CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

# Bundled Payments for Care Improvement: Overview and Basic Parameters


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# Innovation at CMS

- **Center for Medicare & Medicaid Innovation (Innovation Center)**
  - Established by section 1115A of the Social Security Act (as added by Section 3021 of the Affordable Care Act)
  - Created for purpose of developing and testing innovative health care payment and service delivery models within Medicare, Medicaid, and CHIP programs nationwide
- **Innovation Center priorities**
  - Testing new payment and service delivery models
  - Evaluating results and advancing best practices
  - Engaging a broad range of stakeholders to develop additional models for testing
- **Goals of Innovation Center models include better care for patients, better health for communities, and lower costs**

# Delivery system and payment transformation

***Historical State –***

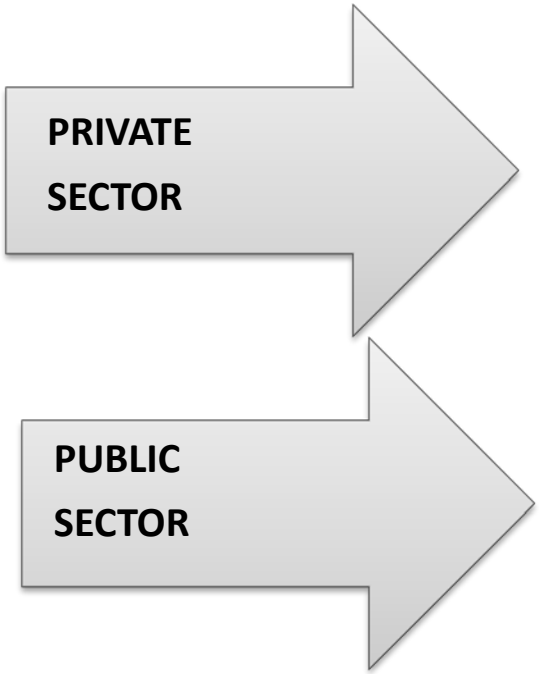
**Producer-Centered**

**Volume Driven**

**Unsustainable**

**Fragmented Care**

**FFS Payment Systems**




***Ideal Future State –***

**People-Centered**

**Outcomes Driven**

**Sustainable**

**Coordinated Care**

**New Payment Systems and Policies (and more)**

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt
- Data Transparency

# CMS Innovations Portfolio: Testing New Models to Improve Quality

**Accountable Care Organizations (ACOs)**

- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

**Primary Care Transformation**

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

**Bundled Payment for Care Improvement**

- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

**Capacity to Spread Innovation**

- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

**Health Care Innovation Awards**

**State Innovation Models Initiative**

**Initiatives Focused on the Medicaid Population**

- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

**Medicare-Medicaid Enrollees**

- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

# The Case for Bundled Payments

- Large opportunity to reduce costs from waste and variation
- Gainsharing incentives align hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
- Improvements “spillover” to private payers
- Strategies learned in bundled payments lay the foundation for success in a value driven market
- Adoption of bundled payments is accelerating across both private and public payers
- Valuable synergies with ACOs, Medicare’s Shared Savings Program and other payment reform initiatives

# Bundled Payments Models

| | Model 1: Retrospective Acute-Care Hospital Stay Only | Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care | Model 3: Retrospective Post-Acute Care Only | Model 4: Prospective Acute Care Hospital Stay Only |
|---|---|---|---|---|
| Episode | All MS-DRGs | Selected DRGs +post-acute period | Post-acute only for selected DRGs | Selected DRGs |
| Services included in the bundle | Part A services during the inpatient stay | Part A and B services during the initial inpatient stay, post-acute period and readmissions | Part A and B services during the post-acute period and readmissions | All Part A and B services (hospital, physician) and readmissions |
| Payment | Retrospective | Retrospective | Retrospective | Prospective |

# Model 2 Background

- Participants choose one or more of the 48 episodes and select a length of each episode (30, 60 or 90 days)
- Episodes are initiated by the inpatient admission of an eligible Medicare FFS beneficiary to an acute care hospital for one of the MS-DRGs included in a selected episode
- Model 2 episode-based payment includes inpatient hospital stay for the anchor DRG
- Includes related care covered under Medicare Part A and Part B within 30, 60, or 90 days following discharge from acute care hospital
- Episode-based payment is retrospective
  - Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries in Model 2 episodes
  - Total payment for a beneficiary's episode is reconciled against a bundled payment amount (the target price) predetermined by CMS

# Model 3 Background

- Participants choose one or more of the 48 episodes and select a length of each episode (30, 60 or 90 days)
- Episode begins at initiation of post-acute services with a participating skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), or home health agency (HHA) following an acute care hospital stay for an anchor MS-DRG or the initiation of post-acute care services where a member physician of a participating physician group practice (PGP) was the attending or operating physician for the beneficiary's inpatient stay.
- Post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and end either a minimum of 30, 60, or 90 days after the initiation of the episode
- Episode includes post-acute care following an inpatient acute care hospital stay and all related care covered under Medicare Part A and Part B within 30, 60, or 90 days following initiation of post-acute services
- Episode-based payment is retrospective
  - Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries in Model 3 episodes
  - Total payment for a beneficiary's episode is reconciled against a bundled payment amount (the target price) predetermined by CMS

# Rationale for BPCI Episode Parameters

- Broad bundles to strongly incentivize care coordination and care for the whole beneficiary, despite the specific clinical episode
- Allow flexibility for providers to select clinical conditions, risk tracks, and episode lengths with greatest opportunity for improvement
- Enable episodes that have a sufficient number of beneficiaries to demonstrate meaningful results
- Assure enough simplicity to allow rapid analysis and implementation of episode definitions
- Achieve episodes with the appropriate balance of financial risk and opportunity
- Build on lessons from prior initiatives and CMS demonstrations

# BPCI Models 2-4 Phases

| Phase 1 | Phase 2 |
| --- | --- |
| Phase 1 represents the initial period of participant preparation for implementation and assumption of financial risk | Phase 2 is the risk-bearing period. |
| Selection is based on CMS' review and acceptance of proposed care redesign plans and program integrity screening. | To move into Phase 2 as an Awardee, participants must be offered an agreement by CMS following a comprehensive review and enter into an agreement with CMS. |
| Participants receive:<br>➢ Monthly beneficiary-level claims data<br>➢ Engagement in variety of learning activities with other BPCI Phase 1 participants<br>➢ Baseline pricing information to inform assessments of opportunities under BPCI. | Agreements allow awardees to:<br>➢ Bear financial risk for the model<br>➢ Continue receiving monthly beneficiary-level claims data<br>➢ May utilize applicable fraud and abuse waivers and payment policy waivers (i.e. gainsharing) |

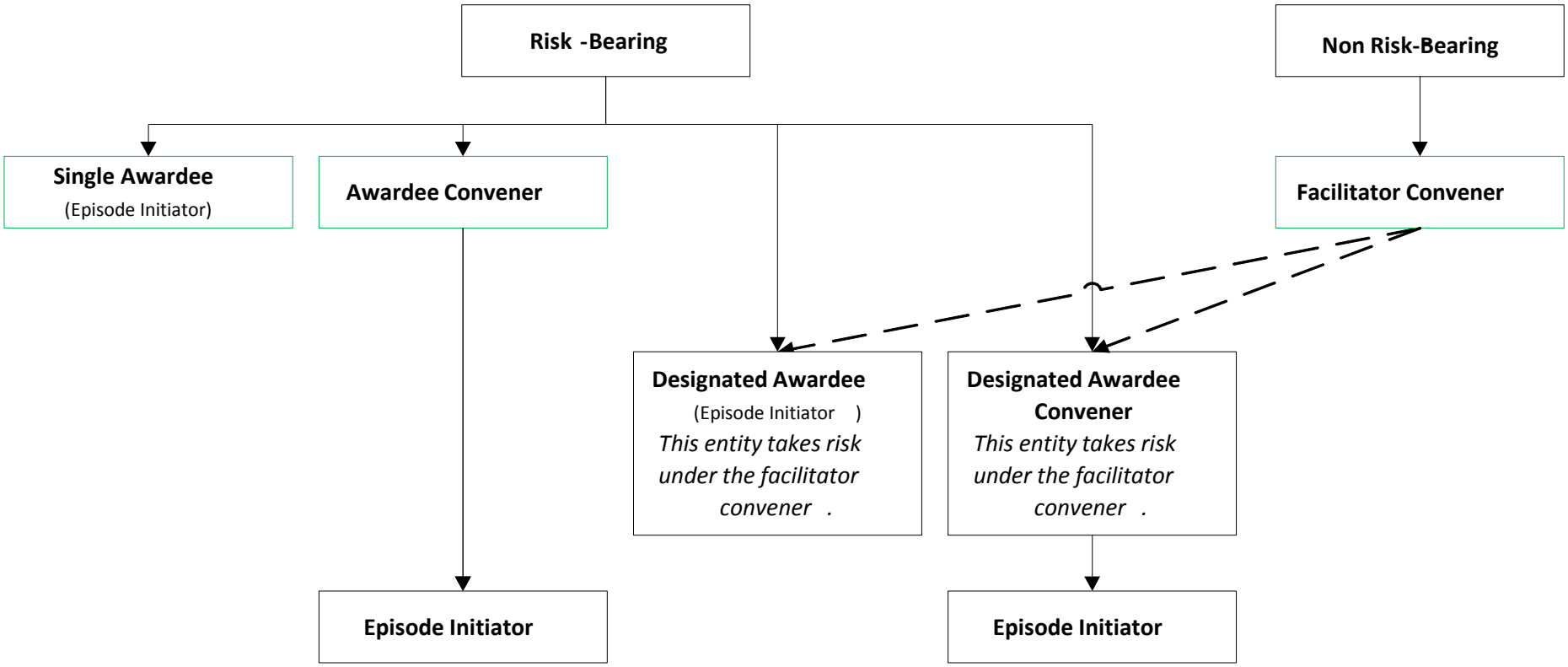
# Trigger Clinical Conditions

| | |
|---|---|
| Acute myocardial infarction | Major bowel procedure |
| AICD generator or lead | Major cardiovascular procedure |
| Amputation | Major joint replacement of the lower extremity |
| Atherosclerosis | Major joint replacement of the upper extremity |
| Back & neck except spinal fusion | Medical non-infectious orthopedic |
| Coronary artery bypass graft | Medical peripheral vascular disorders |
| Cardiac arrhythmia | Nutritional and metabolic disorders |
| Cardiac defibrillator | Other knee procedures |
| Cardiac valve | Other respiratory |
| Cellulitis | Other vascular surgery |
| Cervical spinal fusion | Pacemaker |
| Chest pain | Pacemaker device replacement or revision |
| Combined anterior posterior spinal fusion | Percutaneous coronary intervention |
| Complex non-cervical spinal fusion | Red blood cell disorders |
| Congestive heart failure | Removal of orthopedic devices |
| Chronic obstructive pulmonary disease, bronchitis, asthma | Renal failure |
| Diabetes | Revision of the hip or knee |
| Double joint replacement of the lower extremity | Sepsis |
| Esophagitis, gastroenteritis and other digestive disorders | Simple pneumonia and respiratory infections |
| Fractures of the femur and hip or pelvis | Spinal fusion (non-cervical) |
| Gastrointestinal hemorrhage | Stroke |
| Gastrointestinal obstruction | Syncope & collapse |
| Hip & femur procedures except major joint | Transient ischemia |
| Lower extremity and humerus procedure except hip, foot, femur | Urinary tract infection |

# Episode Initiators

- Models 2:  Acute care hospitals (ACH) and physician group practices (PGPs)
  - When a PGP is an Episode Initiator, an episode is initiated when a physician in the PGP is the admitting or ordering physician for the acute or post acute care for an eligible beneficiary for an included MS-DRG, regardless of the particular hospital where the beneficiary is admitted. All physicians that reassign their right to bill Medicare to the PGP initiate episodes
- Model 3:  Skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), home health agencies (HHAs), PGPs
  - When a PGP is an Episode Initiator, an episode is initiated when a physician in the PGP was the attending or operating physician for the inpatient ACH stay for an eligible beneficiary who is then admitted to or initiates services with a SNF, IRF, LTCH, or HHA within 30 days after the beneficiary has been discharged from that inpatient stay for one of the included MS-DRGs.
- Model 4: ACHs paid under the Inpatient Prospective Payment System (IPPS)

# Description of Participant Roles



# Waivers

- Fraud and abuse waivers
  - Waivers of certain fraud and abuse authorities are available in Phase 2 of Models 2-4 for specified gainsharing, incentive payment, and patient engagement incentive arrangements, narrowly crafted based on the model policies and taking into consideration the provisions of the Awardee Agreement
- Payment policy waivers
  - 3-Day Hospital Stay Requirement for SNF Payment (Model 2)
  - Telehealth (Models 2, 3)
  - Post-Discharge Home Visit (Models 2, 3)

# Timeline of Events for Models 2-4: 2013 - present

| January 2013 | October 2013 | November 2013 | February 2014 |
|---|---|---|---|
| • The Centers for Medicare & Medicaid Services (CMS) announced the health care organizations selected to participate in Phase 1 of the Bundled Payments for Care Improvement initiative Models 2-4 | • Awardees entered into Model 2, 3, or 4 agreements with CMS that, at the Awardee's choice, became effective on either **October 1, 2013** or **January 1, 2014**, at which point Awardees began the risk-bearing phase for some or all of their episodes | • CMS announced that it would consider the addition of both episodes and/or Episode Initiators to current participants in Bundled Payments for Care Improvement Models 2, 3, and 4 | • The Center for Medicare & Medicaid Innovation announced an Open Period for additional organizations to be considered for participation in Models 2-4. In addition, CMS solicited the addition of both episodes and episode initiators to current participants in Bundled Payments for Care Improvement Models 2, 3, and 4 |

# Timeline for Participation in Phase 2 of BPCI

| | |
|---|---|
| Fall 2014 | • CMS provides baseline data for November 2013 and Winter Open periods |
| January 2015 | • New Awardees and Episode Initiators may enter Phase 2 by transitioning at least one Clinical Episode to Phase 2 |
| April 2015 | • Awardees and Episode Initiators must enter Phase 2 by transitioning at least one Clinical Episode to Phase 2 |
| July 2015 | • Awardees and Episode Initiators may transition additional Clinical Episodes from Phase 1 to Phase 2 |
| October 2015 | • Awardees and Episode Initiators may transition additional Clinical Episodes from Phase 1 to Phase 2. **Phase 1 ends** |

# Evaluation and Monitoring

- CMS and its contractors will be carrying out Evaluation and Monitoring activities during the course of this project.

- Areas of focus will include, but are not limited to:
  - Monitoring adherence to the terms and conditions of the Agreement,
  - Monitoring for unintended consequences such as cost shifting, inappropriate increases in utilization, problems with access to care, and lower quality, and
  - Evaluation of the success of the model as well as lessons learned applicable to improving the programs or the potential for expansion of the program

- Model participants will be required to comply with and participate in Evaluation and Monitoring activities and data collection efforts

- It is too early in the program to have meaningful results.

- Continuous process to improve transparency and communication with all parties involved in program. Opportunities to make adjustments to models mid-steam if warranted.

# Questions?

Additional Information can be found at:
http://innovation.cms.gov/initiatives/bundled-payments/

# Contact Information

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