CMS
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Bundled Payments for Care Improvement: Overview and Basic Parameters

CMS Center for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement Team

March 11, 2014

Agenda

- Review principles for Bundled Payments for Care Improvement (BPCI)
- Why should physicians be engaged?
- New and current engagement opportunities for Physicians

Why Engage as a Provider?

- Meaningful gainsharing opportunities, up to 50% more than physician fee schedule equivalent.
- Does not impact fee for service payment under Models 2 and 3.
- Competencies learned in bundled payment position physicians for success in value-based contracting.
- Facilitates physician leadership in care redesign.
- Opportunity to work and learn from others nationally and receive data.

How can physicians or physician group practices further engage?

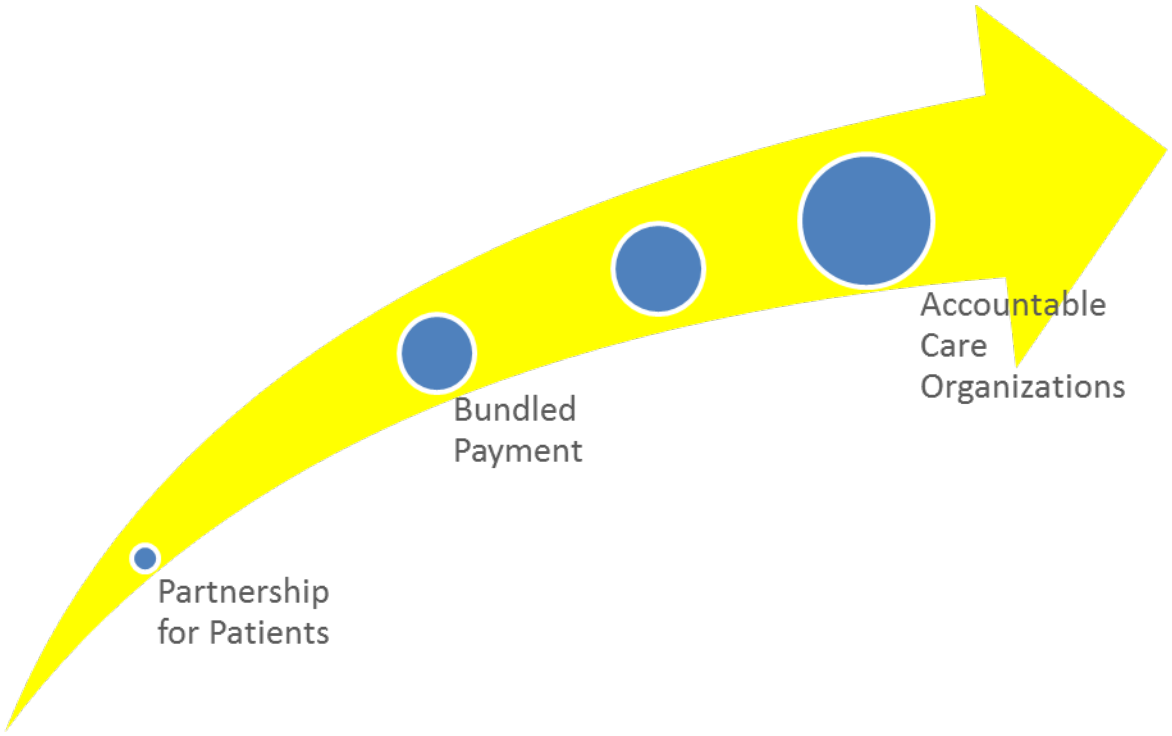
- Speak to hospitals, post-acute care providers and current existing awardees where they admit patients.
- Check website for entities participating in their regions listed on the CMMI website.
- Be aware of opportunities to join current awardees and new prospective participants through the Winter Open Period and quarterly processes.
- Find archived resources for physicians at: http://innovation.cms.gov/initiatives/Bundled-Payments/learning-area.html and https://air-event500.webex.com/air-event500/onstage/g.php?t=a&d=594120927.
- Email inbox with questions.

Delivery Transformation Continuum

Providers choose from a range of care delivery transformations

with escalating amounts of risk, while benefiting from supports and resources designed to spread best practices and improve care.

The Patient-centered Health Care System of the future



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

Rationale for BPCI Episode Parameters

BPCI Episodes Parameters:

- Allow flexibility for providers to select clinical conditions, time frames, and services with greatest opportunity for improvement
- Enable episodes that have sufficient numbers 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

Clinical Episodes

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

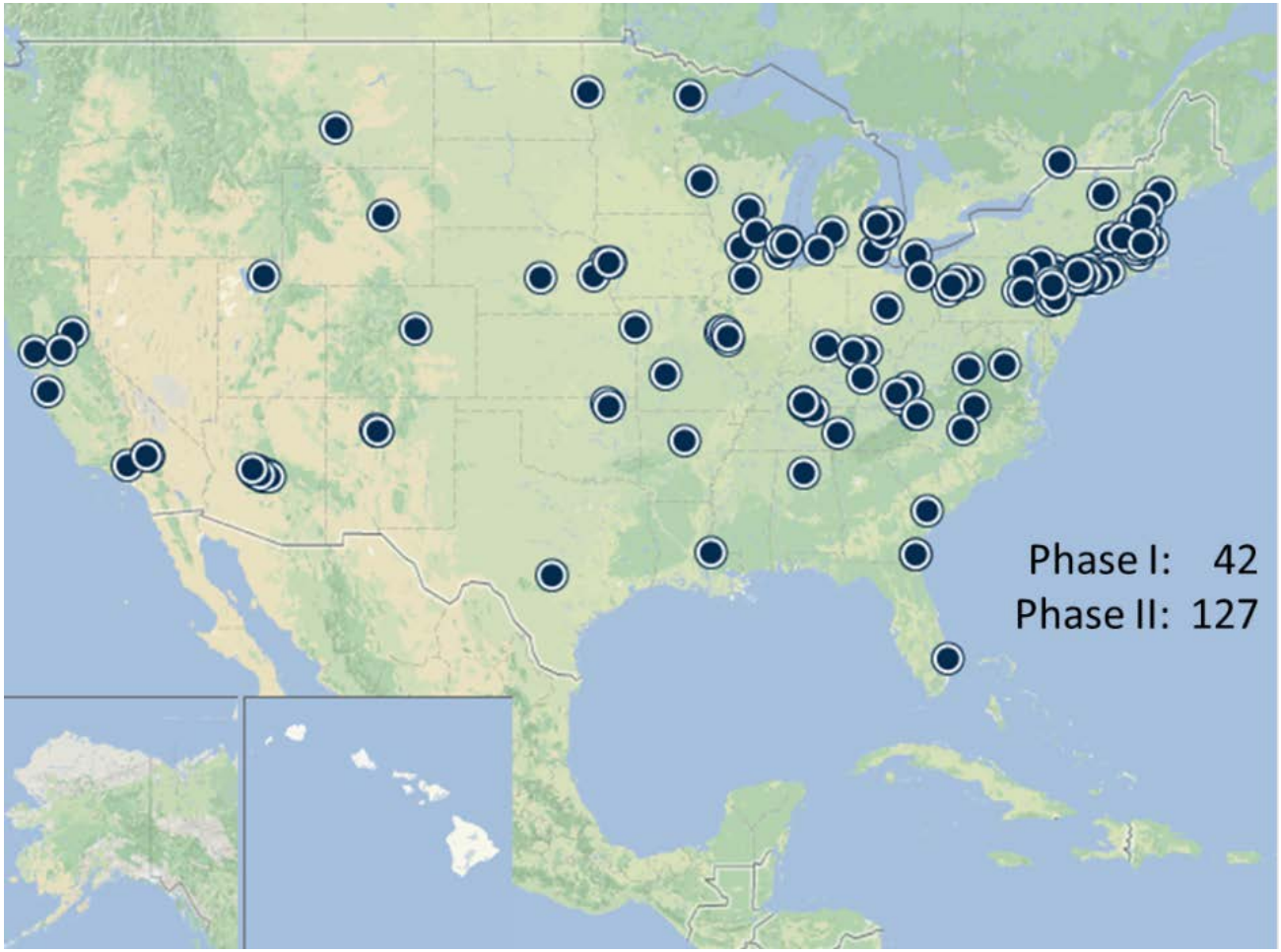
Bundled Payments Models

	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	Selected DRGs +post-acute period	Post acute only for selected DRGs	Selected DRGs
Services included in the bundle	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	Prospective

Model 2 Background

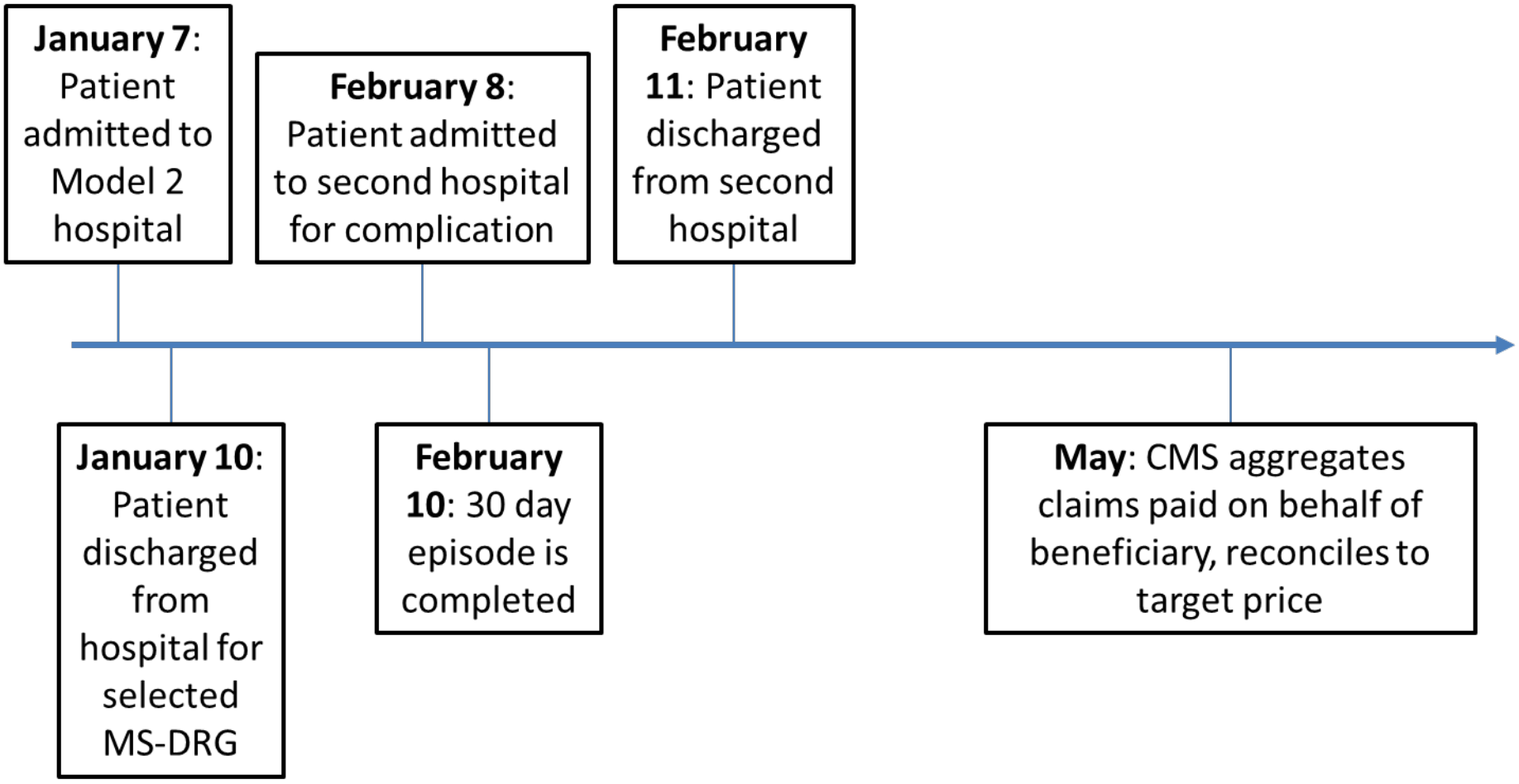
- Participants choose one or more of the 48 episodes and select a length of each episode (30, 60 or 90 days)
- Episodes are initiated by the inpatient admission of an eligible Medicare FFS beneficiary to an acute care hospital for one of the MS-DRGs included in a selected episode
- Model 2 episode-based 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

Current Model 2 Participants



Map and list available at http://innovation.cms.gov/initiatives/BPCI-Model-2/index.html

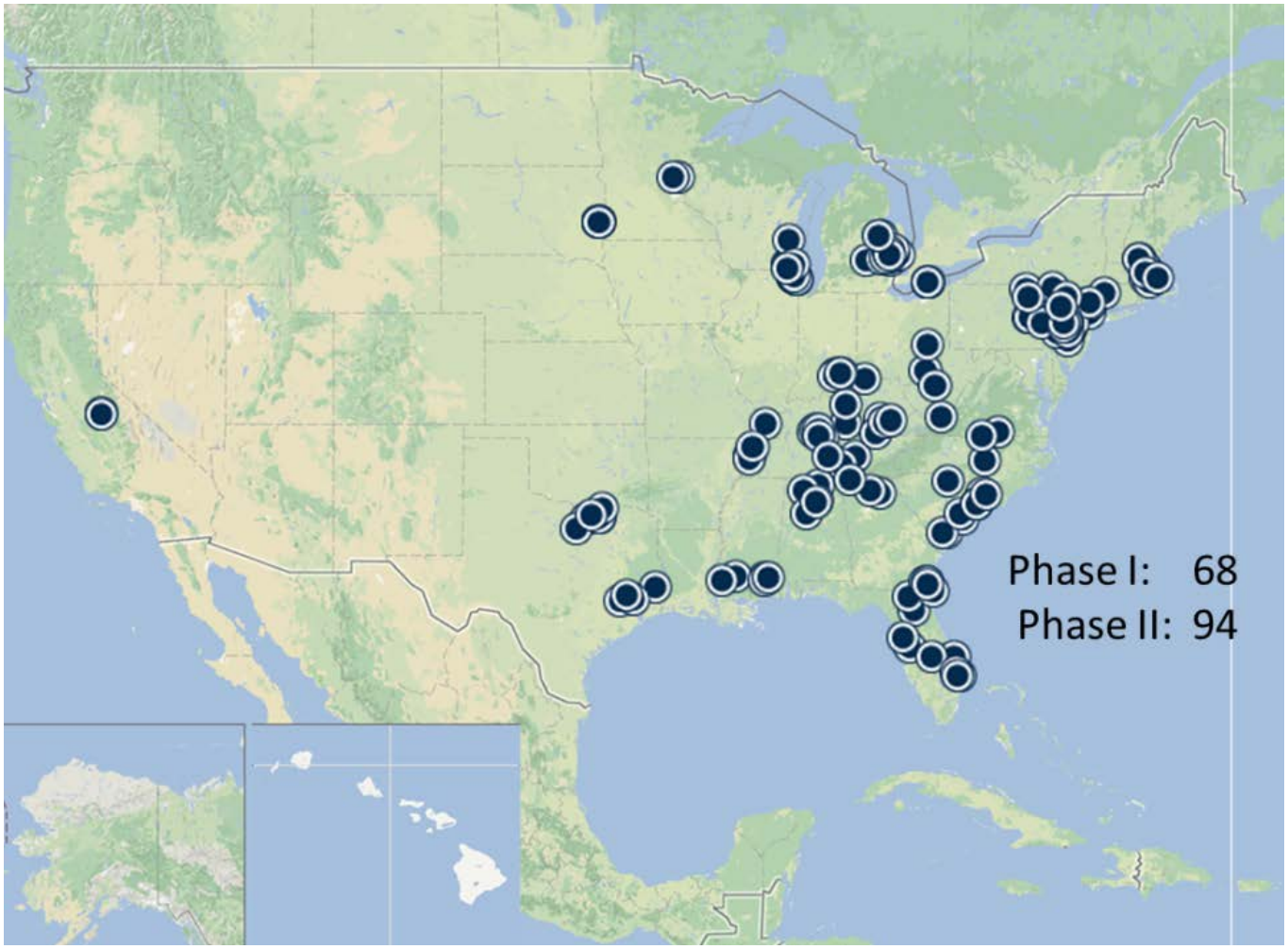
Model 2 Illustrative Timeline



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

Model 3 Participants



Map and list available at http://innovation.cms.gov/initiatives/BPCI-Model-3/index.html

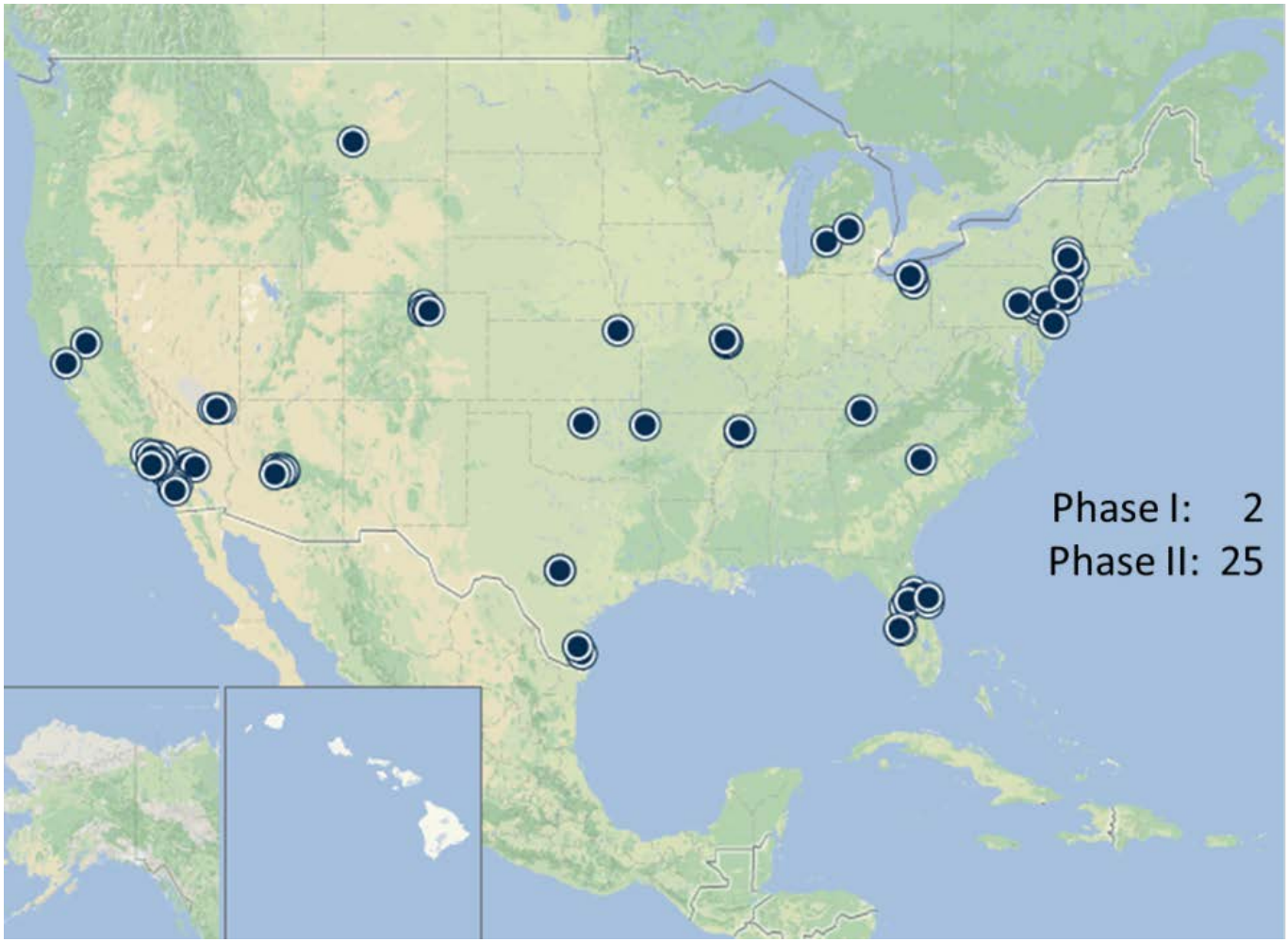
Model 4 Background

- Participants choose one or more of the 48 episodes
- Each episode is initiated by an acute care hospital inpatient admission for one of the MS-DRGs included in an episode selected for participation by the Episode Initiator. Episode initiators submit a Notice of Admission (NOA) when a beneficiary expected to be included in the model is admitted
- Bundled payment includes all Medicare Part A and Part B covered services furnished during the inpatient stay by the hospital, physicians, and nonphysician practitioners, as well as any related readmissions that occur within 30 days after discharge
- Episode-based payment is prospective
  - CMS makes a single, predetermined bundled payment to the Episode Initiator (an acute care hospital) instead of an Inpatient Prospective Payment System (IPPS) payment

Declining Participation in Model 4:
Physicians and Non-physician Practitioners

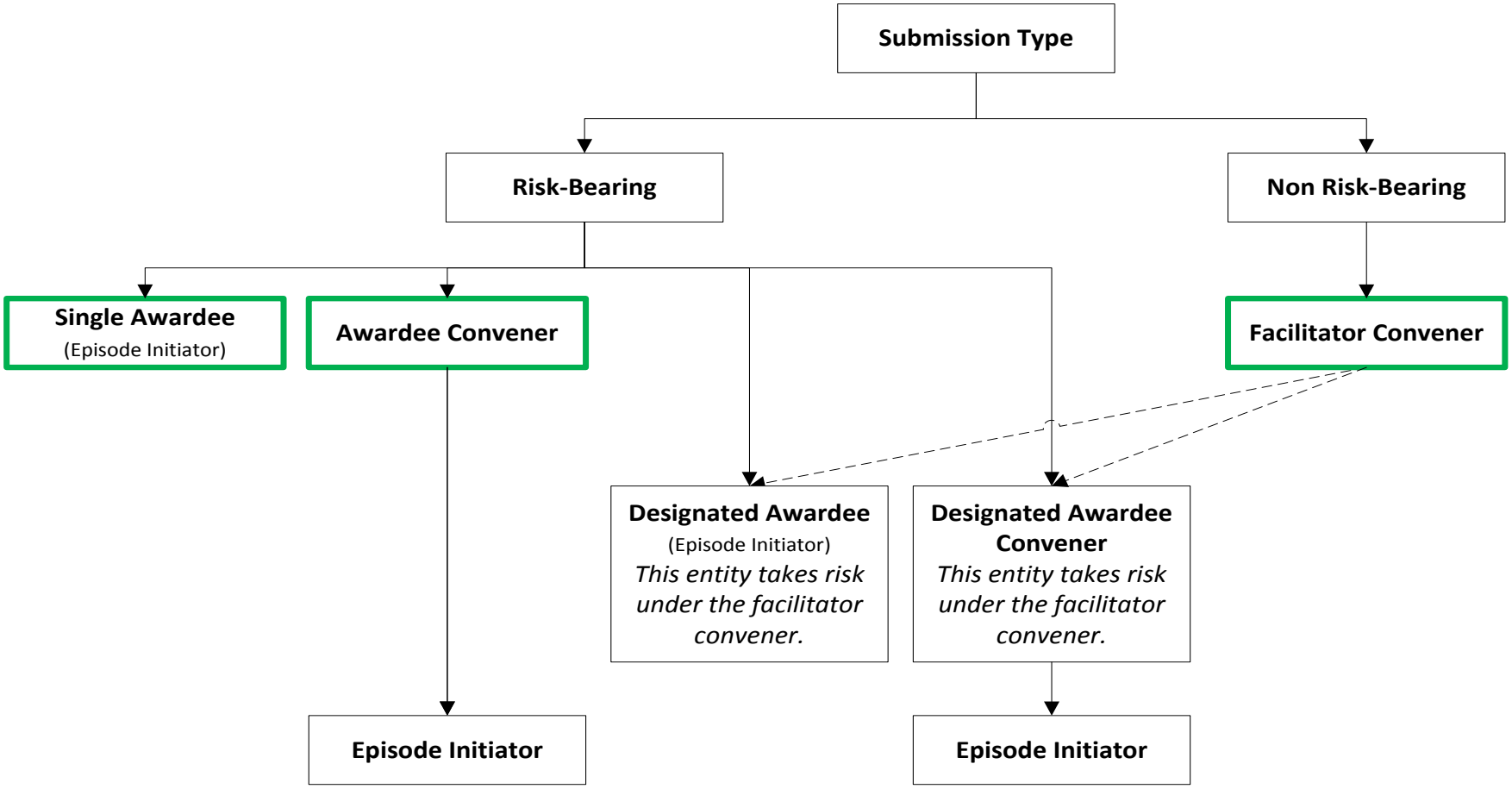
- Physicians or non-physician practitioners will be able to decline participation in Model 4 and be paid regular FFS for Part B services rendered during an inpatient stay.
  - Declinations will be per service
  - Part B claim must be submitted with a HCPCS modifier on every relevant line
  - Payment will flow as normally, and coinsurance can be collected as normally by physician or non-physician practitioner

Model 4 Participants



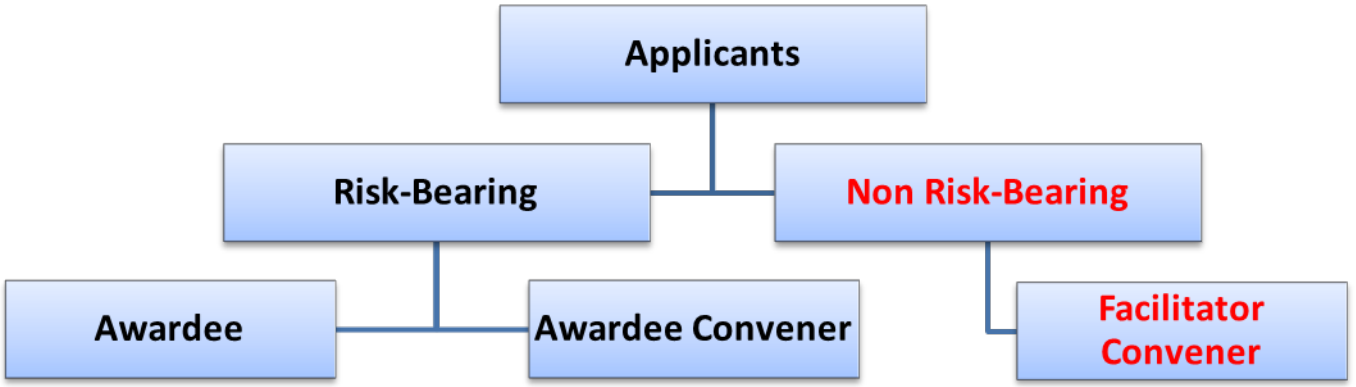
Map and list available at http://innovation.cms.gov/initiatives/BPCI-Model-4/index.html

Submission Types: Description of Roles



Non Risk-Bearing

A BPCI participant is a **Facilitator Convener** if it will not bear risk but would like to facilitate other organizations (called Designated Awardees and Designated Awardee Conveners) that take risk for redesigning care under an episode payment model.



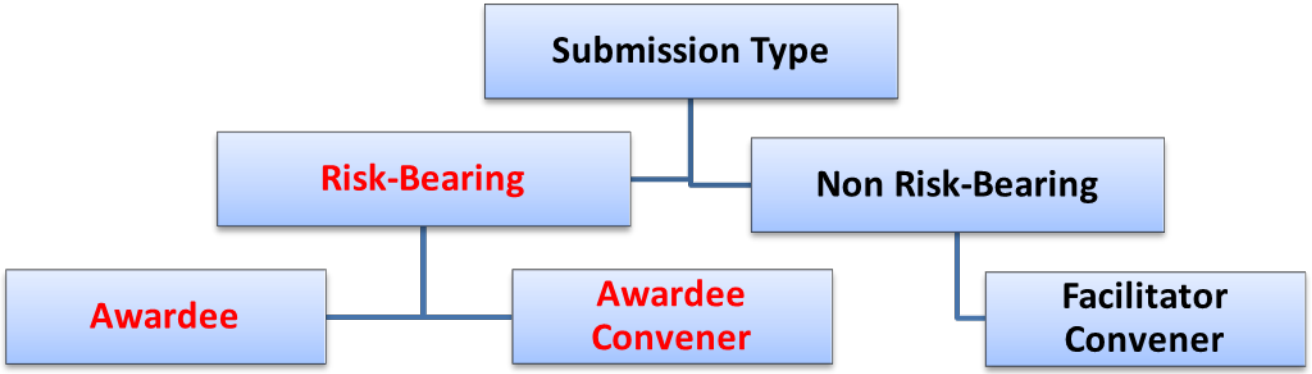
Submission Type: Facilitator Convener

- **Who** would submit intake forms?
  - Organizations that wish to perform a facilitative role without bearing risk or receiving payment from CMS
- **Which beneficiaries** are they responsible for?
  - Each designated awardee/designated awardee convener is responsible, per the definitions in the former slides
- **What kind of partners** would they have?
  - Designated awardees
  - Designated awardee conveners

Risk-Bearing Awardees

A BPCI participant is an **Awardee** if it is a Medicare provider that bears risk for only episodes that it initiates.

A BPCI participant is an **Awardee Convener** if it applies with partners and bears risk for all episodes of its episode initiator partners.



Submission Type: Awardee

- **Who** would submit as this type of applicant?
  - Example: Individual hospital
- **Which beneficiaries** are they responsible for?
  - Only their own Bundled Payment patients
  - All of their own Bundled Payment patients, regardless of the other providers where these patients receive care during the episode

Submission Type: Awardee Convener

- **Who** would submit in this role?
  - Parent companies, health systems, and other organizations that wish to take risk
- **Which beneficiaries** are they responsible for?
  - All of their own bundled payment beneficiaries during the episode if the Awardee Convener is a Medicare provider, regardless of the other providers where these patients receive care during the episode
  - All bundled payment beneficiaries of the Episode Initiators, regardless of the other providers where these patients receive care during the episode
- **What kind of partners** would they have?
  - Episode-initiators

Physician Group Practices

- For the purposes of BPCI, we define a physician group practice with the following requirements:
  - A unique EIN/TIN combination for the PGP. More than one practitioner
  - All practitioners that have reassigned their individual NPI to the PGP for billing purposes. This ensures that the group in its entirety is participating in BPCI

Physician Group Practices as Episode Initiators

- Models 2: Acute care hospitals and physician group practices
  - 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 Medicare benefits to the PGP initiate episodes
- Model 3: Skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, physician group practices
  - When a PGP is an Episode Initiator, an episode is initiated when an eligible beneficiary is admitted to or initiates services with a SNF, IRF, LTCH, or HHA within 30 days after the beneficiary has been discharged from an inpatient stay at an ACH for one of the included MS-DRGs and a physician in the PGP was the attending or operating physician for the inpatient ACH stay
- Model 4: Acute care hospitals Acute care hospitals paid under the Inpatient Prospective Payment System (IPPS)

Current BPCI Participants by type

Participant Type	
Facilitator Convener	9
Single Awardee	27
Designated Awardee Convener (DAC)	3
Awardee Convener (AC)	38
Episode Initiators (under DAC or AC)*	255

Provider Type	
Acute Care Hospital	165
Skilled Nursing Facility	63
Home Health Agency	86
Physician Group Practice	8
Long term care hospital	1
Inpatient Rehabilitation Facility	1

Physician engagement continues to grow.

BPCI Phases

Phase 1	Phase 2
Following the April 2014 submission, new participants are selected for Phase 1. Phase 1 is the risk-bearing phase. 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 selected by CMS following a comprehensive review and enter into an agreement with CMS.
Participants receive: ➢ Monthly beneficiary-level claims data ➢ Engagement in variety of learning activities with other BPCI Phase 1 and Phase 2 participants. ➢ Target pricing information to inform assessments of opportunities under BPCI. ➢ Assessment of opportunities under BPCI.	Agreements allow awardees to: ➢ Bear financial risk for the model ➢ May utilize applicable fraud and abuse waivers and payment policy waivers (i.e. gainsharing)

Evaluation and Monitoring

- CMS intends to measure metrics including:
  - structural and organizational characteristics
  - patient case-mix
  - clinical care and patient safety
  - patient experience
- CMS also monitors utilization and compliance within agreements, fraud and abuse waivers, and Medicare payment policy waivers.

Fraud and Abuse Waivers

- Waivers of certain fraud and abuse authorities are available in Phase 2 for specified gainsharing, incentive payment, and patient engagement incentive arrangements in connection with BPCI Models 2-4, except as otherwise provided in a BPCI Models 2-4 Awardee's agreement with CMS.

Payment Policy Waivers

3-Day Hospital Stay Requirement for SNF Payment (Model 2)

- CMS waives the requirement in section 1861(i) for a 3-day inpatient hospital stay prior to the provision of Medicare covered post-hospital extended care services. For purposes of this waiver, a majority of skilled nursing facilities (SNFs) that the Awardee is partnering with must have a three star or better overall quality rating under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website, for at least 7 out of the 12 months immediately preceding the performance period. All other provisions of the statute and regulations regarding Medicare Part A post-hospital extended care services continue to apply.

Telehealth (Models 2, 3)

- Section 1834(m) of the Act allows Medicare payment for telehealth services where the originating site is one of eight healthcare settings that is located in a geographic area that satisfies certain requirements. CMS waives the geographic area requirement for telehealth services furnished to eligible beneficiaries during a Model 3 episode, as long as the services are furnished in accordance with all other Medicare coverage and payment criteria.

Payment Policy Waivers continued

Post-Discharge Home Visit (Models 2, 3)

- CMS waives the direct supervision requirement in 42 C.F.R. § 410.26(b)(5) for "incident to" services, provided that such services are furnished as follows:
- The services are furnished to a beneficiary who does not qualify for Medicare coverage of home health services under 42 C.F.R. § 409.42, and the services are furnished in the beneficiary's home after the beneficiary has been discharged from an Episode Initiator;
- The services are furnished by licensed clinical staff under the general supervision of a physician or other practitioner as defined in 42 C.F.R. § 410.32(b)(3)(i);
- The services are furnished by licensed clinical staff and billed by the physician or other practitioner using a Healthcare Common Procedures Coding System (HCPCS) G-code specified by CMS;
- The services are furnished not more than once in a 30-day episode, not more than twice in a 60-day episode, and not more than three times in a 90-day episode; and
- The services are furnished in accordance with all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. § 410.26(b).

Engage Now:2014 Winter Open Period Models 2, 3 and 4

- CMS announced the opportunity for additional organizations to be considered for participation in BPCI and current participants to expand their existing activities.
- Background documents for Models 2 – 4, intake forms located at:
  - http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html.
- Submissions are due to CMS for consideration by April 18, 2014 by email via: BundledPayments@cms.hhs.gov.

Winter 2014 Open Period Timeline for New Participants

February 14th

- Winter Open Period 2014 Intake Forms for new participants posted

April 18th

- Organizations submit request to participate in BPCI

Summer-Fall 2014

- Episodes for new prospective Single Awardees will be added to Phase 1
- Data use agreements will be sent
- Awardees and Facilitator Conveners will be notified of the Episodes for new prospective Single Awardees 2
- Episode packets and historical data files to allow replication of target prices

Winter 2014 Open Period Timeline for New Participants (continued)

November

- Awardees will commit to entering Phase 2 for new Episode Initiators by signing an Awardee Agreement

January

- All BPCI episodes must begin Phase 2, the "risk bearing" phase. Phase 1, the "preparation phase" of BPCI will end at this time

Questions

Thank you for your time.

Any questions that are not answered during this session can be submitted to **BundledPayments@cms.hhs.gov**.

Background Documents and Additional Information Found at:

http://innovation.cms.gov/initiatives/bundled-payments/

http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html.