CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CMMI Bundled Payments

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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:

- Test new payment and service delivery models
- Evaluate results and advancing best practices
- Engage a broad range of stakeholders to develop additional models for testing

2

Innovation Center Models

Goals of Innovation Center models:

- Better care
- Smarter spending
- Healthier people

Models range in focus, including:

- Accountable Care Organizations
- Primary Care Transformation
- Bundled Payments for Care Improvement
- New emphasis on specialty care models

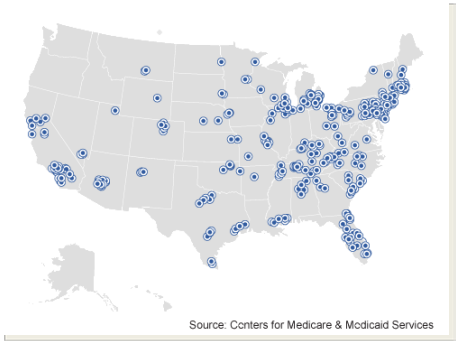
3

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 for Care Improvement

- The bundled payment model targets 48 conditions with a single payment for an episode of care
  - Incentivizes providers to take **accountability for both cost and quality** of care
  - **Four Models**
    - Model 1: Acute care hospital stay only
    - Model 2: Retrospective acute care hospital stay plus post-acute care
    - Model 3: Retrospective post-acute care only
    - Model 4: Acute care hospital stay only
- 360 Awardees and 1755 Episode Initiators in Phase 2 as of July 2015



- Duration of model is scheduled for 3 years:
  - Model 1: April 2013 to present
  - Models 2, 3, 4: October 2013 to present

* Current as of July 2015

Bundled Payments for Care Improvement: Models Overview

Model 1	Bundled payment models for the acute inpatient hospital stay only (11 Awardees)
Model 2	Retrospective bundled payment model for hospitals, physicians, and post-acute providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care (741 Awardees or Episode Initiators)
Model 3	Retrospective bundled payment models for post-acute care where the bundle does not include the acute inpatient hospital stay (1353 Awardees or Episode Initiators)
Model 4	Prospectively administered bundled payment models for hospitals and physicians for the acute inpatient hospital stay only (10 Awardees)

Trigger Clinical Conditions

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

BPCI: Most Prevalent Clinical Episodes in Models 2-4

- Of the 48 Clinical Episodes in the BPCI initiative, the five most prevalent are listed in the table below.

- The most prevalent five Clinical Episodes make up 21.6% of the Clinical Episodes currently being tested in BPCI.

Most Prevalent Clinical Episodes in Models 2-4	Number of Episodes	Percent of Total Episodes
Major joint replacement of the lower extremity	916	6.4%
Simple pneumonia and respiratory infections	595	4.2%
Congestive heart failure	559	4.0%
Chronic obstructive pulmonary disease, bronchitis, asthma	516	3.7%
Hip & femur procedures except major joint	465	3.3%
Total	3,051	21.6%

Orthopedic Episodes Being Tested in BPCI

Amputation	Back and neck except spinal fusion
Cervical spinal fusion	Combined anterior posterior spinal fusion
Complex non-cervical spinal fusion	Double joint replacement of the lower extremity
Fractures femur and hip/pelvis	Hip and femur procedures except major joint
Lower extremity and humerus procedure except hip, foot, femur	Major joint replacement of lower extremity
Major joint replacement of the upper extremity	Medical non-infectious orthopedic
Other knee procedures	Removal of orthopedic devices
Revision of the hip or knee	Spinal fusion (non-cervical)

Orthopedic Episodes being tested in BPCI

Of the 16 Orthopedic Clinical Episodes in the BPCI initiative, the most prevalent 3 Clinical Episodes make up 39% of the total Orthopedic Clinical Episodes in BPCI.

Most Prevalent Orthopedic Clinical Episodes Currently At-risk in BPCI			
	Model 2	Model 3	Model 4
Major joint replacement of the lower extremity	429	482	5
Hip & femur procedures except major joint	169	296	0
Medical non-infectious orthopedic	140	243	0
Total	**738**	**1,021**	**5**

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 Model 2 Summary of Evaluation Results

- Within 90 days of discharge from the hospital, costly institutional Post-Acute Care was substituted by less costly home health care.
- As a result, there were reductions in Medicare Part A payments to Skilled Nursing Facilities (SNF) and Inpatient Rehabilitation Facilities (IRF) accompanied by an increase of Part A payments to Home Health Agencies (HHA).
- There were also reductions in the anchor inpatient length of stay and the 30-day readmission rate.
- In the first quarter, BPCI awardees participated mostly with clinical episodes that fall into orthopedic surgery excluding the spine. Thus, Model 2 results were driven by patient episodes in this clinical episode group.

BPCI Model 3 Summary of Evaluation Results

- Majority of Episode Initiators are Skilled Nursing Facilities (SNF), followed by Home Health Agencies (HHA); few Inpatient Rehabilitation Facilities (IRF), Long-Term Care Hospitals (LTCH)
- Phase 2 SNFs likelier to be urban and not small compared to non-BPCI SNFs
- Model 3 interviewees mentioned the same reasons as Model 2 Awardees for joining BPCI:
  - Anticipate payment reform
  - Opportunities for quality improvement
  - See themselves as leaders and innovators
- Preliminary results for orthopedic-surgical episodes in SNFs suggest:
  - Institutional number of days lower across the baseline and intervention period than for comparison group
  - No difference in the change in Part A payments between the intervention and comparison groups

What is the Comprehensive Care for Joint Replacement model?

- The Comprehensive Care for Joint Replacement model would test bundled payments for lower extremity joint replacement (LEJR) across a broad cross-section of hospitals.

- The model would apply to most Medicare LEJR procedures within select geographic areas with few exceptions.

- The model would be implemented through rule making, and the performance period would begin on January 1, 2016.
  - The policies discussed in this presentation are proposals subject to the notice and comment rulemaking process.

What is the Comprehensive Care for Joint Replacement model designed to do for patients and the health system?

Better Care	• Better care for patients through more coordinated, higher quality care during and after a hip or knee replacement surgery
Smarter Spending	• Smarter spending of health care dollars by holding hospitals accountable for total episode spending, not just inpatient costs
Healthier People and Communities	• Healthier people and communities by improving coordination in health care and by connecting care across hospitals, physicians, and other health care providers

Comprehensive Care for Joint Replacement: Participants

- Participants would include Inpatient Prospective Payment System (IPPS) Hospitals in select Metropolitan Statistical Areas (MSA) not participating in Model 1 or Phase II of Models 2 or 4 of the Bundled Payment for Care Improvement (BPCI) model for the lower extremity joint replacement clinical episode.

- 75 MSAs were selected in a two-step randomization process.
  - MSAs were placed into eight groups based on average wage-adjusted historic LEJR episode payment quartiles and the MSA population size divided at the median.
  - MSAs were then randomly selected within each group using a selection percentage within each payment quartile (30% for lowest payment quartile to 45% for highest payment quartile).

Comprehensive Care for Joint Replacement: Episode Definition

- Episodes would be triggered by hospitalizations of eligible Medicare Fee-for-Service (FFS) beneficiaries discharged with diagnoses:
  - MS-DRG 469: Major joint replacement or reattachment of lower extremity with major complications or comorbidities
  - MS-DRG 470: Major joint replacement or reattachment of lower extremity without major complications or comorbidities

- **Episodes include:**
  - Hospitalization and 90 days post-discharge
  - All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode

Comprehensive Care for Joint Replacement: Beneficiaries

- **Care of Medicare beneficiaries would be included if Medicare is the primary payer and the beneficiary is:**

  - Enrolled in Medicare Part A and Part B throughout the duration of the episode
  - Not eligible for Medicare on the basis of End Stage Renal Disease
  - Not enrolled in a managed care plan (eg, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations).
  - Not covered under a United Mine Workers of America health plan

Comprehensive Care for Joint Replacement: Services in Episode

- **Included services**
  - Physicians' services
  - Inpatient hospitalization (including readmissions)
  - Inpatient Psychiatric Facility (IPF)
  - Long-term care hospital (LTCH)
  - Inpatient rehabilitation facility (IRF)
  - Skilled nursing facility (SNF)
  - Home health agency (HHA)
  - Hospital outpatient services
  - Independent outpatient therapy
  - Clinical laboratory
  - Durable medical equipment (DME)
  - Part B drugs
  - Hospice

- **Excluded services**
  - Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the LEJR surgery
  - Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care

Payment and Pricing: Target Price Setting

- **Target prices**
  - CMS intends to establish for each participant hospital prior to start of applicable performance period
  - Based on 3 years of historical data
  - Includes discount to serve as Medicare's savings
  - Based on blend of hospital-specific and regional episode data (US Census Division), transitioning to regional pricing
    - Years 1&2: 2/3 hospital-specific, 1/3 regional
    - Year 3: 1/3 hospital-specific, 2/3 regional
    - Years 4&5: 100% regional pricing

Payment and Pricing: Risk Structure

- **Retrospective, two-sided risk model with hospitals bearing financial responsibility**
  - Providers and suppliers continue to be paid via Medicare FFS
  - After a performance year, actual episode spending would be compared to the episode target prices
    - If in aggregate target prices are greater than actual episode spending, hospital may receive reconciliation payment
    - If in aggregate target prices are less than actual episode spending, hospitals would be responsible for making a payment to Medicare

- Responsibility for repaying Medicare begins in Year 2, with no downside responsibility in Year 1

Payment and pricing: Link to quality

- **Hospitals must meet minimum threshold on 3 quality metrics to be eligible for reconciliation payments:**
  1. Hospital Level Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
  2. Hospital Level 30 day, All Cause Risk Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
  3. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
- Thresholds for performance would increase over the lifetime of the model to incentivize continuous improvement.
- Participant hospitals would have an additional financial incentive to successfully submit data on a patient-reported functional outcome measure beginning in Year 1.

Financial Arrangements: Gainsharing

- Consistent with applicable law, participant hospitals might have certain financial arrangements with Collaborators to support their efforts to improve quality and reduce costs.
- Collaborators may include the following provider and supplier types:
  - Physician and nonphysician practitioners
  - Home health agencies
  - Skilled nursing facilities
  - Long term care hospitals
  - Physician Group Practices
  - Inpatient rehabilitation facilities
  - Inpatient and outpatient physical and occupational therapists

Notice and Comment Rulemaking Process

- You can read the proposed rule in the Federal Register at https://www.federalregister.gov.

- We encourage all interested parties to submit comments electronically through the CMS e-Regulation website at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking or on paper by following the instructions included in the proposed rule. Submissions must be received by September 8, 2015.

- For more information about the Comprehensive Care for Joint Replacement model, go to http://innovation.cms.gov/initiatives/ccjr/

Thank you!

Questions?

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