**Bundled Payments for Care Improvement Initiative (BPCI)**
**Background on Model 3 for Prospective Participants**

BPCI is testing the effects of innovative episode-based payment approaches on patient experience of care, outcomes, and cost of care for Medicare fee-for-service beneficiaries. Episode-based payment bundles Medicare payments for services related to a particular clinical condition for a period of time across multiple providers and suppliers. The goal of BPCI is to align payment incentives among providers and suppliers with the health care experience of the Medicare beneficiary who is undergoing a period of treatment for a clinical condition.

To test episode-based payment for a variety of clinical conditions, CMS constructed 48 different episodes in BPCI, which can be found on the Innovation Center website at http://innovation.cms.gov/initiatives/Bundled-Payments/index.html. Each episode includes a family of related MS-DRGs, and episodes are linked to an acute care hospital inpatient stay for one of the included MS-DRGs. The hospital admission that triggers or initiates a beneficiary's episode is often referred to as the anchor MS-DRG. Episodes are defined broadly with few exceptions, and include most services covered under Medicare Part A and Part B that are provided to a beneficiary throughout the duration of the episode. The episodes are defined by anchor MS-DRGs and the Part A and B exclusions lists that identify services furnished during the episode period that are not included in the episode can be found on the Innovation Center website at http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html.

**Model 3: Retrospective Post-Acute Care**

In Model 3, the episode-based payment is retrospective. Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries in Model 3 episodes, after which the total payment for a beneficiary's episode is reconciled against a bundled payment amount (the target price) predetermined by CMS. The episode includes post-acute care following an inpatient acute care hospital stay and all related care covered under Medicare Part A and Part B within 30, 60, or 90 days following initiation of post-acute services. The episode begins at initiation of post-acute services with a participating skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), or home health agency (HHA) following an acute care hospital stay for an anchor MS-DRG or the initiation of post-acute care services where a member physician of a participating physician group practice (PGP) was the attending or operating physician for the beneficiary's inpatient stay.

The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants choose to participate in one or more of the 48 episodes, and they must select the length of each episode (30, 60, or 90 days).

There are different ways to participate in BPCI. Participants may enter into agreements with CMS to bear financial risk for the model, and these participants are called Awardees. An Awardee may be a single Medicare provider or supplier or a convening organization that coordinates multiple health care providers' participation in BPCI. Convening organizations may also participate as non-risk bearing organizations that coordinate the BPCI activities of multiple Awardees working with that convener. Such convening organizations do not enter into agreements with CMS.

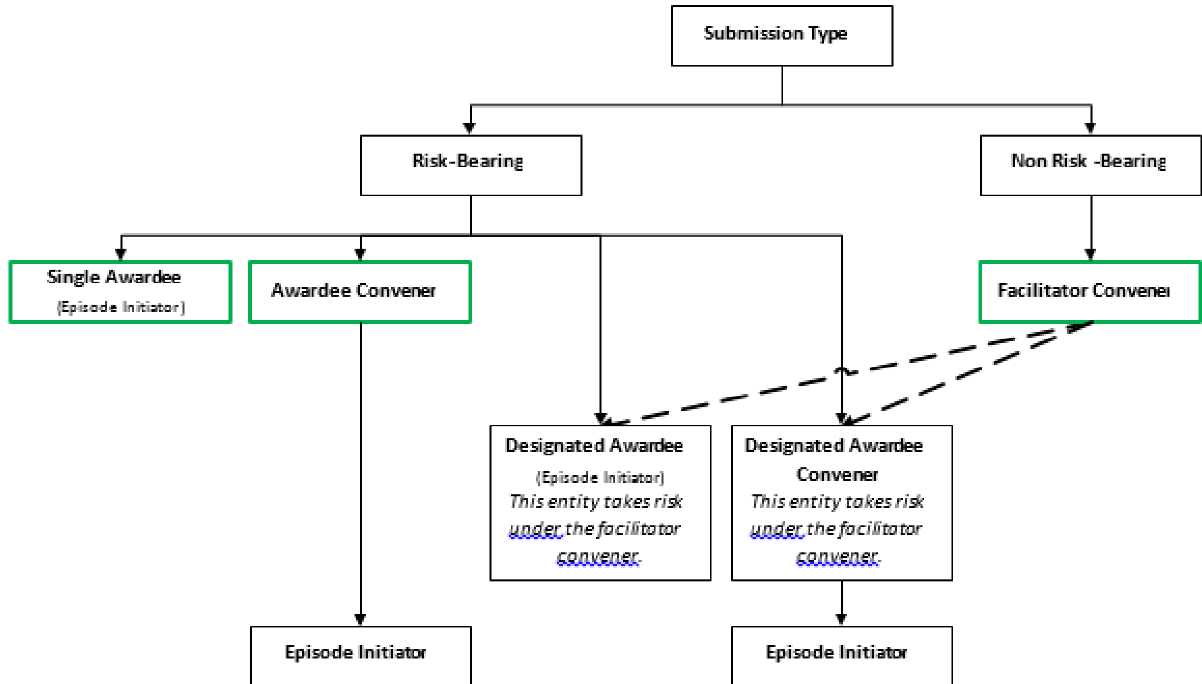
- Single Awardees participate in BPCI without the involvement of a convening entity. Single Awardees are Medicare providers or suppliers that enter into agreements with CMS, bear financial risk for the model, and provide services in the episodes.

- Awardee Conveners participate in BPCI as a convening organization that brings together multiple health care providers. Awardee Conveners enter into agreements with CMS and bear financial risk for the model, including all Episode Initiators (skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, home health agencies, and/or physician group practices under Model 3) that they convene. Awardee Conveners may also be Medicare providers or suppliers that provide services in the episodes.

- Facilitator Conveners participate in BPCI as a convening organization that brings together multiple health care providers. Facilitator Conveners do not enter agreements with CMS, bear financial risk, or receive any payments from CMS. Facilitator Conveners participate in BPCI along with those Designated Awardees and Designated Awardee Conveners that they convene.
  - Designated Awardees are Medicare providers or suppliers that enter into an agreement with CMS to bear financial risk for the model and provide services in the episodes. Designated Awardees have the same role as Single Awardees, except they participate in BPCI in collaboration with a Facilitator Convener.
  - Designated Awardee Conveners enter into an agreement with CMS to bear financial risk for the model. They may be Medicare providers or suppliers that provide services in the episodes. Designated Awardee Conveners have the same role as Awardee Conveners, except they participate in BPCI in collaboration with a Facilitator Convener.

- Episode Initiators in Model 3 are certain types of post-acute care providers (SNFs, IRFs, LTCHs, HHAs) and/or physician group practices (PGPs). When a post-acute care provider is an Episode Initiator, an episode is initiated when an eligible beneficiary is admitted to or initiates services with the Episode Initiator within 30 days after the beneficiary has been discharged from an inpatient stay at an acute care hospital (ACH) for one of the included MS-DRGs. When a PGP is an Episode Initiator, an episode is initiated when an eligible beneficiary is admitted to or initiates services with a SNF, IRF, LTCH, or HHA within 30 days after the beneficiary has been discharged from an inpatient stay at an ACH for one of the included MS-DRGs and a physician in the PGP was the attending or operating physician for the inpatient ACH stay. A physician is considered to be in the PGP if he/she has reassigned the right to receive Medicare payment to the PGP. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient ACH stay and end a minimum of 30, 60, or 90 days after the initiation of the episode. Episode Initiators participate in BPCI either as an Awardee or in collaboration with an Awardee Convener or Designated Awardee Convener.

High Level Schematic of Role




**Phases of Participation**

Model 3 has two phases of participation. Participants are selected for Phase 1 following CMS' review and acceptance of proposed care redesign plans and preliminary program integrity screening. Phase 1 is the initial period of participation in which participants prepare for implementation and assumption of financial risk. To support their preparation, CMS provides Phase 1 participants with monthly beneficiary-level claims data for episodes of care. Phase 1 participants also engage in a variety of learning activities with other BPCI Phase 1 and Phase 2 participants and receive target pricing information to inform their assessment of opportunities under BPCI. BPCI currently has hundreds of organizations participating in Phase 1 of Model 3, and many organizations participating in Phase 2 for certain episodes as well. Phase 2 is the risk-bearing period. To move into Phase 2 as an Awardee, participants must be selected by CMS following a comprehensive review and enter into an agreement with CMS.

**Payments & Reconciliation**

Medicare providers and suppliers continue to receive FFS payments for services they provide during an episode. Episodes include a range of Part A and Part B covered services, durable medical equipment (DME), and Part B drugs for eligible beneficiaries. The episodes are defined by anchor MS-DRGs and the Part A and B exclusions lists can be found on the Innovation Center website at http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html. Eligible

beneficiaries must be eligible for Medicare Part A and enrolled in Part B. To be eligible, beneficiaries must not have End Stage Renal Disease; not be enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations); and not be covered under United Mine Workers. Medicare must be the primary payer.

The total Medicare spending for included items and services for an eligible beneficiary during the length of the episode is compared to a predetermined bundled payment amount (the target price) following the conclusion of the episode. This retrospective reconciliation compares the total dollar amount of Medicare FFS expenditures for items and services (collectively referred to as “Aggregate FFS Payment” or “AFP”) furnished by the Awardee, the Episode Initiator, and other providers and suppliers during an episode with the target price. The calculation of target prices and reconciliation excludes Indirect Medical Education (IME), Disproportionate Share Hospital (DSH), and capital payments in Model 3. This retrospective reconciliation determines whether amounts are owed to the Awardee or to CMS. If the AFP is less than the target price, the Awardee receives the difference from CMS. If the AFP exceeds the target price, the Awardee is responsible for paying the difference to CMS because the Awardee bears the risk of exceeding the target price.

The episode cost to Medicare is calculated for each episode for Episode Initiators using three years of historical data (July 1, 2009 – June 30, 2012). Claims data are used to build episodes based on the included and excluded services for individual beneficiaries. If a minimum threshold of historical data is not available for a particular Episode Initiator for an episode, regional data are used to supplement the Episode Initiator’s historical data to calculate the episode cost. All episodes costs are trended to 2012 using national, episode-specific growth rates so that CMS can determine the cost of the episode in 2012 dollars. CMS then trends the 2012 episode cost to the participation year, and applies a discount that results in the target price. In Model 3, 30-day, 60-day, and 90-day episode costs are discounted by 3 percent.

Awardees may choose among three levels of reconciliation risk, or Risk Tracks, for each episode. Awardee may opt to bear risk up to the $75^{th}$, $95^{th}$, or $99^{th}$ percentile. Awardees bear 100 percent of the risk up to the risk track threshold and 20 percent of payments above the threshold for a given risk track. Risk tracks may be changed quarterly.

CMS monitors Part A and Part B spending for beneficiaries in Model 3 during the 30 days following the episode period to determine if spending in the post-episode period increases due to cost-shifting or other reasons. Awardees are responsible for paying CMS any excess amount that exceeds a threshold of spending in the post-episode period.

**Evaluation and Monitoring**

Participants are required to comply fully with CMS’ requests that support monitoring and evaluation of BPCI. CMS intends to measure quality metric domains, including structural and organizational characteristics; patient case-mix; clinical care and patient safety; patient experience; and utilization and cost. These include, but are not limited to, measures such as complication, mortality, and readmission

rates. Participants are required to provide CMS with ongoing monitoring information by tracking and reporting various data.

CMS' evaluation and monitoring activities may include, but are not limited to, the following:

- Interviews, surveys, and focus groups with beneficiaries, beneficiary proxies, family members and caregivers;
- Interviews, surveys, and focus groups with health care providers and participants' employees and contractors;
- Review and abstractions of charts, medical records, and other data from health care providers and participants' employees and contractors; and
- Site visits.

Participants are required to collect a subset of measures included in the BPCI Continuity Assessment Record and Evaluation (B-CARE) tool to evaluate beneficiary condition at discharge from the hospital.

**BPCI Agreements**

Agreements signed by Awardees cover three years of participation in Phase 2 of BPCI, which will begin on January 1, 2015 for new participants entering BPCI Model 3 through the Winter 2014 Open Period. While we do not anticipate this circumstance, CMS reserves the right to terminate an agreement at any time for reasons specified in the agreement, including but not limited to lack of funds to support BPCI Model 3 or termination of BPCI Model 3 pursuant to Section 1115A(b)(3)(B) of the Social Security Act. Awardees may also terminate their agreements with CMS at any time for any reason after providing notice to CMS.

**Fraud and Abuse Waivers**

Waivers of certain fraud and abuse authorities are available in Phase 2 for specified gainsharing, incentive payment, and patient engagement incentive arrangements in connection with BPCI Model 3, except as otherwise provided in a BPCI Model 3 Awardee's agreement with CMS.

**Medicare Payment Policy Waivers**

CMS has issued waivers of certain Medicare payment policies in connection with BPCI Model 3. For activities or services to qualify for a waiver, all of the terms of the applicable waiver as set forth in the agreement between an Awardee and CMS must be satisfied. As follows is a general summary of the waivers:

*Post-Discharge Home Visit*

CMS waives the direct supervision requirement in 42 C.F.R. § 410.26(b)(5) for "incident to" services, provided that such services are furnished as follows:

The services are furnished to a beneficiary who does not qualify for Medicare coverage of home health services under 42 C.F.R. § 409.42, and the services are furnished in the beneficiary's home after the beneficiary has been discharged from an Episode Initiator;

The services are furnished by licensed clinical staff under the general supervision of a physician or other practitioner as defined in 42 C.F.R. § 410.32(b)(3)(i);

The services are furnished by licensed clinical staff and billed by the physician or other practitioner using a Healthcare Common Procedures Coding System (HCPCS) G-code specified by CMS;

The services are furnished not more than once in a 30-day episode, not more than twice in a 60-day episode, and not more than three times in a 90-day episode; and

The services are furnished in accordance with all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. § 410.26(b).

*Telehealth*

Section 1834(m) of the Act allows Medicare payment for telehealth services where the originating site is one of eight healthcare settings that is located in a geographic area that satisfies certain requirements. CMS waives the geographic area requirement for telehealth services furnished to eligible beneficiaries during a Model 3 episode, as long as the services are furnished in accordance with all other Medicare coverage and payment criteria.

Summary Table of Model 3:

| **Model 3: Retrospective Post-Acute Care Stay** | |
|---|---|
| Examples of organizations that may participate in Model 3 | • Skilled nursing facilities<br>• Inpatient rehabilitation facilities<br>• Long-term care hospitals<br>• Home health agencies<br>• Physician group practices<br>• Conveners of health care providers<br>• Health systems |
| Entities that can initiate episodes in Model 3 | • Skilled nursing facilities (SNF)<br>• Inpatient rehabilitation facilities (IRF)<br>• Long-term care hospitals (LTCH)<br>• Home health agencies (HHA)<br>• Physician group practices (PGP) |
| Criteria for beneficiary inclusion in episode: | • The beneficiary is eligible for Part A and enrolled in Part B<br>• The beneficiary is admitted to or initiates services with an Episode Initiator within 30 days after the beneficiary has been discharged from an acute care hospital for an MS-DRG included in a clinical episode associated with the Episode Initiator.<br>• The beneficiary must not have End Stage Renal Disease<br>• The beneficiary must not be enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations). |

| Model 3: Retrospective Post-Acute Care Stay | |
|---|---|
| Start of episode: | • Post-acute care with an Episode Initiator (SNF, LTCH, IRF, or HHA) within 30 days after discharge from an acute care hospital for an MS-DRG included in a clinical episode associated with the Episode Initiator. In the case of a PGP Episode Initiator, post-acute care by any SNF, IRF, LTCH, or HHA within 30 days after discharge from an acute care hospital for an MS-DRG included in a clinical episode associated with the PGP Episode Initiator where any physician member of the PGP was the operating or admitting physician for the inpatient stay. |
| End of episode: | • 30, 60, or 90 days after the initiation of the episode |
| Types of services included in Bundle, which include broad clinical episode categories | • Physicians' services<br>• Inpatient post-acute care services<br>• Inpatient hospital readmission services<br>• Long term care hospital services<br>• Inpatient rehabilitation facility services<br>• Skilled nursing facility services<br>• Home health agency services<br>• Clinical laboratory services<br>• Durable medical equipment<br>• Part B drugs |
| Payment from CMS to providers: | • Traditional FFS payments |
| Discount provided to Medicare are defined by episode length: | • 3% discount for episodes of 30 ,60, or 90 days in length |
| Reconciliation | • Medicare pays the Awardee the difference between the target price and the actual cost of care for an episode if the actual cost of care is less than the target price. If the actual cost of care exceeds the target price, the Awardee pays Medicare the difference between the target price and actual spending. |