

Bundled Payments for Care Improvement Initiative (BPCI) Background on Model 4 for Prospective Participants

BPCI is testing the effects of innovative episode-based payment approaches on patient experience of care, outcomes, and cost of care for Medicare fee-for-service (FFS) beneficiaries. Episode-based payment bundles Medicare payments for services related to a particular clinical condition for a period of time across multiple providers and suppliers. The goal of BPCI is to align payment incentives among providers and suppliers with the health care experience of the Medicare beneficiary who is undergoing a period of treatment for a clinical condition.

To test episode-based payment for a variety of clinical conditions, CMS constructed 48 different episodes in BPCI, which can be found on the Innovation Center website at <http://innovation.cms.gov/initiatives/Bundled-Payments/index.html>. Each episode includes a family of related MS-DRGs, and episodes are linked to an acute care hospital inpatient stay for one of the included MS-DRGs. The hospital admission that triggers or initiates a beneficiary's episode is often referred to as the anchor MS-DRG. Episodes are defined broadly with few exceptions, and include most services covered under Medicare Part A and Part B that are provided to a beneficiary throughout the duration of the episode. 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>.

Model 4: Prospective Acute Care Hospital Stay

In Model 4, the 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. The 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. Model 4 Episode Initiators can participate in any number of the 48 different 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. 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

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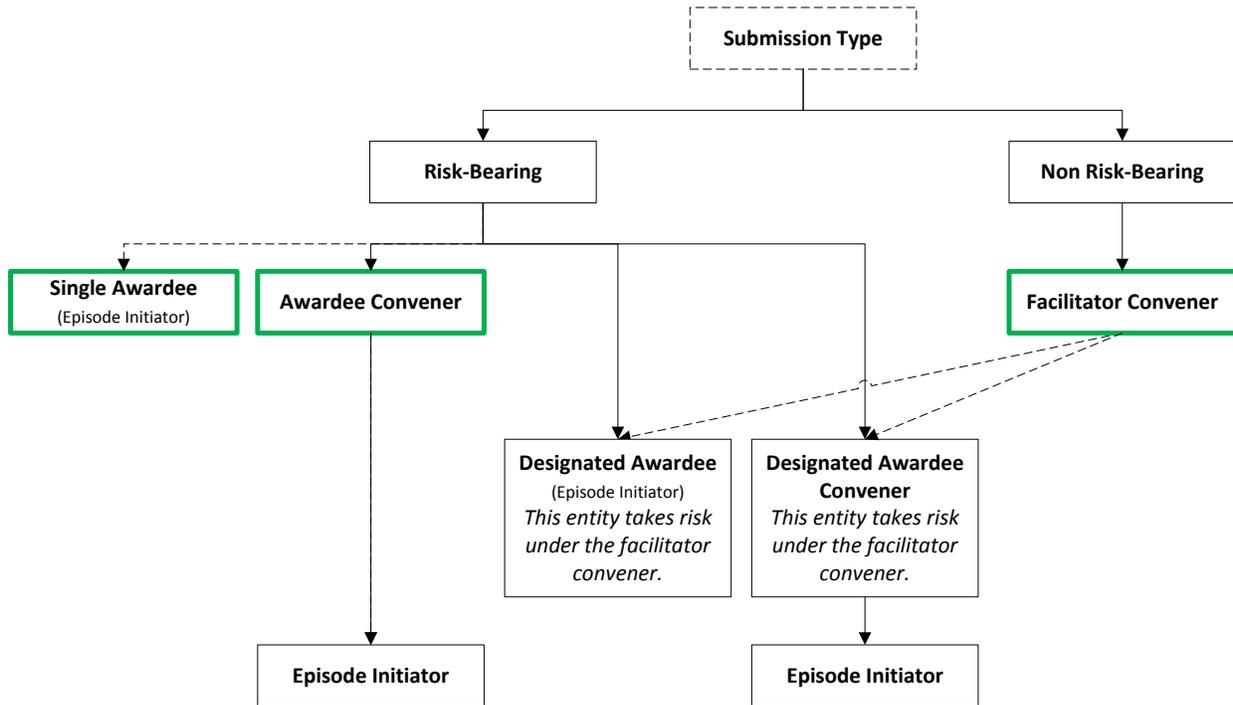
repaying those amounts to CMS. Beneficiary coinsurance and deductibles are affected by the Model 4 payment methodology.

There are different ways to participate in BPCI. Participants may enter into agreements with CMS to bear financial risk for the model, and these participants are called Awardees. An Awardee may be a single Medicare provider or a convening organization that coordinates multiple health care providers' participation in BPCI. Convening organizations may also participate as non-risk bearing organizations that coordinate the BPCI activities of multiple Awardees working with that convener. Such convening organizations do not enter into agreements with CMS.

- Single Awardees participate in BPCI without the involvement of a convening entity. Single Awardees are Medicare providers or suppliers that enter into agreements with CMS, bear financial risk for the model, and provide services in the episodes.
- Awardee Conveners participate in BPCI as a convening organization that brings together multiple health care providers. Awardee Conveners enter into agreements with CMS and bear financial risk for the model, including all Episode Initiators (acute care hospitals under Model 4) that they convene. Awardee Conveners may also be Medicare providers or suppliers that provide services in the episodes.
- Facilitator Conveners participate in BPCI as a convening organization that brings together multiple health care providers. Facilitator Conveners do not enter agreements with CMS, bear financial risk, or receive any payments from CMS. Facilitator Conveners participate in BPCI along with those Designated Awardees and Designated Awardee Conveners that they convene.
 - Designated Awardees are Medicare providers or suppliers that enter into an agreement with CMS to bear financial risk for the model and provide services in the episodes. Designated Awardees have the same role as Single Awardees, except they participate in BPCI in collaboration with a Facilitator Convener.
 - Designated Awardee Conveners enter into an agreement with CMS to bear financial risk for the model. They may be Medicare providers or suppliers that provide services in the episodes. Designated Awardee Conveners have the same role as Awardee Conveners, except they participate in BPCI in collaboration with a Facilitator Convener.
- Episode Initiators are acute care hospitals (ACH) in Model 4. Episode Initiators participate in BPCI either as an Awardee or in collaboration with an Awardee Convener or Designated Awardee Convener.

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High Level Schematic of Roles



Phases of Participation

Model 4 has two phases of participation. Participants are selected for Phase 1 following CMS' review and acceptance of proposed care redesign plans and preliminary program integrity screening. Phase 1 is the initial period of participation in which participants prepare for implementation and assumption of financial risk. To support their preparation, CMS provides Phase 1 participants with monthly beneficiary-level claims data for episodes of care. Phase 1 participants also engage in a variety of learning activities with other BPCI Phase 1 and Phase 2 participants and receive target pricing information to inform their assessment of opportunities under BPCI. 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.

Payments & Reconciliation

Episode Initiators in Model 4 receive a single, prospectively determined bundled payment amount from Medicare for an episode instead of an IPPS payment. The episodes are defined by anchor MS-DRGs and the Part A and B exclusions lists can be found on the Innovation Center website at <http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html>. The prospective bundled payment amount includes both the MS-DRG payment for the hospital and a fixed amount for the Part B services anticipated to be rendered during the admission. Separate payment for physicians and other practitioners' professional services performed during the inpatient hospital stay is not made by Medicare. Physicians and other practitioners' claims are processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of

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physicians and other practitioners. Model 4 hospitals receive periodic reports about no-pay claims processed for services furnished by physicians and nonphysician practitioners.

Model 4 eligible beneficiaries must have Medicare FFS, be eligible for Part A, enrolled in Part B coverage and receive inpatient hospital care at a Model 4 Episode Initiator. At the time of admission to the Episode Initiator, eligible beneficiaries must either have one lifetime reserve day or one day of utilization that is also a day of entitlement remaining. Beneficiaries with End Stage Renal Disease; enrolled in managed care plans (for example, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations); and covered under the United Mine Workers are not eligible for Model 4. Medicare must be the primary payer.

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 bundled payment amount. Model 4 prospective payments may be updated on a quarterly basis to take into account payment policy changes made under the Physician Fee Schedule (PFS) and IPPS. The calculation of bundled payment amounts excludes IME, DSH, outlier, and capital payments.

In Model 4, episode costs are discounted by 3 percent for episodes that do not include MS-DRGs included in the Medicare Acute Care Episode (ACE) Demonstration and 3.25 percent for episodes that include MS-DRGs that were included in the ACE Demonstration. Model 4 episodes including MS-DRGs that were also included in the ACE Demonstration are listed in the table below.

BPCI Episodes Containing MS-DRGs Included in the ACE Demonstration		
Episode Name	MS-DRGs Included in Episode	Model 4 Episode Discount Amount
Cardiac valve	216, 217, 218, 219, 220, 221	3.25%
Coronary artery bypass graft	231, 232, 233, 234, 235, 236	3.25%
Double joint replacement of the lower extremity	461, 462	3.25%
Major joint replacement of the lower extremity	469, 470	3.25%
Other knee procedures	485, 486, 487, 488, 489	3.25%

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BPCI Episodes Containing MS-DRGs Included in the ACE Demonstration		
Episode Name	MS-DRGs Included in Episode	Model 4 Episode Discount Amount
Pacemaker	242, 243, 244	3.25%
Pacemaker device replacement or revision	258, 259, 260, 261, 262	3.25%
Percutaneous coronary intervention	246, 247, 248, 249, 250, 251	3.25%
Revision of the hip or knee	466, 467, 468	3.25%

When a readmission occurs for a related MS-DRG within 30 days of discharge to the same Model 4 hospital at which the anchor hospitalization took place, the claim for this readmission is not paid. However, CMS pays IME, DSH, outlier, and capital payments associated with the stay under the regular FFS rules. When a readmission occurs for a related MS-DRG within 30 days of discharge to a different hospital, all associated claims (both inpatient and physician) are paid by Medicare as usual. During payment reconciliation, the Awardee is financially responsible for the total payments made during that readmission. Model 4 hospitals do not directly pay acute care hospitals at which readmissions occur. Readmissions for Model 4 include admissions to IPPS hospitals, Maryland hospitals, cancer hospitals, children’s hospitals, inpatient psychiatric facilities, and critical access hospitals.

CMS monitors Part A and Part B spending for beneficiaries in Model 4 during the 30 days following the episode period to determine if spending in the post-episode period increases due to cost-shifting or other reasons. Awardees are responsible for paying CMS any excess amount that exceeds a threshold of spending in the post-episode period.

Physicians and nonphysician practitioners are able to decline participation in Model 4 by submitting a HCPCS modifier on the relevant claim line and be paid regular FFS for Part B services rendered during an inpatient stay for a Model 4 episode. For every Medicare payment made to a physician or nonphysician practitioner who declines Model 4 participation, that amount of money is drawn back from the Model 4 Awardee during payment reconciliation. Model 4 hospitals receive periodic reports about Medicare payments for claims submitted by physicians and nonphysician practitioners who have declined participation.

Evaluation and Monitoring

Participants are required to comply fully with CMS’ requests that support monitoring and evaluation of BPCI. CMS intends to measure quality metric domains, including structural and organizational characteristics; patient case-mix; clinical care and patient safety; patient experience; and utilization and cost. These include, but are not limited to, measures such as complication, mortality, and readmission

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rates. Participants are required to provide CMS with ongoing monitoring information by tracking and reporting various data.

CMS' evaluation and monitoring activities may include, but are not limited to, the following:

- Interviews, surveys, and focus groups with beneficiaries, beneficiary proxies, family members and caregivers;
- Interviews, surveys, and focus groups with health care providers and participants' employees and contractors;
- Review and abstractions of charts, medical records, and other data from health care providers and participants' employees and contractors; and
- 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.

BPCI Agreements

Agreements signed by Awardees cover three years of participation in Phase 2 of BPCI, which will begin on January 1, 2015 for new participants entering BPCI Model 4 through the Winter 2014 Open Period. While we do not anticipate this circumstance, CMS reserves the right to terminate an agreement at any time for reasons specified in the agreement, including but not limited to lack of funds to support BPCI Model 4 or termination of BPCI Model 4 pursuant to Section 1115A(b)(3)(B) of the Social Security Act. Awardees may also terminate their agreements with CMS at any time for any reason after providing notice to CMS.

Fraud and Abuse Waivers

Waivers of certain fraud and abuse authorities are available in Phase 2 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 Model 4 Awardee's agreement with CMS.

Summary Table of Model 4:

Model 4: Prospective Acute Care Hospital Stay	
Examples of organizations that may participate in Model 4:	<ul style="list-style-type: none"> • Acute care hospitals • Health systems • Physician hospital organizations • Conveners of acute care hospitals
Entities that can initiate episodes in Model 4:	<ul style="list-style-type: none"> • Acute care hospitals paid under the Inpatient Prospective Payment System (IPPS)

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Model 4: Prospective Acute Care Hospital Stay	
Criteria for beneficiary inclusion in episode:	<ul style="list-style-type: none"> • The beneficiary is eligible for Part A and enrolled in Part B • Receives inpatient hospital care at an Episode Initiator, and on the day of admission, has either one lifetime reserve day or one day of utilization that is also a day of entitlement remaining • The beneficiary must not have End Stage Renal Disease • The beneficiary must not be enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations) • The beneficiary must not be covered under United Mine Workers; and • Medicare must be the primary payer
Start of episode:	<ul style="list-style-type: none"> • Acute care hospital admission by Episode Initiator for included clinical conditions (identified via anchor MS-DRG).
End of episode:	<ul style="list-style-type: none"> • 30 days after acute care hospital discharge for anchor MS-DRG (following discharge, only related readmissions are included in the episode for the 30 day period)
Types of services included in Bundle, which include broad clinical episode categories:	<ul style="list-style-type: none"> • Physicians' services for inpatient hospital care • Inpatient hospital services • Inpatient hospital readmission services
Payment from CMS to Episode Initiators:	<ul style="list-style-type: none"> • Single prospectively determined bundled payment
Discount provided to Medicare:	<ul style="list-style-type: none"> • 3% discount for episodes that do not include MS-DRGs included in the ACE Demonstration • 3.25% discount for episodes that include MS-DRGs that were included in the ACE Demonstration
Reconciliation:	<ul style="list-style-type: none"> • Medicare pays a predetermined bundled payment amount to the Episode Initiator, which is responsible for paying physicians and nonphysician practitioners that furnished services to the beneficiary during the episode.