

Bundled Payments for Care Improvement Initiative (BPCI) Background on Model 2 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 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 2: Retrospective Acute Care Hospital Stay Plus Post-Acute Care

In Model 2, the 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, after which the total payment for a beneficiary's episode is reconciled against a bundled payment amount (the target price) predetermined by CMS. The target price includes the inpatient hospital stay for the anchor MS-DRG and all related care covered under Medicare Part A and Part B within 30, 60, or 90 days following discharge from the acute care hospital. Participants choose to participate in one or more of the 48 episodes, and they must select the length of each episode (30, 60, or 90 days following discharge). Each episode is 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.

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 supplier 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

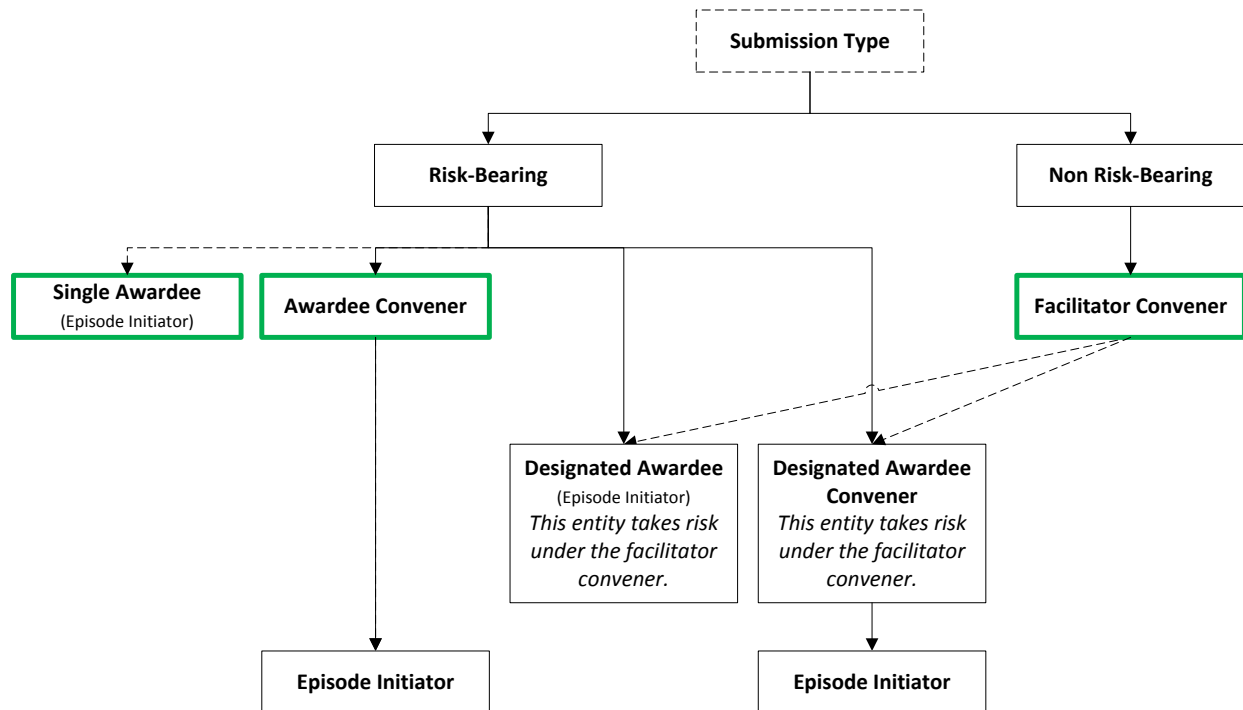
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financial risk for the model, including all Episode Initiators (acute care hospitals and/or physician group practices under Model 2) that they convene. Awardee Conveners may also be Medicare providers or suppliers that provide services in the episodes.

- 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) or physician group practices (PGP). When an ACH is an Episode Initiator, an episode is initiated when an eligible beneficiary is admitted as an inpatient to the ACH for one of the included MS-DRGs. When a PGP is an Episode Initiator, an episode is initiated when an eligible beneficiary is admitted as an inpatient to any ACH for one of the included MS-DRGs and a physician in the PGP is the attending or operating physician for the inpatient stay. A physician will be considered to be in the PGP if he/she has reassigned the right to receive Medicare payment to the PGP. 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 2 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. BPCI currently has hundreds of organizations participating in Phase 1 of Model 2, and many organizations participating in Phase 2 for certain episodes as well. 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

Medicare providers and suppliers continue to receive fee-for-service (FFS) payments for services they provide during an episode. Episodes include a range of Part A and Part B covered services, durable medical equipment (DME), and Part B drugs for eligible beneficiaries. 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>. Eligible beneficiaries must be eligible for Medicare Part A and enrolled in Part B. To be eligible, beneficiaries must not have End Stage Renal Disease; not be enrolled in any managed care plan (for example,

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Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations); and not be covered under United Mine Workers. Medicare must be the primary payer.

The total Medicare spending for included items and 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. This retrospective reconciliation compares the total dollar amount of Medicare FFS expenditures for items and services (collectively referred to as “Aggregate FFS Payment” or “AFP”) furnished by the Awardee, the Episode Initiator, and other providers and suppliers during an episode with the target price. The calculation of target prices and reconciliation excludes Indirect Medical Education (IME), Disproportionate Share Hospital (DSH), and capital payments in Model 2. This retrospective reconciliation determines whether amounts are owed to the Awardee or to CMS. If the AFP is less than the target price, the Awardee receives the difference from CMS. If the AFP exceeds the target price, the Awardee is responsible for paying the difference to CMS because the Awardee bears the risk of exceeding the target price.

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. In Model 2, 30 day or 60 day episode costs are discounted by 3 percent and 90 day episode costs are discounted by 2 percent.

Awardees may choose among three levels of reconciliation risk, or Risk Tracks, for each episode. Awardee may opt to bear risk up to the 75th, 95th, or 99th percentile. Awardees bear 100 percent of the risk up to the risk track threshold and 20 percent of payments above the threshold for a given risk track. Risk tracks may be changed quarterly.

CMS monitors Part A and Part B spending for beneficiaries in Model 2 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.

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

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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 2 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 2 or termination of BPCI Model 2 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, and patient engagement incentive arrangements in connection with BPCI Model 2, except as otherwise provided in a BPCI Model 2 Awardee's agreement with CMS.

Medicare Payment Policy Waivers

CMS has issued waivers of certain Medicare payment policies in connection with BPCI Model 2. For activities or services to qualify for a waiver, all of the terms of the applicable waiver as set forth in the agreement between an Awardee and CMS must be satisfied. As follows is a general summary of the waivers:

3-Day Hospital Stay Requirement for SNF Payment

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.

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Post-Discharge Home Visit

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).

Telehealth

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 2 episode, as long as the services are furnished in accordance with all other Medicare coverage and payment criteria.

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Summary Table of Model 2:

Model 2: Retrospective Acute Care Hospital Stay Plus Post-Acute Care	
Examples of organizations that may participate in Model 2	<ul style="list-style-type: none"> • Acute care hospitals • Health systems • Physician hospital organizations • Physician group practices • Conveners of health care providers
Entities that can initiate episodes in Model 2	<ul style="list-style-type: none"> • Acute care hospitals • Physician group practices
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 • 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 MS-DRG)
End of episode:	<ul style="list-style-type: none"> • 30, 60, or 90 days after acute care hospital discharge
Types of services included in Bundle, which include broad episode categories	<ul style="list-style-type: none"> • Physicians' services • Inpatient hospital services • Inpatient hospital readmission services • Long term care hospital services (LTCH) • Inpatient rehabilitation facility services (IRF) • Skilled nursing facility services (SNF) • Home health agency services (HHA) • Hospital outpatient services • Independent outpatient therapy services • Clinical laboratory services • Durable medical equipment • Part B drugs
Payment from CMS to Providers and Suppliers:	<ul style="list-style-type: none"> • Traditional FFS payments
Discount provided to Medicare are defined by episode length:	<ul style="list-style-type: none"> • 3% discount for episodes of 30 or 60 days in length • 2% discount for episodes 90 days in length
Reconciliation	<ul style="list-style-type: none"> • Medicare pays the Awardee the difference between the target price and the actual cost of care for an episode if the actual cost of care is less than the target price. If the actual cost of care exceeds the target price, the Awardee pays Medicare the difference between the target price and actual spending.