

Medicare Bundled Payments for Care Improvement Initiative

The Centers for Medicare & Medicaid Services (CMS) on August 23, 2011 invited providers to apply for participation in a new Bundled Payment Initiation. Under this Bundled Payment initiative, CMS would link payments for multiple services patients receive during an episode of care. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Providers will have significant flexibility in selecting conditions and services to include within the bundle, participating partners within their health care delivery structure, and determining how payments will be allocated among participating providers.

Similar to the shared savings or capitated policies that underpin Accountable Care Organizations (ACOs), episode payment models create a framework that rewards providers for taking accountability for more effective, coordinated and efficient care. However, episode payment models support accountability at the level of an individual patient’s care, rather than at the population level. In addition, the bundled model differs from the ACO in that the payment is typically limited to a defined set of conditions and/or services as opposed to the entire care of the patient, and is in effect for a shorter period of time—the length of the episode. These differences reduce risk and operational complexity for the provider and provides a generally safer environment to explore alternatives to payment than under the current Fee-for-Service (FFS) model.

The current set of bundled payment opportunities being offered by CMS only address acute care conditions; in the future CMS will be requesting applicants to assume bundled payments for chronic care conditions. To be successful under any of these opportunities, applicants will need to redesign how care is delivered among their participating providers to make it more effective and efficient, This would require the development of such enhancements as reengineered care pathways using evidence-based medicine, standardized care using checklists, and care coordination. The bundled payment opportunities currently being offered by CMS also include opportunities for gainsharing among participating providers---another way to increase the efficiency of care delivery. These payment models are primarily directed towards acute hospital settings, Physician-hospital organizations, health systems, post acute care provider settings, and large group practices.

Interested provider entities can apply to CMS to participate under one or more of the following bundled episode payment models:

Model 1---Retrospective Acute Care Hospital Stay Only --- the episode of care would be defined as the inpatient stay in the general acute care hospital. Medicare will pay the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System (IPPS). Medicare will pay physicians separately for their services under the Medicare Physician Fee Schedule without discount. Hospitals and

physicians will be permitted to engage in gain sharing to improve care coordination and efficiency. This model would:

- Include all patients admitted to the participating hospital regardless of their diagnoses (MS-DRG).
- Provide the participating providers with an opportunity to decrease their own internal expenses through the implementation of more efficient services and the increased freedom to employ gain sharing opportunities within their system.
- Expose participating providers to risk of payback of fees received from CMS if combined Part A (discounted) and Part B expenditures for beneficiaries provided care under this model exceeded historic trends.

Model 2---Retrospective Acute Care Hospital Stay and Post Acute Care --- the episode of care would include the inpatient stay and post-acute care and would end, at the applicant's option, either a minimum of 30 or 90 days after discharge. The bundle would include physicians' services, care by one or more post-acute providers (e.g. Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Long Term Care Hospital (LTCH), Home Health Agency), related readmissions, and other services proposed in the episode definition provided by the applicant such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and Part B drugs. This model would:

- Allow the applicant to target the specific patient populations (based upon acute hospital admission diagnoses (MS-DRG) and the providers and supplies to include in the bundled payment.
- Allow all participating providers to receive regular FFS payments throughout the course of the episode.
- Require the applicant to propose a discounted target price for all services included in the bundle based on historic CMS expenditure trends within the geographic area.
- Include a reconciliation of the aggregate traditional FFS payments provided by CMS for the bundled episode with the discounted target price.
 - If FFS payments exceeded the target price, the provider entity would be required to pay back a portion of received fees to CMS.
 - If the FFS payments were less than the target price, the provider entity would receive the difference.

Model 3 --- Retrospective Post Acute Discharge Services Only --- the episode of care would begin at discharge from the inpatient stay and would end no sooner than 30 days after discharge. The bundle would include physicians' services, care by one or more post-acute providers (e.g. Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Long Term Care Hospital (LTCH), Home Health Agency), related readmissions, and other services proposed in the episode definition provided by the applicant such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and Part B drugs. This model would:

- Allow applicant to target the specific patient populations (based upon acute hospital admission diagnoses (MS-DRG) and the providers and supplies to include in the bundled payment.
- Allow all participating providers to receive regular FFS payments throughout the course of the episode.
- Require the applicant to propose a discounted target price for all services included in the bundle based on historic CMS expenditure trends.
- Include a reconciliation of the aggregate traditional FFS payments provided by CMS for the bundled episode with the discounted target price.
 - If FFS payments exceeded the target price, the provider entity would be required to pay back a portion of received fees to CMS.
 - If the FFS payments were less than the target price, the provider entity would receive the difference..

Model 4 --- Prospective Acute Care Hospital Only --- the episode of care would be defined as the inpatient stay in the general acute care hospital. CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians and other practitioners. Physicians and other practitioners would submit “no-pay” claims to Medicare and would be paid by the hospital out of the bundled payment. This model would:

- Allows applicant to include only those patients admitted to the participating hospital with the defined set of diagnoses (MS-DRG).
- The prospective payment would be a discount from CMS historic expenditure trends.
- Not require any payment reconciliation.
- Place the applicant at risk of being unable to provide the bundled services within the agreed upon discounted prospective rate.
- Provide the applicant with an opportunity to profit through a decrease their own internal expenses through the implementation of more efficient services and the increased freedom to employ gain sharing opportunities within their system

All four models would require applicants to propose, monitor, and report to CMS a set of quality measures. CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs. In addition, all applicants would be expected to provide beneficiaries with information about the applicant’s participation in this initiative, as well as proposed plans for beneficiary engagement and inclusion in redesigning care. There is nothing in this initiative that limits in any way a Medicare beneficiary’s right to receive care from any health care provider of their own choosing

A comparison of the four models is below. Further information regarding this initiative, including application materials and deadlines, is available on the Center for Medicare and Medicaid Innovations’ Bundled Payment for Care Improvement website at <http://innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>

MODEL FEATURE	MODEL 1 – Inpatient Stay Only	MODEL 2 – Inpatient Stay plus Post-discharge Services	MODEL 3 - Post-discharge Services Only	MODEL 4 – Inpatient Stay Only
Eligible Awardees	<ul style="list-style-type: none"> • Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Conveners of participating health care providers 	<ul style="list-style-type: none"> • Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Post-acute providers • Conveners of participating health care providers 	<ul style="list-style-type: none"> • Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Long-term care hospitals • Inpatient rehabilitation facilities • Skilled nursing facilities • Home health agency • Physician-hospital organizations • Conveners of participating health care providers 	<ul style="list-style-type: none"> • Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Conveners of participating health care providers
Payment of Bundle and Target Price	Discounted IPPS payment; no separate target price	Retrospective comparison of target price and actual FFS payments	Retrospective comparison of target price and actual FFS payments	Prospectively set payment
Clinical Conditions Targeted	All MS-DRGs	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay
Types of Services Included in Bundle	Inpatient hospital services	<ul style="list-style-type: none"> • Inpatient hospital and physician services • Related post-acute care services • Related readmissions • Other services defined in the bundle 	<ul style="list-style-type: none"> • Post-acute care services • Related readmissions • Other services defined in the bundle 	<ul style="list-style-type: none"> • Inpatient hospital and physician services • Related readmissions
Expected Discount Provided to Medicare	To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. to 2% in Year 3	To be proposed by applicant; CMS requires minimum discount of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode	To be proposed by applicant	To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration
Payment from CMS to Providers	<ul style="list-style-type: none"> • Acute care hospital: IPPS payment less pre-determined discount • Physician: Traditional fee schedule payment (not included in episode or subject to discount) 	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment
Quality Measures	All Hospital IQR measures and additional measures to be proposed by applicants	To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs		

Comparison of the Medicare Bundled Payments for Care Improvement Initiative Models