

# 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
  - o Overview
  - o 4 Models
  - o Application Process
- > Keys to Success

Medicare Bundled Payment Initiative Opportunity

# BUNDLED PAYMENTS TODAY

## What are bundled payments?

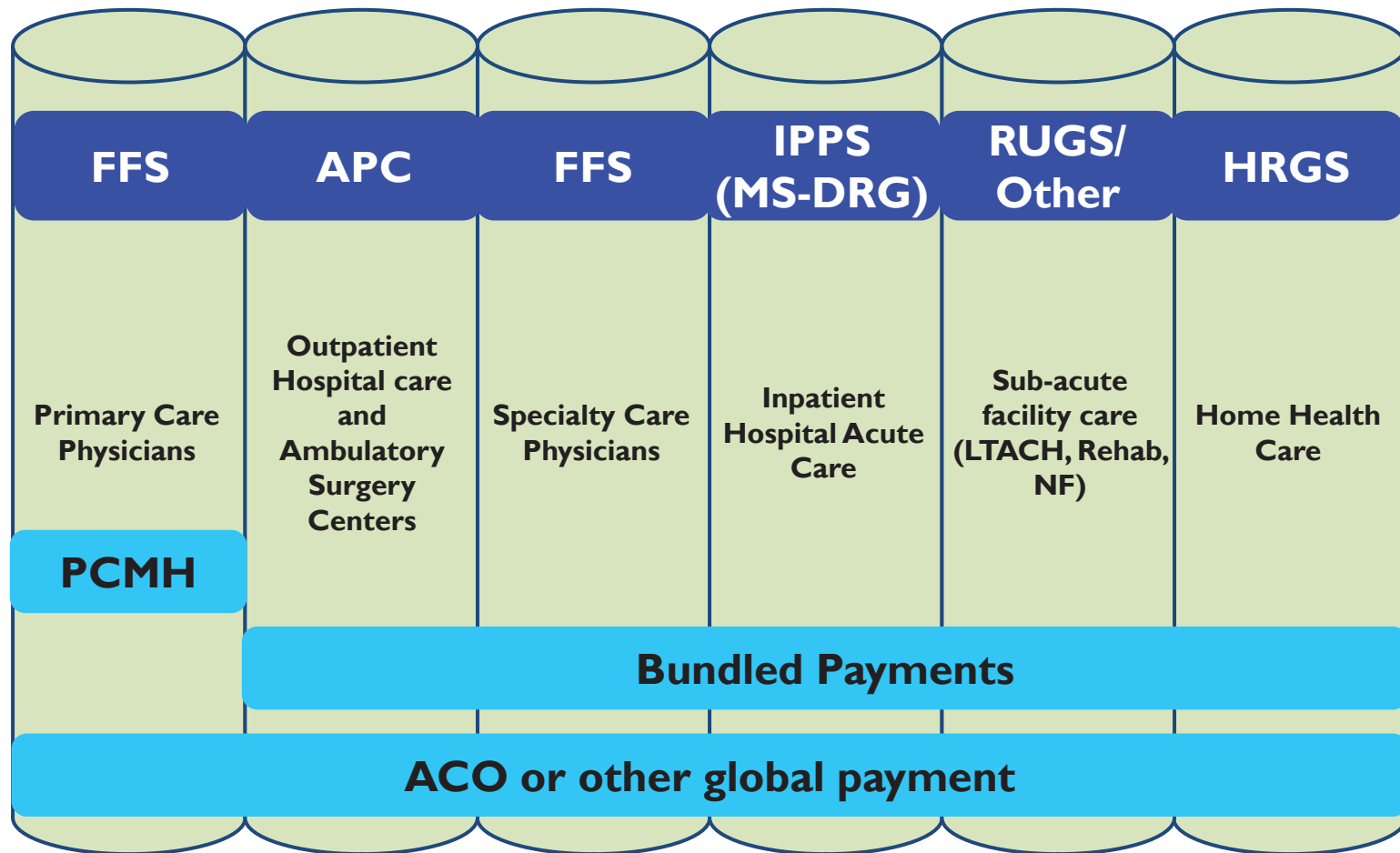
- > Bundled payments combine payment for physician, hospital and other provider services during an episode of care
  - o Episodes of care are selected conditions over a defined period of time
- > Bundled payments often cover multiple providers across care settings, incentivizing coordination and alignment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

## 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

## BUNDLED PAYMENTS TODAY

Typical range of covered service varies by payment model



## CMS anticipates savings from bundled payment programs

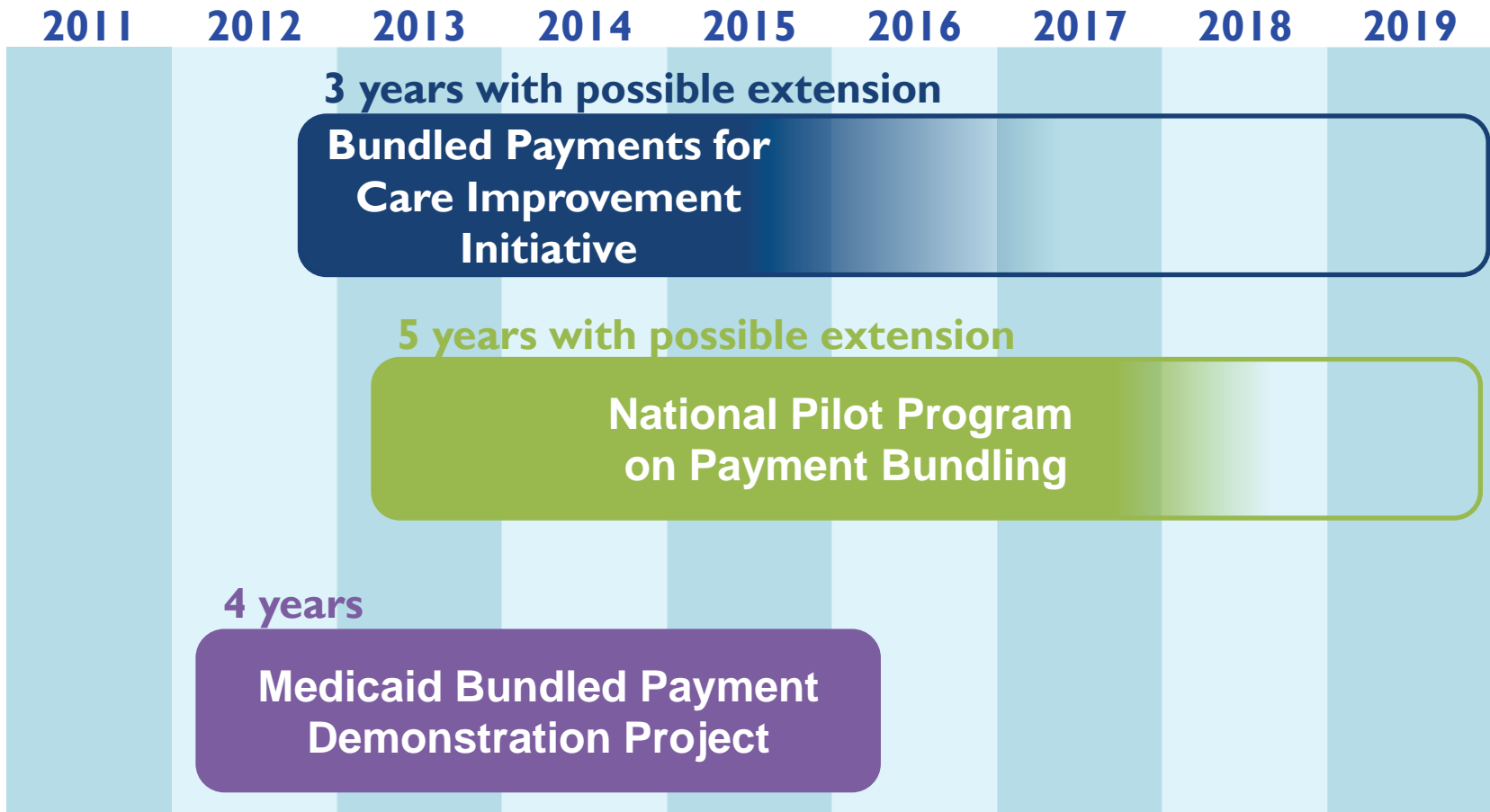
- > Estimated Medicare savings of \$18 billion could be achieved through 2019 by moving the hospital industry toward bundled payments (OMB, 2/26/09)
  - o Savings build to about 0.5% of Medicare spending
- > Mostly achieved through reduction in readmissions

| 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%   |

# CMS will launch several bundled payment programs

| Program  | Characteristics   |
|--|---|
| <p><b>Bundled Payments for Care Improvement Initiative</b></p> | <ul style="list-style-type: none"> <li>&gt; Medicare</li> <li>&gt; Operated by CMMI – Flexible bidding process</li> <li>&gt; RFA issued in August, LOIs due Oct. 6<sup>th</sup> or Nov 4<sup>th</sup></li> <li>&gt; Applications due March 15, 2012</li> <li>&gt; Starts Q4 2012</li> </ul> |
| <p><b>National Pilot Program on Payment Bundling</b></p>       | <ul style="list-style-type: none"> <li>&gt; Medicare</li> <li>&gt; In PPACA, regulations not issued yet</li> <li>&gt; Starts Q1 2013</li> </ul>   |
| <p><b>Medicaid Bundled Payment Demonstration Project</b></p>   | <ul style="list-style-type: none"> <li>&gt; Medicaid</li> <li>&gt; In PPACA</li> <li>&gt; Limited to 8 states</li> <li>&gt; Starts Q1 2012</li> </ul>   |

# Bundled Payment Implementation



Medicare Bundled Payment Initiative Opportunity

# BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE: OVERVIEW

## 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

## 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

## 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

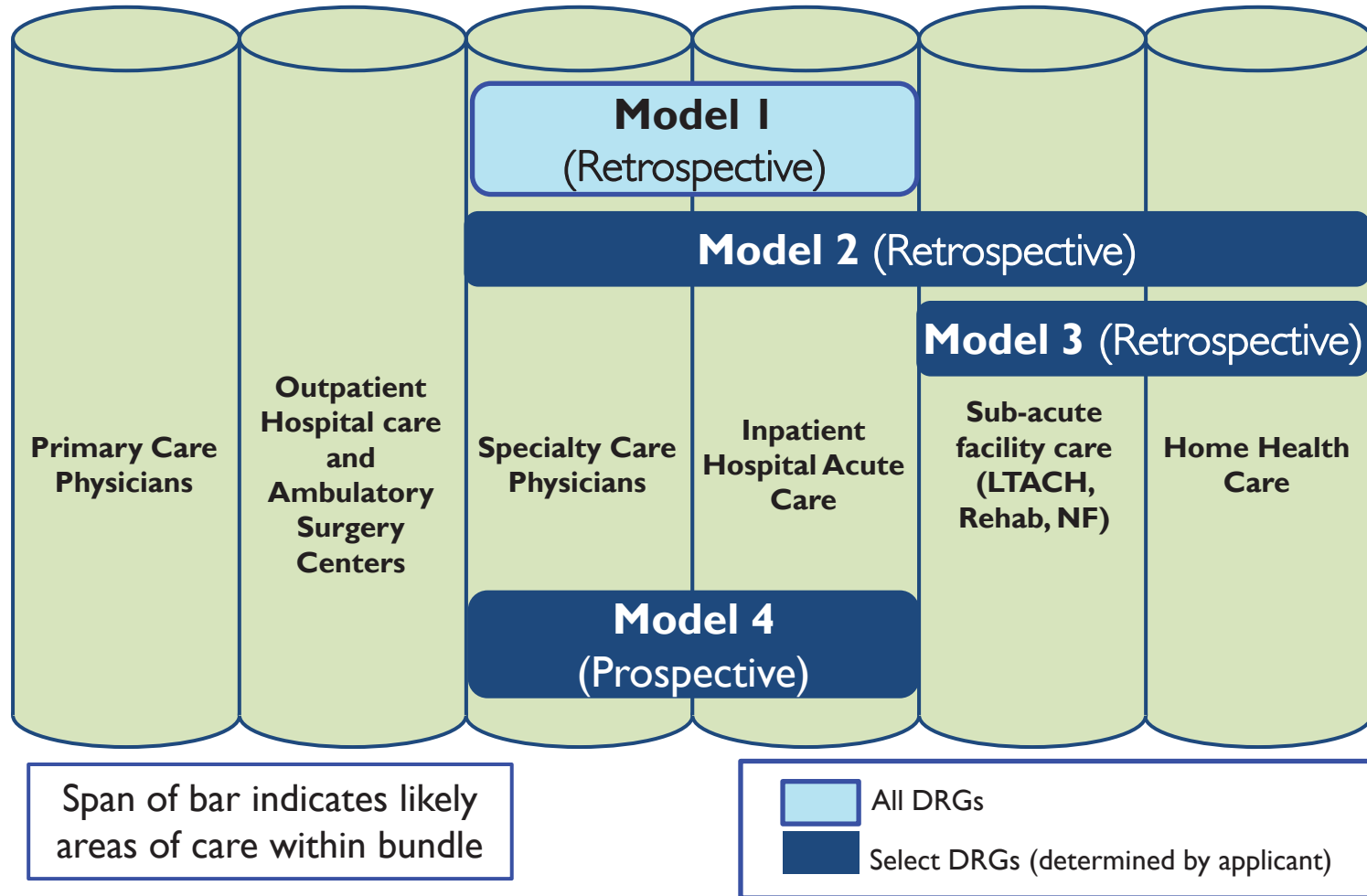
## Potential reasons for termination

- > 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

# BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE: 4 MODELS

# 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"

## 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

## 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

# 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

## 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

## 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

# BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE: APPLICATION PROCESS

## 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

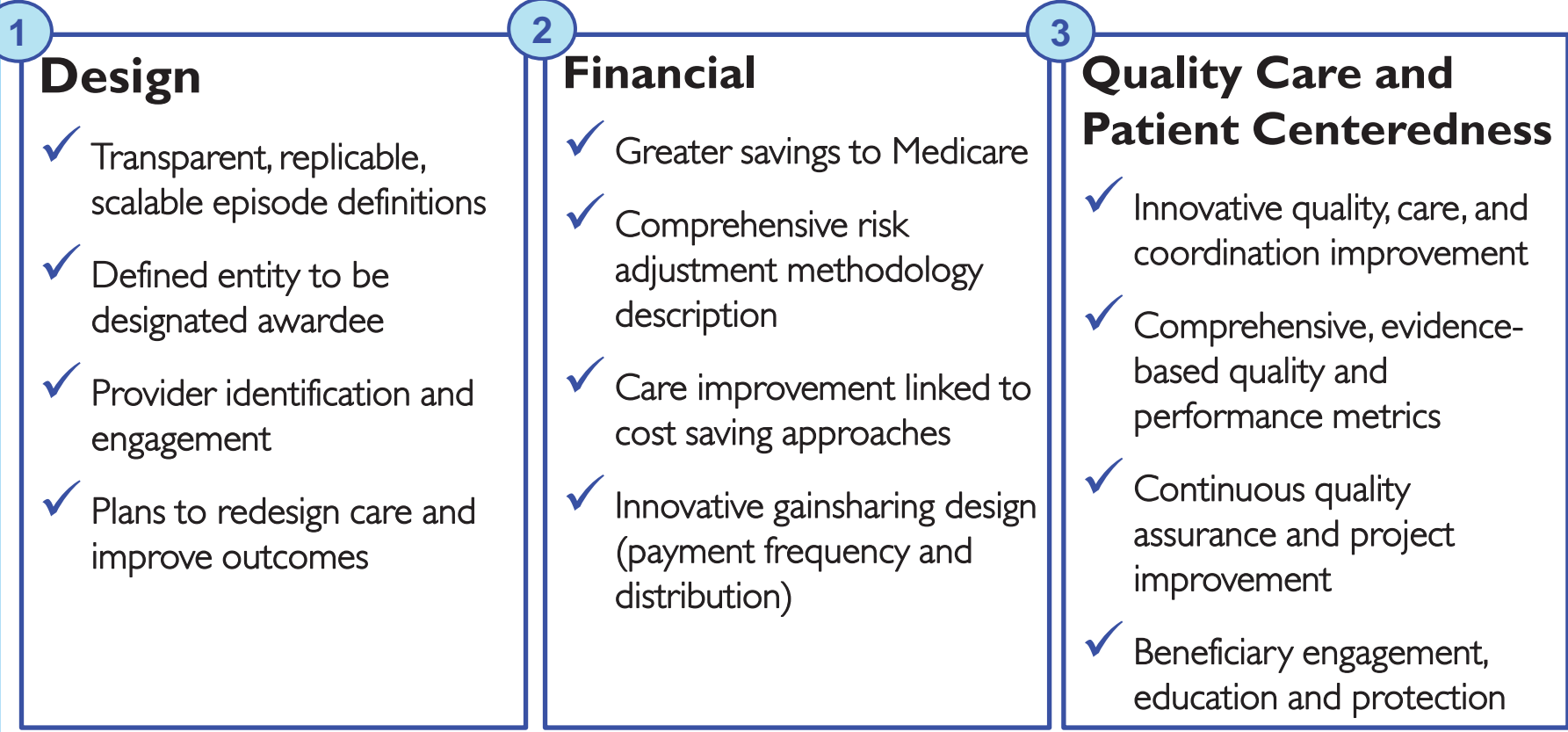
## There will be a preference for applicants already on their way to integrated, quality care

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

# CMS is seeking proposals that meet three broad categories of criteria



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

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

# KEYS TO SUCCESS

## KEYS TO SUCCESS

# Key requirements for successful bundled payments

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

## 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

## 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

## 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)

# 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

# DISCUSSION AND QUESTIONS

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