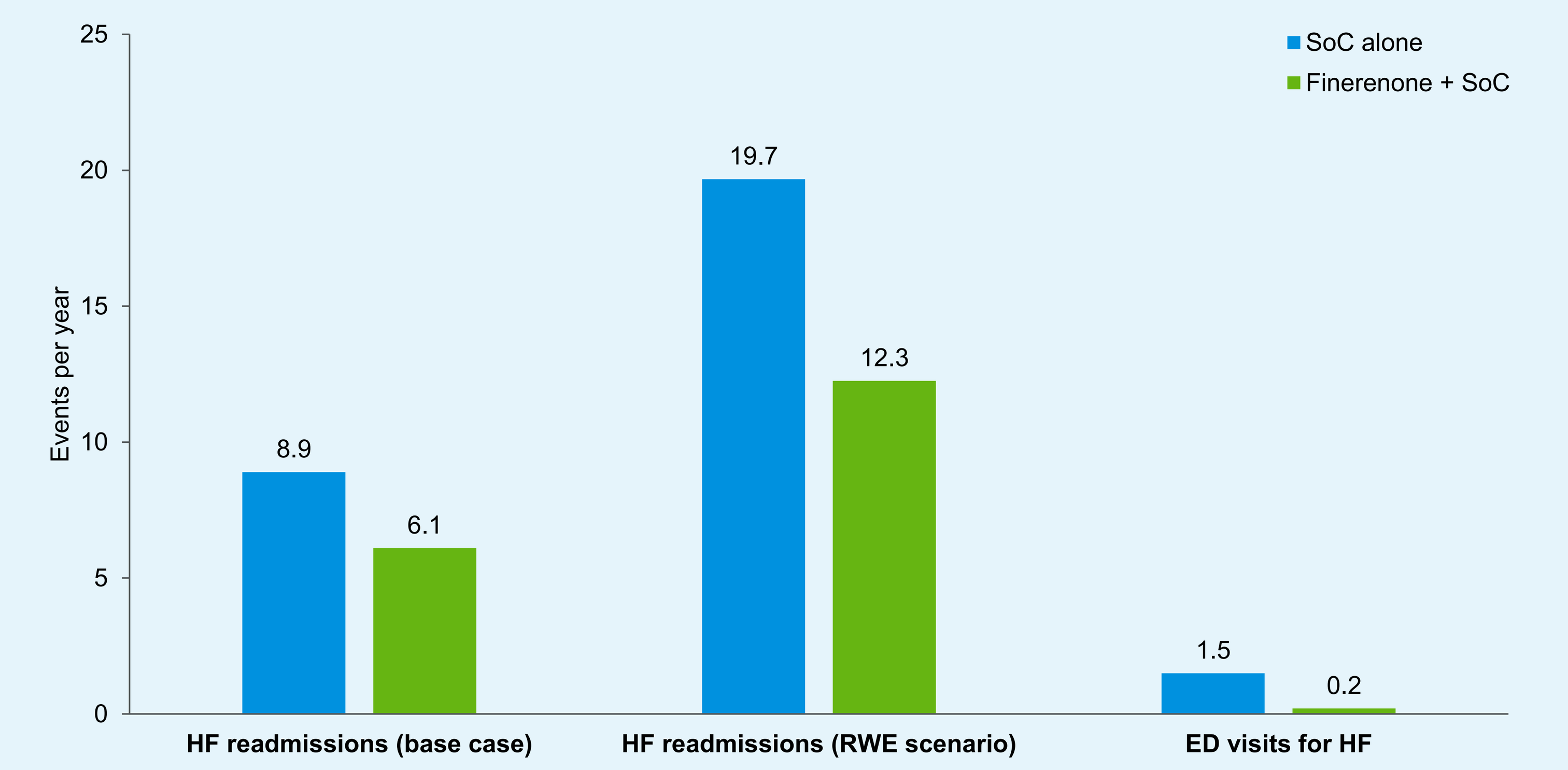
Timeframe	SoC alone	Finerenone + SoC
HF Readmissions: Base Case		
Days 1-30	3.6%	1.8%
Days 31-90	3.6%	3.2%
HF Readmissions: RWE Scenario		
Days 1-30	8.7%	4.8%
Days 31-90	7.3%	5.2%
ED Visits for HF		
Days 1-30	0.8%	0.2%
Days 31-90	0.4%	0.0%

ED, emergency department; HF, heart failure; RWE, real-world evidence; SoC, standard of care.

Results

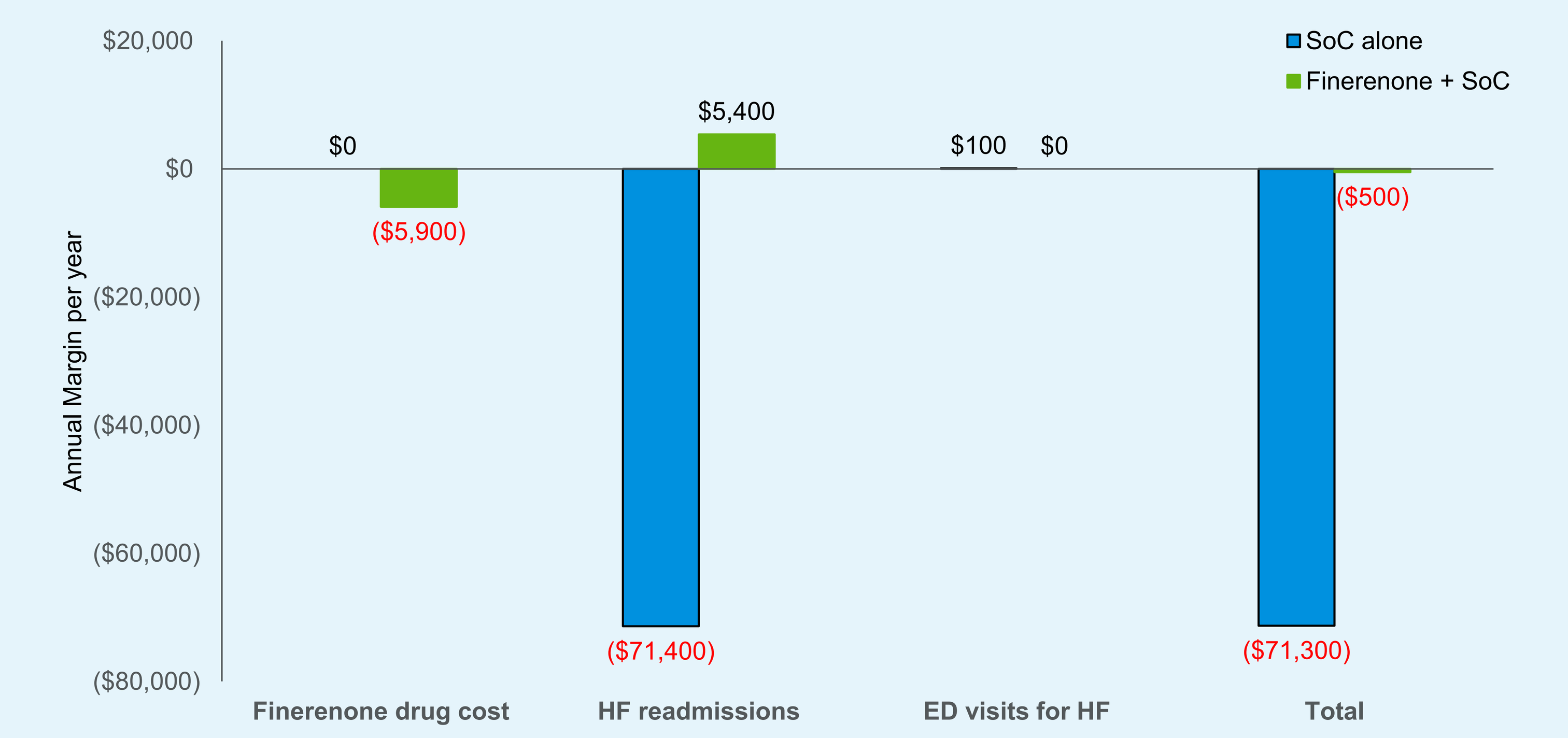
- For an average US community hospital, there were 123 Medicare patients with HF and LVEF ≥40% per year hospitalized for HF and eligible for finerenone
- Treatment with finerenone was associated with 3 fewer HF readmissions and 1 less ED visit for HF per year in the base case (**Figure 2**)
- Finerenone treatment was associated with an increase in total margin of $70,800 per hospital per year (**Figure 3, Table 3**)
- In OWSA, total annual margin was most sensitive to uncertainty in parameters affecting HRRP: reimbursed amount for all-cause hospitalizations, Medicare admission volume, and participation in HRRP
- Scenario analyses indicated that results were highly sensitive to HRRP assumptions, and the RWE scenario showed a greater increase in annual hospital margin (**Figure 4**)

Figure 2. Total HF Events Per Hospital Per Year



ED, emergency department; HF, heart failure; RWE, real-world evidence; SoC, standard of care.

Figure 3. Annual Hospital Margin by Category



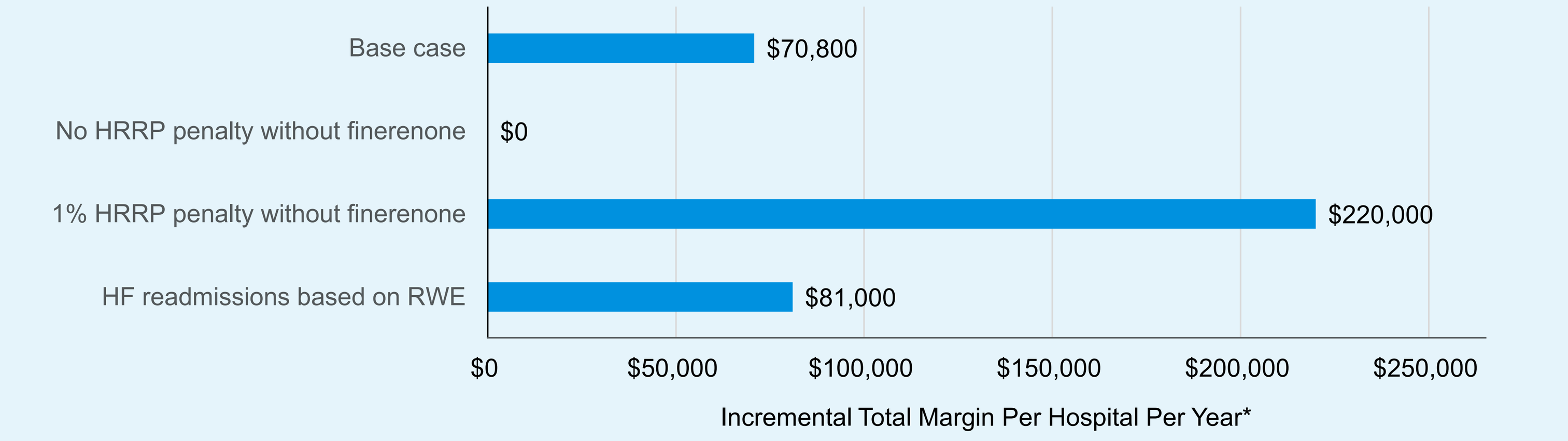
ED, emergency department; HF, heart failure; SoC, standard of care.

Table 3. Base Case Annual Financial Impact to Hospitals with CMS APM Participation

Margin Category	SoC Alone	Finerenone + SoC	Difference
Finerenone drug cost	$0	-$5,900	-$5,900
HF readmissions	-$71,400	$5,400	$76,800
FFS margin	-$600	-$400	$200
MSSP bonus	$0	$5,600	$5,600
HRRP penalty	-$70,800	$0	$70,800
BPCI-A net payment	$0	$300	$200
ED visits for HF	$100	$0	-$100
Total	**-$71,300**	**-$500**	**$70,800**

APM, alternative payment model; BPCI-A, Bundled Payments for Care Initiative Advanced Program; CMS, Centers for Medicare and Medicaid Services; ED, emergency department; FFS, fee-for-service; HF, heart failure; HRRP, Hospital Readmissions Reduction Program; MSSP, Medicare Shared Savings Program.

Figure 4. Scenario Analysis Results



*When treating patients with finerenone + SoC vs SoC alone
HF, heart failure; HRRP, Hospital Readmissions Reduction Program; RWE, real-world evidence; SoC, standard of care.

Conclusions

- Adoption of finerenone as a treatment for Medicare patients hospitalized for HF with LVEF ≥40% would increase annual margins for the average US community hospital participating in CMS APMs.
- HRRP assumptions are a major driver of financial impact due to its broad application to all Medicare inpatient payments, regardless of cause

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