UNDERSTANDING THE MEDICARE BUNDLED PAYMENT INITIATIVE OPPORTUNITY

Philadelphia Bar Association

Health Care Law Committee

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Agenda

- Bundled Payments Today
- Bundled Payments for Care Improvement Initiative
  - Overview
  - 4 Models
  - Application Process
- Keys to Success

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Medicare Bundled Payment Initiative Opportunity

BUNDLED PAYMENTS TODAY

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What are bundled payments?

- Bundled payments combine payment for physician, hospital and other provider services during an episode of care
  - Episodes of care are selected conditions over a defined period of time
- Bundled payments often cover multiple providers across care settings, incentivizing coordination and alignment
- Payments may be retrospective or prospectively
- The entity receiving the payment is responsible for distribution to all stakeholders

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Why bundled payments may work

- Hospital has the incentive to improve quality, reduce readmissions, and avoid other unnecessary services
- Hospitals can reward physicians for efforts improve quality and reduce costs
- Supports better coordination of care and information exchange across care settings

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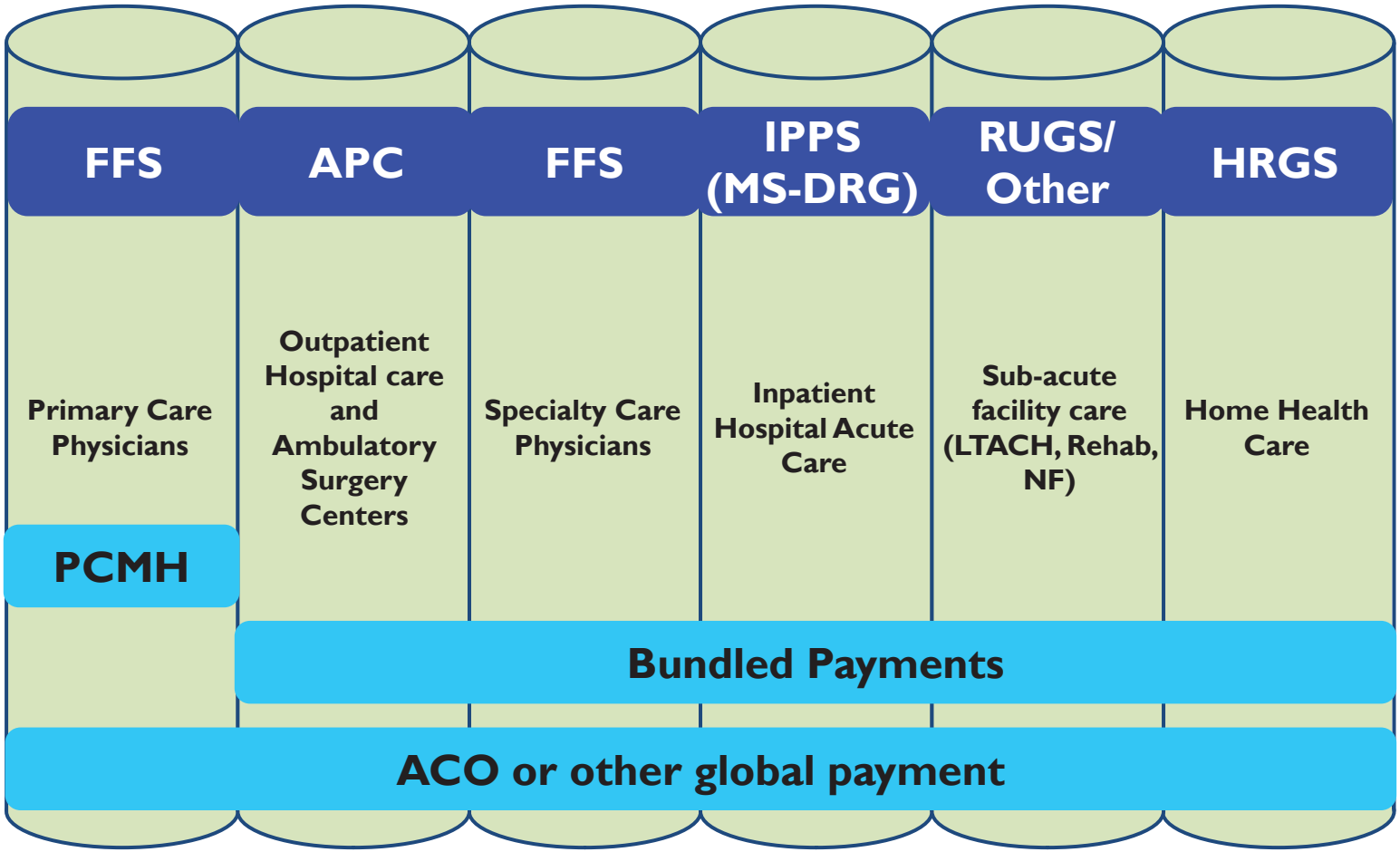
Typical range of covered service varies by payment model



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CMS anticipates savings from bundled payment programs

- Estimated Medicare savings of $18 billion could be achieved through 2019 by moving the hospital industry toward bundled payments (OMB, 2/26/09)
  - Savings build to about 0.5% of Medicare spending
- Mostly achieved through reduction in readmissions

Estimated Bundled Payment Savings (Billions)							
Year	2013	2014	2015	2016	2017	2018	2019
Projected Medicare Spending	$ 618	$ 653	$ 689	$ 727	$ 768	$ 810	$ 855
Estimated savings	0.2	0.8	1.9	2.8	3.8	4.1	4.4
% of Medicare Spending	0.0%	0.1%	0.3%	0.4%	0.5%	0.5%	0.5%

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CMS will launch several bundled payment programs

Program	Characteristics
Bundled Payments for Care Improvement Initiative	> Medicare > Operated by CMMI – Flexible bidding process > RFA issued in August, LOIs due Oct. 6th or Nov 4th > Applications due March 15, 2012 > Starts Q4 2012
National Pilot Program on Payment Bundling	> Medicare > In PPACA, regulations not issued yet > Starts Q1 2013
Medicaid Bundled Payment Demonstration Project	> Medicaid > In PPACA > Limited to 8 states > Starts Q1 2012

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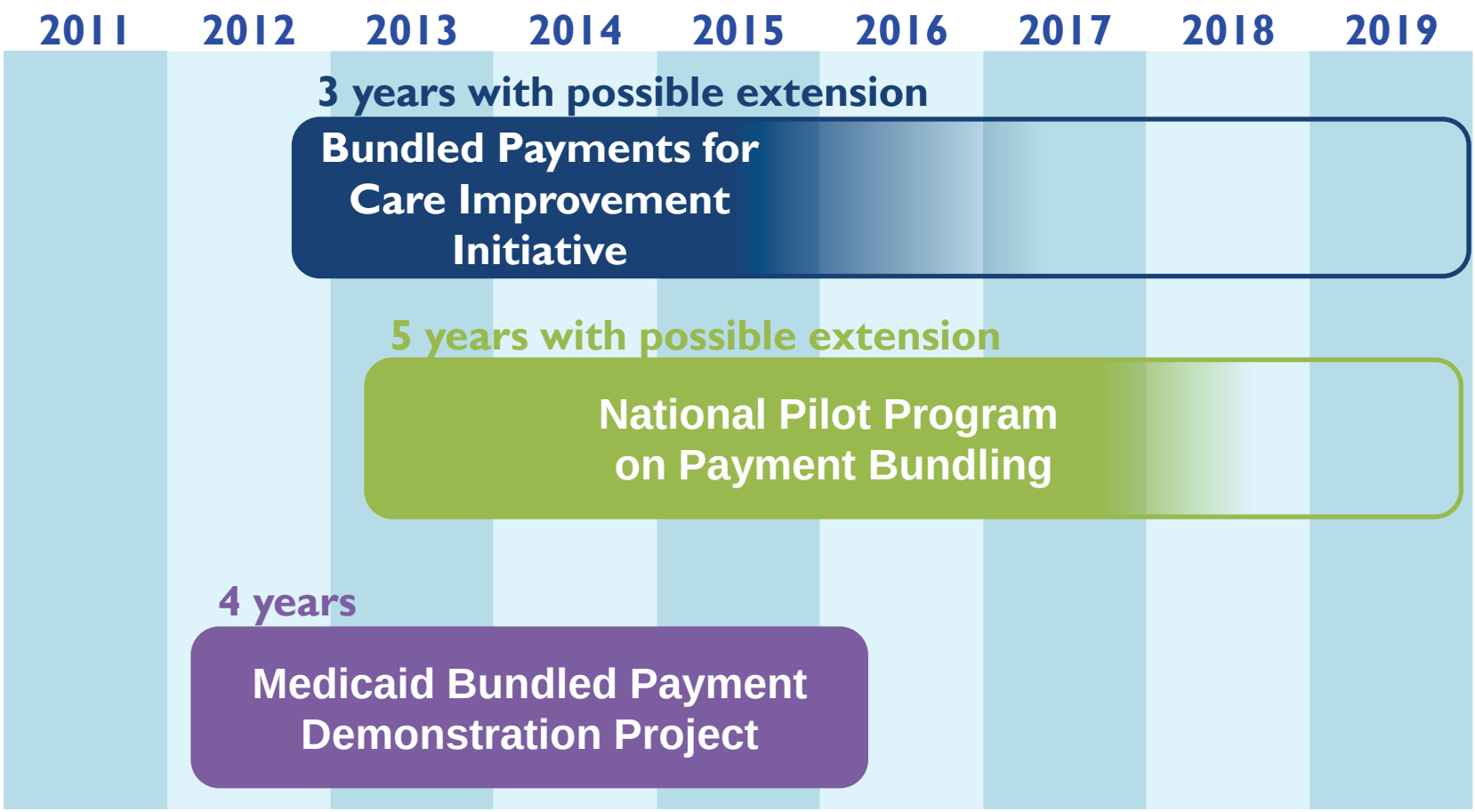
Bundled Payment Implementation



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BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE: OVERVIEW

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Bundled Payments for Care Improvement Initiative

- Under the initiative, CMMI has designed four broadly defined bundled payment models, and encourages organizations to submit proposals to help test and develop the models
- The models give providers flexibility in selecting conditions, defining eligible care providers, and determining payment allocation

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The initiative is designed to incentivize care redesign, engage beneficiaries, and learn and spread best payment practices

- Support and encourage providers with demonstrated interest in better health, better care, and lower costs through continuous improvement
- A positively reinforcing cycle leading to decreased cost and improved quality of acute and associated post-acute care episodes
- Develop and test payment models that create extended accountability for better health, better care, and lower cost outcomes
- Shorten the cycle time for adoption of evidence-based care
- Create environments that stimulate rapid development of new evidence-based knowledge

Source: "Bundled Payments for Care improvement Initiative: Request for Application", CMMI

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CMS performance review

- CMS will collect claims and enrollment data to monitor performance for the duration of the agreement period
  - Decreased performance during this initiative may result in termination of the awardee/provider agreement
  - Participant must pay Medicare for the excess if spending exceeds the risk threshold
- If reviews conducted after 2-3 years show that the program lowers costs or improves outcomes at the same cost, the program may be expanded and/or extended

Source: "Bundled Payments for Care improvement Initiative: Request for Application" CMMI

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Potential reasons for termination

- Awardee does not meet quality performance thresholds
- Consistent increase in post-episode Medicare expenditures related to episode
- Noncompliance with physician self-referral prohibition laws, CMP, Anti-kickback statute, or other antifraud laws, rules or regulations
- Awardee restricts access to necessary care
- Failure to pay Medicare predetermined discounts or costs exceeding risk threshold or target price
- Failure to satisfy the Conditions of Participation
- CMS no longer has the funds to support the program

Source: "Bundled Payments for Care improvement Initiative: Request for Application", CMMI

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BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE: 4 MODELS

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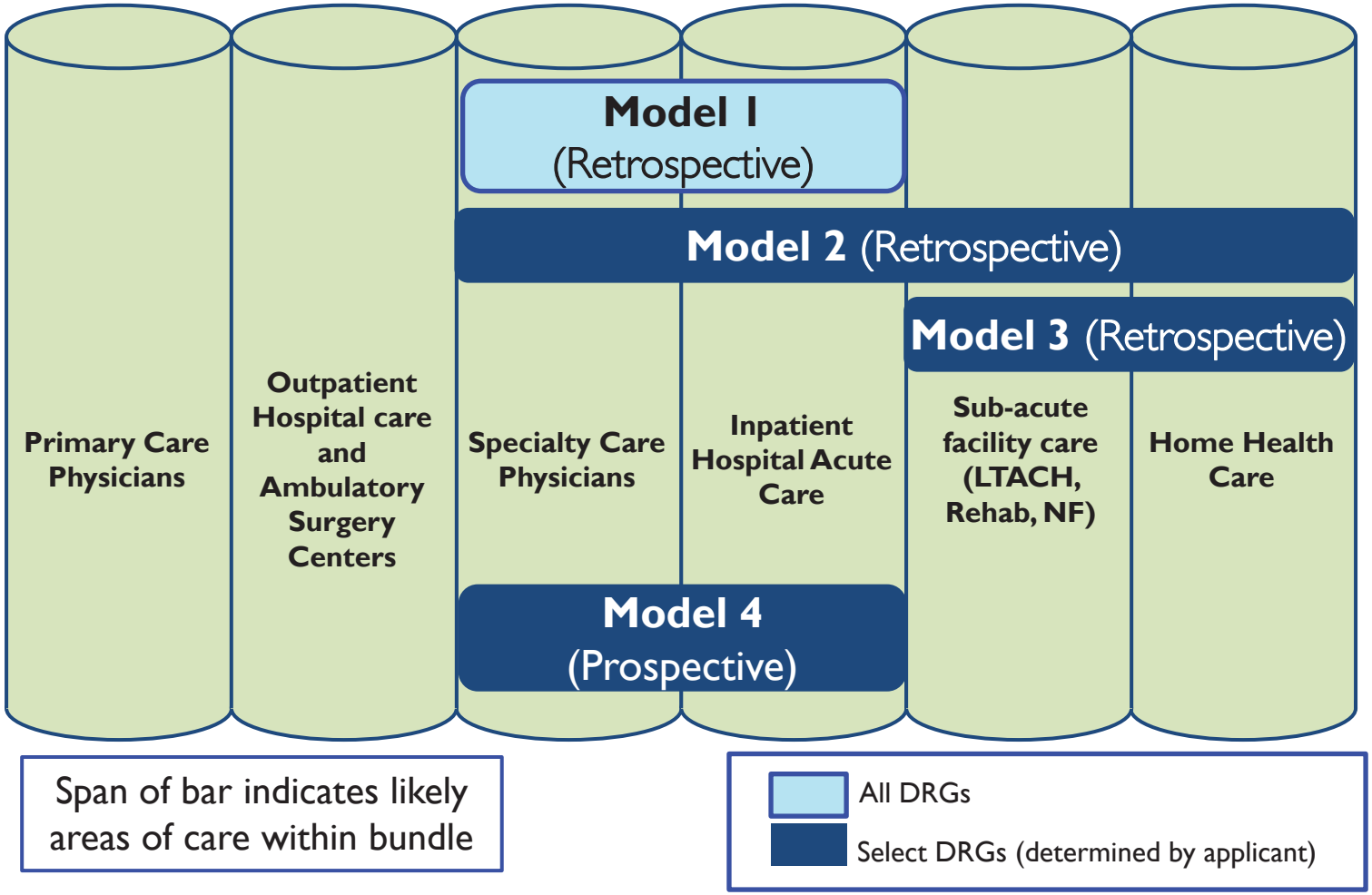
Integration requirements will depend on the characteristics of the model chosen



Source: Based on "Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs"

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Common features across the models

- All eligible beneficiaries must be included (patients with Part A and Part B, Medicare FFS is primary payer; based on MS-DRG)
- CMS will monitor care for 30 days after the end of the episode; if spending exceeds a risk threshold above expected costs, the participant must pay Medicare for excess
- Significant quality reporting and assurance that quality does not decline
- Allow for gainsharing but require voluntary physician participation
- Models 1-3 (retrospective): If aggregate FFS payments are less than predetermined target price, Medicare pays difference to participant

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Model 1:
Retrospective Acute Care Hospital Stay Only

Treatment Episode

> All inpatient acute care MS-DRGs

Payment Model

> Required rate of discount on Part A payments will be phased in as follows:
  - First six months: no discount required
  - Second six months: minimum discount of 0.5%
  - Year 2: minimum discount of 1%
  - Year 3: minimum discount of 2%

> Claims for inpatient stays still processed under IPPS; CMS will reduce IPPS payments by the agreed-upon discount

> Claims for Part B services during the episode will be paid by Medicare

> If aggregate FFS payments are less than predetermined target price, Medicare pays difference to participant

Source: "Bundled Payments for Care improvement Initiative: Request for Application" CMMI

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Model 2: Retrospective Acute Care Hospital Stay and Post Acute Care

Treatment Episode

- Inpatient acute care and post acute care for certain MS-DRGs
  - Option 1: 30-89 days after discharge
  - Option 2: At least 90 days after discharge
- All Part A and Part B services including diagnostic imaging and therapeutic services in three days prior to and during hospital stay

Payment Model

- Discount provided to Medicare
  - Option 1: Minimum 3% discount on included Part A and Part B charges
  - Option 2: Minimum 2% discount on included Part A and Part B charges
- Claims processed under IPPS, PFS, and post-acute payment systems
- CMS will reduce IPPS payments by the agreed-upon discount
- If aggregate FFS payments are less than predetermined target price, Medicare pays difference to participant

Source: "Bundled Payments for Care improvement Initiative: Request for Application" CMMI

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Model 3: Retrospective Post Acute Care Only

Treatment Episode

- Post acute care starting within 30 days of discharge from acute care for certain MS-DRGs
  - Episode at least 30 days, exact length of episode to be proposed by participant
- All Part A and Part B services during episode period, including related readmissions

Payment Model

- Discount provided to Medicare
  - Applicant proposes discount to Medicare fees to set target price
- Claims processed under appropriate FFS system (PFS, and post-acute payment system or IPPS)
- If aggregate FFS payments are less than predetermined target price, Medicare pays difference to participant

Source: "Bundled Payments for Care improvement Initiative: Request for Application" CMMI

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Model 4:
Prospective Acute Care Hospital Stay Only

Treatment Episode

- Acute care inpatient hospitalization, for certain MS-DRGs
- All Part A services including diagnostic imaging and therapeutic services in three days prior to and during hospital stay; Part B professional services

Payment Model

- The payments are prospectively-established bundled payments for the agreed-upon MS-DRGs
- Physician is paid by hospital, claims submitted to Medicare as "no-pay"
- Builds on the ACE demonstration, expanding to additional geographic areas and clinical conditions
- Discount of at least 3% expected to Medicare fees (greater discounts required for ACE MS-DRGS)

Source: "Bundled Payments for Care improvement Initiative: Request for Application" CMMI

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BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE: APPLICATION PROCESS

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Applicants will apply for one or more of the four defined bundled payments models

Model	Letter of Intent Due	Application Due
1	October 6, 2011	November 18, 2011
2-4	November 4, 2011	March 15, 2012

- Interested organizations must submit a letter of intent and an application for the bundled payment model(s) of choice
- Applicants are encouraged to apply for more than one model but a separate application must be submitted for each
  - A separate letter of intent must be written for model 1, but only one letter is necessary for models 2-4
- CMS encourages applicants considering/involved with the Medicare Shared Savings ACO, Pioneer ACO, the medical homes initiatives, and other CMMI initiatives to apply

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There will be a preference for applicants already on their way to integrated, quality care

Desired Applicant Profile

- Experience with cross-provider care improvement, gainsharing and pay-for-performance
- Strong hospital-provider alignment
- Care redesign experience or readiness
- Accountable financial arrangements
- HIT infrastructure (e.g., ideally 50% meaningful use)
- Demonstrated PQRS participation
- Patient, provider, and consumer representation in governing bodies
- Ability to bear financial risk

Source: "Bundled Payments for Care improvement Initiative: Request for Application" CMMI

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CMS is seeking proposals that meet three broad categories of criteria

1 Design

- ✓ Transparent, replicable, scalable episode definitions
- ✓ Defined entity to be designated awardee
- ✓ Provider identification and engagement
- ✓ Plans to redesign care and improve outcomes

2 Financial

- ✓ Greater savings to Medicare
- ✓ Comprehensive risk adjustment methodology description
- ✓ Care improvement linked to cost saving approaches
- ✓ Innovative gainsharing design (payment frequency and distribution)

3 Quality Care and Patient Centeredness

- ✓ Innovative quality, care, and coordination improvement
- ✓ Comprehensive, evidence-based quality and performance metrics
- ✓ Continuous quality assurance and project improvement
- ✓ Beneficiary engagement, education and protection

CMS reserves the right to negotiate the content of the proposals for approval

Source: "Bundled Payments for Care improvement Initiative: Request for Application" CMMI

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KEYS TO SUCCESS

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KEYS TO SUCCESS

Key requirements for successful bundled payments

Provider-Hospital Coordination	> Coordination, communication, transparency across all providers
Effective Information Systems	> EMR or comprehensive patient record across care settings > Capital resources
Dedicated Management	> Clinical and operation management
Active Board Leadership	> Implementation of delivery system changes > Establishment of organization goals and reporting system,
Sufficient Patient Population	> Risk-adjusted payment rates (larger entities benefit from greater risk diversification)
Hardwire Best Practices	> Evidence-based guidelines input into HIT systems for greater compliance
Clear Episode Definition	> Well-defined guidelines and episode durations > Active physician engagement and leadership in defining the bundle and division of care

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Potential benefits are significant

- Closer alignment with key physicians through gainsharing
- Burning platform to engage physicians in reducing cost and improving quality
- Prepare for future accountability for cost and quality
- Keep some of savings generated
- Access to Medicare data in the application process
- More familiar territory for hospitals than ACOs or global payment

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Potential risks are considerable

- Impact of the discount required
- Pay Medicare if fail to generate savings
- Lose savings if fail to maintain quality
- Possible patient perception of withholding care
- Possible physician frustration

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There are several operational challenges

- Setting up the right organizational structure and committing the resources needed
- Creating a good gainsharing model
- Cooperation among providers
- Information technology
- Broadening perspective to include post-acute care (Models 2 & 3)
- Paying claims (Model 4)

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Creating a successful application

- Analyzing the Medicare dataset
- Choosing which MS-DRGs to include and the span of care
- Assessing the financial impact of the options
- Planning care process redesign
- Determining risk-adjustment mechanisms (if any)
- Designing gainsharing model
- Defining quality of care measurements
- Picking the right discount level

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DISCUSSION AND QUESTIONS

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