Bundled Payments for Care Improvement Initiative: Model 1 Open Period Model Parameters

Background

CMS is committed to achieving better health, better care, and lower costs through continuous improvement for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. To this end, the Center for Medicare and Medicaid Innovation is testing four episode payment models under the Bundled Payments for Care Improvement initiative. Testing of Model 1 began in April 2013.

As described in the *Federal Register* notice CMS-5504-N3, the Center for Medicare and Medicaid Innovation is announcing an open period for additional organizations to be considered for participation in Model 1 of the Bundled Payments for Care Improvement initiative.

Description of Model Components: Retrospective payment model for an acute inpatient hospital stay

The Model 1 episode of care is the acute inpatient hospital stay for all Medicare fee-for-service (FFS) beneficiaries admitted to an awardee hospital for any clinical condition. The episode includes all Part A services furnished to included beneficiaries during the hospital stay, as would typically be included in an MS-DRG payment. Under this model, awardees may be allowed to share gains from improved care among participating providers, physicians, and practitioners.

Awardees must accept a discount from the usual Part A hospital inpatient payments. This discount will be taken off the base operating MS-DRG (calculated as the wage adjusted standardized amount incorporating any transfer adjustment or new technology add-on payments). The discount will be phased in as shown in the table below. Claims for all inpatient hospital stays will continue to be processed under existing Inpatient Prospective Payment System (IPPS) payment rules, and CMS will reduce the IPPS payment by the discount as claims are paid.

CMS will monitor care provided to include beneficiaries during the episode and a 30 day post-episode period. Expected aggregate Medicare Part A and Part B FFS expenditures for these periods will be calculated using a historical baseline and a trending factor, and a risk threshold will be set to account for random variation. Awardees will be expected to pay Medicare for expenditures above this threshold.

Model Parameters	
Entities eligible for consideration:	• Acute care hospitals paid under the IPPS. • Facilitator conveners of acute care hospitals paid under the IPPS.
Episode definition	• *Criteria for beneficiary inclusion in episode*: Admission to an acute care hospital for a claim paid under the IPPS under any MS-DRG • Types of services included in bundle: Part A inpatient hospital services • *End of Episode:* Acute care hospital discharge
Payment from CMS to providers:	• *Acute care hospital*: Traditional FFS with a predetermined discount included in prospective payment. • *Physician*: Traditional FFS.

Model Parameters	
Expected discount provided to Medicare (on all Part A allowed charges):	• Year 1: 0% for start date through month 6; 0.5% for months 7-12 • Year 2: 1% • Year 3: 2%

Beneficiary Inclusion

The Bundled Payments for Care Improvement efforts will be targeted to all Medicare FFS beneficiaries with Part A coverage, with the exception of those beneficiaries with end-stage renal disease (ESRD) and those for whom Medicare is not the primary payer.

Eligible Candidates

Model 1 is currently open to acute care hospitals paid under the IPPS, as well as conveners of acute care hospitals paid under the IPPS. Convening organizations may participate as facilitator conveners and would not have an agreement with CMS, bear financial risk, or receive any payment from CMS. The facilitator convener could share in the financial risk or cost savings from increased efficiencies experienced by participating hospitals through contracts between the convener and the hospital(s). No financial arrangements made among providers and other entities (including States) in connection with this program can be used to increase federal Medicaid matching funds.

An organization convening participating hospitals in a facilitator role must specify the participating hospitals in the Model 1 Open Period Information Intake form and accompanying spreadsheet. In all cases, the acute care hospital must agree to accept financial responsibility to Medicare for the Model.

Candidates may participate in multiple models of this initiative, and they may simultaneously participate in a shared savings initiative (as BPCI is not a shared savings program with Medicare).

Gainsharing Arrangements

Gainsharing may be a component of Model 1. These arrangements will consist of the hospital distributing gainsharing payments to physician(s) and/or other practitioners. These payments will represent a share of the gains resulting from collaborative efforts to improve quality and efficiency.

- Waiver of Statutory Requirements

More information on waivers that may be available for the testing of this model will be available after submission of the Model 1 Open Period Informational Intake form.

- Gainsharing Program Requirements

Gainsharing arrangements must meet the following criteria.

- Gainsharing must support care redesign to achieve improved quality and patient experience, and anticipated cost savings.

- Total incentive payments to an individual physician or nonphysician practitioner must be limited to 50 percent of the aggregate annual Medicare payment amount determined under the

Physician Fee Schedule paid to the physician or nonphysician practitioner for furnishing services to Model 1 beneficiaries.

- Incentive Payments must not be based on the volume or value of referrals, or business otherwise generated, between a hospital and a physician or nonphysician practitioner.
- Physician or nonphysician practitioner participation in gainsharing must be voluntary.
- Individual physicians and nonphysician practitioners must meet quality thresholds and engage in quality improvement to be eligible to participate in gainsharing.

Length of Agreement

Awardee agreements will include a performance period of 3 years. The start of the period of performance may be as early as the first quarter of CY 2014 for new awardees in Model 1.

Termination of Bundled Payments for Care Improvement Agreements

While we do not anticipate this circumstance, CMS reserves the right to modify or terminate the initiative in whole or in part, at any time prior to the end of the three year initiative if it determines that continuing the project is no longer in the public interest or for any reason determined by CMS. CMS will promptly notify the awardee in writing of the determination, the reasons for such termination, and the effective termination date. Awardees may also terminate the agreement at any time by providing CMS with prior notice.

Evaluation and Monitoring

All awardees will be required to comply fully with CMS and its contractor(s)' requests for monitoring and evaluation, including providing data, being available for site visits, and participating in surveys and interviews. Awardees will be expected to provide CMS with ongoing monitoring information by tracking and reporting various information. Awardees will be expected to collect a subset of measures from the Continuity Assessment Record and Evaluation (CARE) tool to evaluate beneficiary condition at discharge from the hospital.

Awardees are required to have received the full IPPS and OPPS annual payment update for reporting quality measures to CMS (through www.qualitynet.org) since at least FY 2008 and CY 2009, respectively. Hospitals and physicians are expected to maintain or improve their overall quality performance on the measures reported through Hospital IQR and Hospital Outpatient Quality Data Reporting Program (HOP QDRP) and ensure that the percentage of physicians participating in the PQRS at the Model 1 hospital is maintained or improved during the effective period of the agreement as compared to the participation rate in the year prior to the start.

Beneficiary Protections

Beneficiaries in traditional FFS Medicare are entitled to exercise their freedom of choice to obtain health services from health care providers and entities. Nothing in this initiative should be construed to limit that choice, and medically necessary services must be furnished to Model 1 beneficiaries in accordance with applicable laws, regulations and guidance. Awardees must agree to notify beneficiaries of their participation in the initiative upon admission to a Model 1 hospital.