Bundled Payments for Care Improvement: Overview and Basic Parameters

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CMMI
Centers for Medicare and Medicaid Services
Innovation at CMS

• Center for Medicare & Medicaid Innovation (Innovation Center)
  ▪ Established by section 1115A of the Social Security Act (as added by Section 3021 of the Affordable Care Act)
  ▪ Created for purpose of developing and testing innovative health care payment and service delivery models within Medicare, Medicaid, and CHIP programs nationwide

• Innovation Center priorities
  ▪ Testing new payment and service delivery models
  ▪ Evaluating results and advancing best practices
  ▪ Engaging a broad range of stakeholders to develop additional models for testing

• Goals of Innovation Center models include better care for patients, better health for communities, and lower costs
Delivery system and payment transformation

**Historical State –**

- Producer-Centered
- Volume Driven
- Unsustainable
- Fragmented Care
- FFS Payment Systems

**Ideal Future State –**

- People-Centered
- Outcomes Driven
- Sustainable
- Coordinated Care

**New Payment Systems and Policies (and more)**

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt
- Data Transparency
CMS Innovations Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

Primary Care Transformation
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation
- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

Initiatives Focused on the Medicaid Population
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents
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
# Bundled Payments Models

<table>
<thead>
<tr>
<th>Model 1: Retrospective Acute-Care Hospital Stay Only</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>Episode</td>
<td>Episode</td>
<td>Episode</td>
<td>Episode</td>
</tr>
<tr>
<td>All MS-DRGs</td>
<td>Selected DRGs + post-acute period</td>
<td>Post-acute only for selected DRGs</td>
<td>Selected DRGs</td>
</tr>
<tr>
<td>Services included in the bundle</td>
<td>Services</td>
<td>Services</td>
<td>Services</td>
</tr>
<tr>
<td>Part A services during the inpatient stay</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>Part A and B services (hospital, physician) and readmissions</td>
</tr>
<tr>
<td>Payment</td>
<td>Payment</td>
<td>Payment</td>
<td>Payment</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
</table>
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
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.
Rationale for BPCI Episode Parameters

- Broad bundles to strongly incentivize care coordination and care for the whole beneficiary, despite the specific clinical episode
- Allow flexibility for providers to select clinical conditions, risk tracks, and episode lengths with greatest opportunity for improvement
- Enable episodes that have a sufficient number 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
# BPCI Models 2-4 Phases

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 offered an agreement by CMS following a comprehensive review and enter into an agreement with CMS.</td>
</tr>
</tbody>
</table>
| Participants receive:  
- Monthly beneficiary-level claims data  
- Engagement in variety of learning activities with other BPCI Phase 1 participants  
- Baseline pricing information to inform assessments of opportunities under BPCI. | Agreements allow awardees to:  
- Bear financial risk for the model  
- Continue receiving monthly beneficiary-level claims data  
- May utilize applicable fraud and abuse waivers and payment policy waivers (i.e. gainsharing) |
## Trigger Clinical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<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>
</tr>
<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>
</table>
Episode Initiators

- Models 2: Acute care hospitals (ACH) and physician group practices (PGPs)
  - 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 right to bill Medicare to the PGP initiate episodes.

- Model 3: Skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), home health agencies (HHAs), PGPs
  - When a PGP is an Episode Initiator, an episode is initiated when a physician in the PGP was the attending or operating physician for the inpatient ACH stay for an eligible beneficiary who is then admitted to or initiates services with a SNF, IRF, LTCH, or HHA within 30 days after the beneficiary has been discharged from that inpatient stay for one of the included MS-DRGs.

- Model 4: ACHs paid under the Inpatient Prospective Payment System (IPPS)
Description of Participant Roles

**Risk-Bearing**

- Single Awardee (Episode Initiator)
- Awardee Convener
  - Designated Awardee
    - (Episode Initiator)
    - *This entity takes risk under the facilitator convener.*
  - Episode Initiator
- Facilitator Convener

**Non Risk-Bearing**

- Designated Awardee Convener
  - *This entity takes risk under the facilitator convener.*
- Episode Initiator
Waivers

- **Fraud and abuse waivers**
  - Waivers of certain fraud and abuse authorities are available in Phase 2 of Models 2-4 for specified gainsharing, incentive payment, and patient engagement incentive arrangements, narrowly crafted based on the model policies and taking into consideration the provisions of the Awardee Agreement.

- **Payment policy waivers**
  - 3-Day Hospital Stay Requirement for SNF Payment (Model 2)
  - Telehealth (Models 2, 3)
  - Post-Discharge Home Visit (Models 2, 3)
## Timeline of Events for Models 2-4: 2013 - present

<table>
<thead>
<tr>
<th>January 2013</th>
<th>October 2013</th>
<th>November 2013</th>
<th>February 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Centers for Medicare &amp; Medicaid Services (CMS) announced the health care organizations selected to participate in Phase 1 of the Bundled Payments for Care Improvement initiative Models 2-4</td>
<td>• Awardees entered into Model 2, 3, or 4 agreements with CMS that, at the Awardee’s choice, became effective on either <strong>October 1, 2013</strong> or <strong>January 1, 2014</strong>, at which point Awardees began the risk-bearing phase for some or all of their episodes</td>
<td>• CMS announced that it would consider the addition of both episodes and/or Episode Initiators to current participants in Bundled Payments for Care Improvement Models 2, 3, and 4</td>
<td>• The Center for Medicare &amp; Medicaid Innovation announced an Open Period for additional organizations to be considered for participation in Models 2-4. In addition, CMS solicited the addition of both episodes and episode initiators to current participants in Bundled Payments for Care Improvement Models 2, 3, and 4</td>
</tr>
</tbody>
</table>
### Timeline for Participation in Phase 2 of BPCI

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fall 2014</strong></td>
<td>- CMS provides baseline data for November 2013 and Winter Open periods</td>
</tr>
<tr>
<td><strong>January 2015</strong></td>
<td>- New Awardees and Episode Initiators may enter Phase 2 by transitioning at least one Clinical Episode to Phase 2</td>
</tr>
<tr>
<td><strong>April 2015</strong></td>
<td>- Awardees and Episode Initiators must enter Phase 2 by transitioning at least one Clinical Episode to Phase 2</td>
</tr>
<tr>
<td><strong>July 2015</strong></td>
<td>- Awardees and Episode Initiators may transition additional Clinical Episodes from Phase 1 to Phase 2</td>
</tr>
<tr>
<td><strong>October 2015</strong></td>
<td>- Awardees and Episode Initiators may transition additional Clinical Episodes from Phase 1 to Phase 2. <strong>Phase 1 ends</strong></td>
</tr>
</tbody>
</table>
Evaluation and Monitoring

- CMS and its contractors will be carrying out Evaluation and Monitoring activities during the course of this project.

- Areas of focus will include, but are not limited to:
  - Monitoring adherence to the terms and conditions of the Agreement,
  - Monitoring for unintended consequences such as cost shifting, inappropriate increases in utilization, problems with access to care, and lower quality, and
  - Evaluation of the success of the model as well as lessons learned applicable to improving the programs or the potential for expansion of the program

- Model participants will be required to comply with and participate in Evaluation and Monitoring activities and data collection efforts
  - It is too early in the program to have meaningful results.
  - Continuous process to improve transparency and communication with all parties involved in program. Opportunities to make adjustments to models mid-steam if warranted.
Questions?

Additional Information can be found at:
http://innovation.cms.gov/initiatives/bundled-payments/
Contact Information

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