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Bundled Payments for Care Improvement: Winter Open Period 2014 for Models 2,3,4

CMS Center for Innovation Bundled Payments for Care Improvement Team

March 4, 2014

Agenda

- Review principles of Bundled Payments for Care Improvement (BPCI) initiative
- Overview of Models 2 – 4
- New engagement opportunities

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.
- The Open Period was announced in the Federal Register, 79 FR 8974, on February 13, 2014
- 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

Clinical Episodes and Anchor MS-DRGs

- The episodes are defined by anchor MS-DRGs and the Part A and B exclusions lists that identify services furnished during the episode period that are not included in the episode can be found on the Innovation Center website at http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html.
- 48 clinical episodes include 180 Anchor MS-DRGs
- Represent approximately 70% of all possible episodes by Medicare volume and expenditures
- Episodes structured to promote high quality care for the whole patient throughout the episode, including appropriate management of pre-existing chronic conditions, coordination across settings, and safety in individual care settings

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

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 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

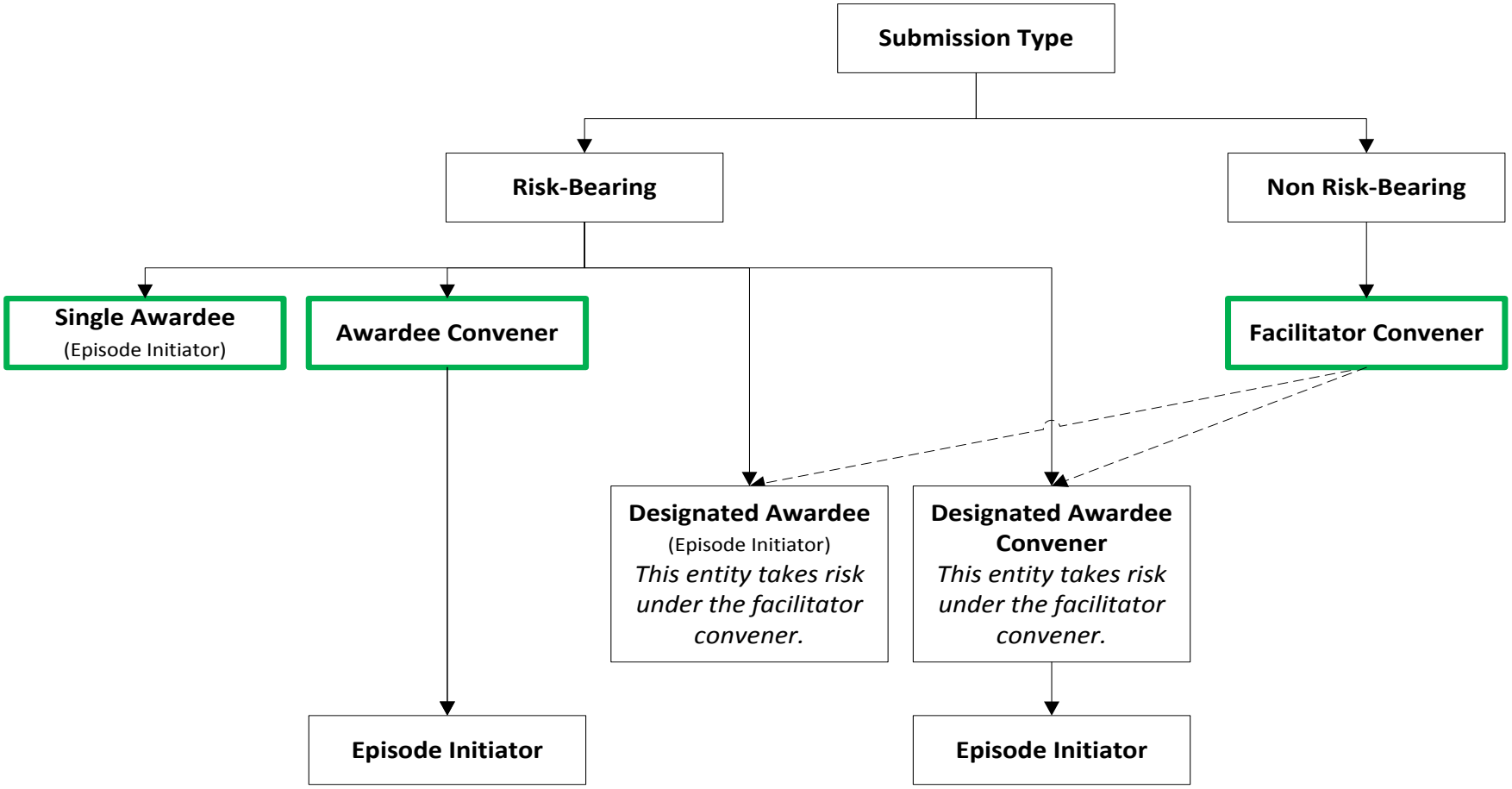
Model 3 Background

- 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

Model 4 Background

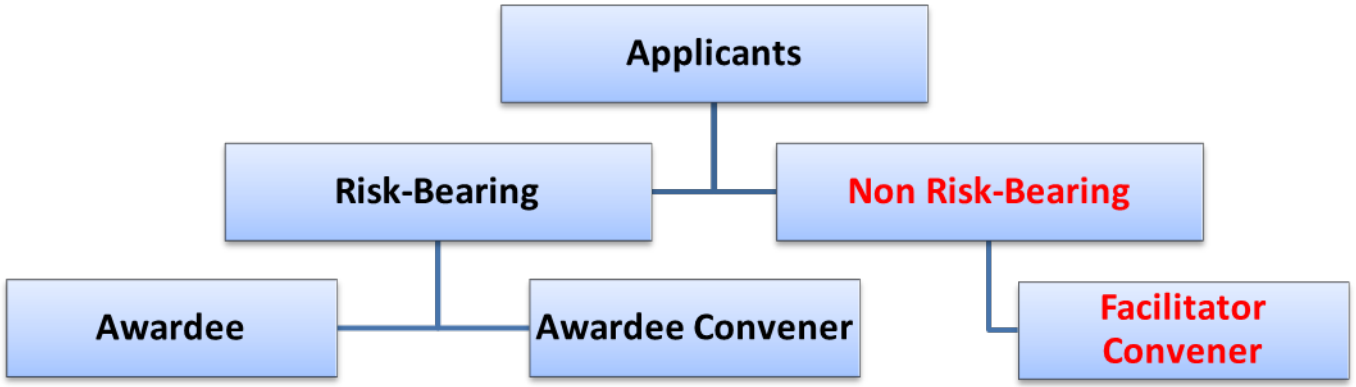
- Participants choose one or more of the 48 episodes
- Each episode is initiated by an acute care hospital inpatient admission for one of the MS-DRGs included in an episode selected for participation by the Episode Initiator. Episode Initiators submit a Notice of Admission (NOA) when a beneficiary expected 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

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.



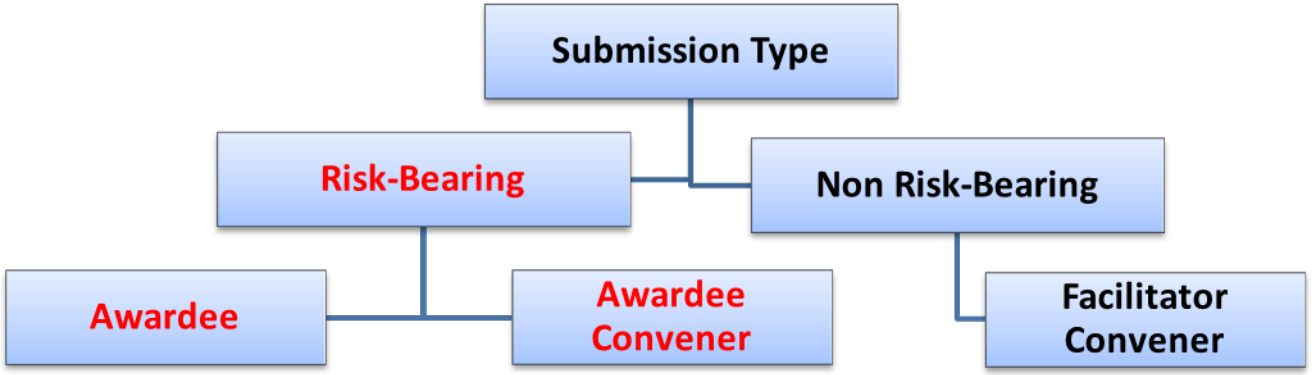
Submission Type: Facilitator Convener

- **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 in this role?
  - Example: Individual hospital
- **Which beneficiaries** are they responsible for?
  - Only their own bundled payment beneficiaries
  - All of their own bundled payment beneficiaries, 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

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 paid under the Inpatient Prospective Payment System (IPPS)

Physician Group Practices

- For the purposes of BPCI, we define a physician group practice with the following requirements:
  - A unique EIN/TIN for the PGP. Based off of the fluid and potential multiplicative nature of the National Provider Identifier (NPI), a group NPI is insufficient to identify a unique 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

BPCI Phase 1

- Following the April 2014 submission, new participants are selected for Phase 1
- Selection is based on CMS' review and acceptance of proposed care redesign plans and program integrity screening.
- Phase 1 represents the initial period of participant preparation for implementation and assumption of financial risk
- Phase 1 participation provides:
  - Monthly beneficiary-level claims data for episodes of care
  - Engagement in a variety of learning activities with other BPCI Phase 1 and Phase 2 participants
  - Target pricing information to inform assessment of opportunities under BPCI

BPCI Phase 2

- Phase 2 is the risk-bearing period
- 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
- Agreements allow awardees to:
  - Bear financial risk for the model
  - 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 and 3, and for specified gainsharing, incentive payment, patient engagement incentive, and professional services fee arrangements in connection with BPCI Model 4, except as otherwise provided in a BPCI Awardee Agreement with CMS.
  - Waivers of certain Medicare payment policies are also available in Phase 2 of BPCI Models 2 and 3.

Episode Payment

Target Price (Models 2 and 3) and Bundled Payment Amount (Model 4) Calculations

- The episode cost to Medicare is calculated for each episode for each Episode Initiator using three years of historical data (July 1, 2009 – June 30, 2012)
- Claims data are used to build episodes based on the included and excluded services for individual beneficiaries.
  - If a minimum threshold of historical data is not available for a particular Episode Initiator for an episode, regional data are used to supplement the Episode Initiator's historical data to calculate the episode cost
- All episodes costs are trended to 2012 using national, episode-specific growth rates so that CMS can determine the cost of the episode in 2012 dollars
- CMS then trends the 2012 episode cost to the participation year, and applies a discount that results in the target price or bundled payment amount

Models 2 and 3 Payment Reconciliation

- The total Medicare spending for included services for an eligible beneficiary during the length of the episode is compared to a predetermined bundled payment amount (the target price) following the conclusion of the episode
- Determines the payments to the Awardee, the risk-bearing organization
  - If the actual spending is less than the target price, the Awardee receives the difference from CMS
  - If the actual spending exceeds the bundled payment amount, the Awardee is responsible for paying the difference to CMS

Model 4 Payment

- Upon submission of the NOA, hospitals are given a $500 payment and receive the balance of the prospectively established bundled payment amount when the hospital claim is processed
- The Model 4 hospital is also paid indirect medical education (IME), disproportionate share hospital (DSH), outlier, and capital payments as usual under fee-for-service (FFS)
- Physicians and nonphysician practitioners submit “no-pay” claims to Medicare for the services they furnish during the episode. The Episode Initiator is responsible for paying physicians and nonphysician practitioners from the bundled payment amount for the services they furnish during the episode, unless they choose to opt out of this payment methodology and instead receive payment from CMS under the Medicare FFS payment rules
- If any Medicare FFS claims are paid by CMS for services included in the episode as part of the initial inpatient stay or any related readmissions, the Awardee is responsible for repaying those amounts to CMS
- Beneficiary coinsurance and deductibles are affected by the Model 4 payment methodology.

Evaluation and Monitoring

- CMS intends to monitor and evaluate numerous aspects of the models, including:
  - structural and organizational characteristics
  - patient case-mix
  - clinical care and patient safety
  - patient experience
  - Utilization and cost

Evaluation and Monitoring (continued)

- CMS' evaluation and monitoring activities may include:
  - Interviews, surveys, and focus groups with various stakeholders including beneficiaries, family members caregivers, providers, and participants' employees
  - Review and abstractions of charts, medical records, and other data from providers and participants' employees and contractors
  - Site visits

- Participants are required to collect a subset of measures included in the BPCI Continuity Assessment Record and Evaluation (B-CARE) tool to evaluate beneficiary condition at discharge from the hospital

- CMS also monitors utilization and compliance with the agreements, 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 Awardees 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).

Winter Open Period Additions Recap

- Additions that may be possible:
  - New **episodes** added to existing single awardees, awardee conveners, designated awardees, or designated awardee conveners
  - New **Episode Initiators** added to existing single awardees (awardee type would change), awardee conveners, designated awardees (awardee type would change), or designated awardee conveners.
  - New **Awardees**, **Awardee Conveners**, **Designated Awardees, Designated Awardee Conveners,** or **Facilitator Conveners**

- Can new hospitals or post-acute providers join BPCI independently, without working with an existing convener?
  - Answer: Yes
- Can new conveners join BPCI?
  - Answer: Yes
- If I am an Awardee Convener do I need to submit with an episode initiator as well?
  - Answer: Yes, you need at least one episode initiator
- If I am a Facilitator Convener, do I need to submit to participate with a Designated Awardee or Designated Awardee Convener?
  - Answer: Yes.

Winter Open Period Documents

- Interested organizations must submit an intake form and accompanying spreadsheet found at: http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html, under "New Awardees."
- Background documents are also available at: http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html.
- CMS will review information provided and screen organizations for suitability for participation in Models 2, 3, and 4
- All forms are due on April 18, 2014
- Submissions will only be processed for consideration if both the intake form (Word document) and the accompanying intake spreadsheet (Excel file) are submitted to the BPCI inbox at BundledPayments@cms.hhs.gov by the deadline. Ensure that you include the organization's name in the files' names.

Intake Form

- **The intake form** containing several narrative questions, which must be completed by the organization that is requesting to participate in BPCI. For submission to CMS, replace 'NewParticipantName' in the file name with the name of the organization of that is submitting the request for participation. This organization would be the proposed Single Awardee, Awardee Convener, or Facilitator Convener.
- The intake forms attached to this document are separated by role for Single Awardees, Awardee Conveners, and Facilitator Conveners. Only complete the questions for the submitting organization's intended role.
- ***Single Awardees respond to the questions starting on page 4.***
- ***Awardee Conveners respond to the questions starting on page 6.***
- ***Facilitator Conveners respond to the questions starting on page 8.***

Accompanying Spreadsheet

- The **intake spreadsheet** on which the participants must list each proposed new Awardee, Convener, Episode Initiator, and episode.
- Instructions on completing the spreadsheet are provided in that intake spreadsheet on Tab 1, titled, “Instructions.”
- If you are unsure of your submitter type, refer to the Background Model Documents and instructions tab.
- Be sure to correctly enter information and pay careful attention to not enter duplicate NPIs.

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. Phase 1 of BPCI will end at this time

Winter 2014 Open Period Timeline for Current Participants

February 14th

- Winter Open Period 2014 Intake Forms for addition of new episodes and/or Episode Initiators (reflected on an intake form and intake spreadsheet).

April 18th

- Organizations submit request to add new episodes and/or Episode Initiators (reflected on an intake form and intake spreadsheet).

Summer-Fall 2014

- **July 2014**
  - New episodes and Episode Initiators will be added to Phase 1 following CMS' preliminary review. At this time, these new episodes and Episode Initiators will be included in ongoing monthly data feeds received by Phase 1 participants.
  - In some scenarios, new entities may be required to submit Data Use Agreements (DUAs) or DUA signature addenda. If this is the case, CMMI will contact you with further information.
- **September 2014**
  - CMS will notify awardees of the outcome of CMS' full consideration of proposed new Episode Initiators for participation in Phase 2.
  - Where applicable, CMS will offer the opportunity to amend awardee agreements or sign new awardee agreements for inclusion of these Episode Initiators in Phase 2.
  - CMS will distribute episode packets and historical data files to allow replication of target prices for new episodes and Episode Initiators that are offered participation in Phase 2.

Winter 2014 Open Period Timeline for Current Participants (continued)

November

- Awardees must commit to entering Phase 2 for new episodes and/or Episode Initiators by amending an existing awardee agreement or signing a new one.

January

- All BPCI episodes must begin Phase 2. Phase 1 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**.

Open Period Documents can be found at

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