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

<table>
<thead>
<tr>
<th></th>
<th>Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care</th>
<th>Model 3: Retrospective Post-Acute Care Only</th>
<th>Model 4: Prospective Acute Care Hospital Stay Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>Selected DRGs +post-acute period</td>
<td>Post acute only for selected DRGs</td>
<td>Selected DRGs</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td>Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>Part A and B services during the post-acute period and readmissions</td>
<td>All Part A and B services (hospital, physician) and readmissions</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
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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


Phase I: 42
Phase II: 127
Model 2 Illustrative Timeline

- **January 7:** Patient admitted to Model 2 hospital
- **February 8:** Patient admitted to second hospital for complication
- **February 11:** Patient discharged from second hospital
- **January 10:** Patient discharged from hospital for selected MS-DRG
- **February 10:** 30 day episode is completed
- **May:** CMS aggregates claims paid on behalf of beneficiary, reconciles to target price
• 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

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

Submission Types: Description of Roles

- **Risk-Bearing**
  - Single Awardee (Episode Initiator)
  - Awardee Convener
  - Designated Awardee (Episode Initiator)
  - Designated Awardee Convener
  - Episode Initiator

- **Non Risk-Bearing**
  - Facilitator Convener
  - Episode Initiator
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
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.
• **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
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**

<table>
<thead>
<tr>
<th>Participant Type</th>
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</thead>
<tbody>
<tr>
<td>Facilitator Convener</td>
<td>9</td>
</tr>
<tr>
<td>Single Awardee</td>
<td>27</td>
</tr>
<tr>
<td>Designated Awardee Convener (DAC)</td>
<td>3</td>
</tr>
<tr>
<td>Awardee Convener (AC)</td>
<td>38</td>
</tr>
<tr>
<td>Episode Initiators (under DAC or AC)*</td>
<td>255</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>165</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>63</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>86</td>
</tr>
<tr>
<td>Physician Group Practice</td>
<td>8</td>
</tr>
<tr>
<td>Long term care hospital</td>
<td>1</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>1</td>
</tr>
</tbody>
</table>

Physician engagement continues to grow.
# BPCI Phases

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
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<tbody>
<tr>
<td>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</td>
<td>Phase 2 is the risk-bearing period.</td>
</tr>
<tr>
<td>Selection is based on CMS’ review and acceptance of proposed care redesign plans and program integrity screening.</td>
<td>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.</td>
</tr>
<tr>
<td>Participants receive:</td>
<td>Agreements allow awardees to:</td>
</tr>
<tr>
<td>- Monthly beneficiary-level claims data</td>
<td>- Bear financial risk for the model</td>
</tr>
<tr>
<td>- Engagement in variety of learning activities with other BPCI Phase 1 and Phase 2 participants.</td>
<td>- May utilize applicable fraud and abuse waivers and payment policy waivers (i.e. gainsharing)</td>
</tr>
<tr>
<td>- Target pricing information to inform assessments of opportunities under BPCI.</td>
<td></td>
</tr>
<tr>
<td>- Assessment of opportunities under BPCI.</td>
<td></td>
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</tbody>
</table>
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.
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.
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:

• Submissions are due to CMS for consideration by April 18, 2014 by email via: [BundledPayments@cms.hhs.gov](mailto:BundledPayments@cms.hhs.gov).
Winter Open Period 2014 Intake Forms for new participants posted

Organizations submit request to participate in BPCI

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/