# BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE

## OVERVIEW

On January 31, 2013, the Centers for Medicare & Medicaid Services (CMS) announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative, an innovative new payment model. Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.

## BACKGROUND

*Bundled Payments*

Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings. Payment rewards the quantity of services offered by providers rather than the quality of care furnished. Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.

*The Innovation Center*

The Bundled Payments for Care Improvement initiative was developed by the Center for Medicare and Medicaid Innovation (InnovationCenter). The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care for beneficiaries.

## INITIATIVE DESIGN

The Bundled Payments initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Model 1 includes an episode of care focused on the acute care inpatient hospitalization. Awardees agree to provide a standard discount to Medicare from the usual Part A hospital inpatient payments.

Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Model 4 involves a prospective bundled payment arrangement, where a lump sum payment is made to a provider for the entire episode of care. Over the course of the three-year initiative, CMS will work with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare.

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| **Episode** | All acute patients, all DRGs | Selected DRGs, hospital plus post-acute period | Selected DRGs, post-acute period only | Selected DRGs, hospital plus readmissions |

| | | | | |
|---|---|---|---|---|
| **Services included in the bundle** | All Part A services paid as part of the MS-DRG payment | All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions | All non-hospice Part A and B services during the post-acute period and readmissions | All Part non-hospice A and B services (including the hospital and physician) during initial inpatient stay and readmissions |
| **Payment** | Retrospective | Retrospective | Retrospective | Prospective |

Plans for all models include care redesign and enhancements, such as reengineered care pathways using evidence-based medicine, standardized operating protocols, improved care transitions, and care coordination. All may also include proposals for gainsharing among provider partners.

*Retrospective Payment Bundling*

Model 1: Retrospective Acute Care Hospital Stay Only.

Under Model 1, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare will pay the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare will continue to pay physicians separately for their services under the Medicare Physician Fee Schedule. Under certain circumstances, hospitals and physicians will be permitted to share gains arising from the providers' care redesign efforts. Participation will begin as early as April, 2013 and no later than January, 2014 and will include most Medicare fee-for-service discharges for the participating hospitals.

Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care.

In Model 2, the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical condition episodes.

Model 3: Retrospective Post-Acute Care Only.

For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes.

In both Models 2 and 3, the bundle will include physicians' services, care by post-acute providers, related readmissions, and other related Medicare Part B services included in the episode definition such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies; and Part B drugs. A target price will be set that will be based on historical fee-for-service payments for the participant's Medicare beneficiaries in

the episode and will include a discount. Payments will be made at the usual fee-for-service payment rates, after which the aggregate Medicare payment for the episode will be reconciled against the target price. Any reduction in expenditures beyond the discount reflected in the target price will be paid to the participant and may be shared among their provider partners. Any expenditures that are above the target price will be repaid to Medicare by the participant.

*Prospective Payment Bundling*

Model 4: Acute Care Hospital Stay Only.
Under Model 4, CMS will 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 will submit "no-pay" claims to Medicare and will be paid by the hospital out of the bundled payment. Related readmissions for 30 days after hospital discharge will be included in the bundled payment amount. Participants can select up to 48 different clinical condition episodes.

**MODELS 2-4 – 2 PHASES OF IMPLEMENTATION**
Implementation of Models 2, 3, and 4 is divided into two phases. CMS will work with participants in Models 2, 3, and 4 during an initial period (Phase 1) to prepare for financial and performance accountability for episodes of care prior to becoming awardees and entering the "risk-bearing" period of performance (Phase 2).

**Phase 1** (January-July 2013), also referred to as the "no risk preparation" period, is the initial period of the initiative, where CMS and participants prepare for implementation and assumption of financial risk. All candidates included in Phase 1 submitted a final list of their episodes and planned partners in December 2012.

The "risk-bearing implementation" period, **Phase 2**, is expected to begin in July 2013. Those participants in Phase 1 of Models 2, 3, and 4, that are ultimately approved by CMS and decide to move forward with implementation and assume financial risk, may enter into a Bundled Payments for Care Improvement Model agreement with CMS and begin Phase 2 of the Model.

Phase 2 is expected to begin in July 2013. The beginning of Phase 2 would mark the beginning of the performance period, or risk-bearing period.

**SELECTION PROCESS**
Through the Bundled Payments for Care Improvement initiative, organizations are given flexibility in selecting clinical conditions to bundle, developing partnerships across the continuum of care within their communities, and determining how to redesign care delivery. CMS invited organizations to apply to help test and develop four different models of bundled payments in 2011. Expert technical review panels reviewed all applications and provided recommendations to CMS based on the applicants' capabilities, readiness, and commitment to implement care redesign and enhancements. Candidates then submitted final plans confirming partner organizations, specific episodes, episode length, and other key details in 2012.

**MORE INFORMATION**
For more information on the Bundled Payments for Care Improvement initiative, including a list of participants, please go to:http://innovation.cms.gov/initiatives/Bundled-Payments

###