Bundled Payment Primer

CMS Opened Application
February 14, 2014

Why this matters to you!

Bundling is a New Business Model

Bundling is a focused opportunity to manage risk and achieve gain

Control of a bundle or clinical episode determined by “precedence” rules

Under bundled payment, care is a cost center rather than a revenue center and creating “value” becomes key to success
Health Care Reform Brings New Focus on Post-Acute Care

Rethinking the Organization of Care

BPCI- moving to pay-for-improvement

- The CMS BPCI (Bundled Payment for Care Improvement) is a three year demonstration on a pay-for-improvement reimbursement model designed to reduce healthcare spending within a network of providers.
- Risk bearing organizations (Awardees and Conveners) who excel in managing episodic costs will earn a share of the Medicare savings... and risk paybacks for cost over-runs.
- Conveners may choose to bear risk for a 30/60/90 day period in 3 risk tracks for each of the 48 DRG families representing 181 DRG’s.
- Risk and gain sharing is done through quarterly retrospective reconciliation of 30, 60 or 90 day claims.
- CMS has a goal of expanding risk bearing programs to 30% of all beneficiaries by 2016 and 50% by 2018.

Fee-for-Service  “Bundled Payment”

- patient has PAC healthcare needs
- Payor defines “bundle price” for a defined DRG & period
- Convener manages actual costs
- Payor pays providers for services billed
- Convener gets reward or penalty based on bundle price & actual costs

- patient has PAC healthcare needs
- Patient accesses PAC providers
- Providers bill payor for service
- Payor pays providers for services billed
Rapid Expansion of Bundling

In the next 3 years, bundled payments will represent 35% of U.S. health systems’ revenue.

24% of health plans currently implementing bundled payment contracts.

Health Systems
Average Percentage of Hospital Revenues by 2018:

- Fee-for-Service: 38%
- Bundled Payments: 35%
- Capitated or other payments w/insurance risk: 27%

Health Plans
Bundled Payment Implementation Plans:

- Currently implemented: 24%
- Planning to implement: 34%
- No plans: 42%

Bundled Payment Implementation Progress:

- Early: 12%
- Mid: 24%
- Late: 26%
- Unsure: 38%

2Source: Avality, The Health Plan Readiness to Operationalize New Payment Models, April 2013. The study was administered by independent research firm Porter Research in the fourth quarter of 2012. Porter Research completed interviews with qualified participants of 39 health plans that represented more than 50% of total covered lives in the United States. Target respondents included: quality management leadership, medical directors, and chief medical officers.

Why Post-Acute Care is Critical to the Success of Bundling
Conundrum of Volume Based Reimbursement in PAC

Improving clinical efficiency and efficacy requires investment in staff, training, systems

Highly efficient PAC providers are paid less than inefficient providers
Tremendous Variation in PAC Spending Provides Opportunity for Value Creation

If regional variation in PAC spending did not exist, Medicare spending variation would fall by 73%

Source: Variation in Health Care Spending, Institute of Medicine, October 2013

Significance of Post-acute Costs Vary by Clinical Condition

Source: MedPAC September 2012; MedPAC Analysis of 2004-2006 5% Medicare claims files
Four Models of BPCI

<table>
<thead>
<tr>
<th>Types of Services Included in Bundle</th>
<th>Model 1 Acute Hospital Stay Only</th>
<th>Model 2 Acute Hospital + Post-Acute</th>
<th>Model 3 Post-Acute Care Only</th>
<th>Model 4 Acute Hospital Stay + Readmissions</th>
</tr>
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<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Related post-acute care services</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-acute care services</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Related readmissions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other services defined in the bundle (Part A &amp; Part B)</td>
<td>✓</td>
<td>✓</td>
<td></td>
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</tr>
</tbody>
</table>

Awardees as of June 2014: 21, 148, 152, 22

Model 2 Versus Model 3

**Model 2**
Bundle Holder/At-Risk Entity = Hospital or PGP

- Episode-Initiating Hospital Admission
- PAC Services
- Physician Services
- Readmissions
- Other Services*

**Model 3**
Bundle Holder/At-Risk Entity = PAC Provider or PGP

- Episode-Initiating PAC Service
- Other PAC Services
- Physician Services
- Readmissions
- Other Services*

Note: Bundle holders may put in place contracts with downstream providers in which they share both financial risk and reward for the episodes.
* Includes Part B drugs, hospital outpatient services, DME, and laboratory services.
Potential Roles for Post-Acute Providers

**Model 2**  
ACH/PGP  
- **Episode Integrated Provider** to Model 2 Bundler  
- **Partner/Vendor** to Model 2 Bundler

**Model 3**  
PGP/PAC  
- **Model 3 Awardee or Awardee Convener**  
- **Model 3 Facilitator Convener**  
- **Episode Integrated Provider** to Model 3 Awardee  
- **Partner/Vendor** to Model 3 Awardee

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**Model 2 or Model 3: Controlling Readmissions Is Key to Success in PAC**

Cost of 30-Day Fixed Length Episode With and Without Readmission

<table>
<thead>
<tr>
<th>MS-DRG 247</th>
<th>MS-DRG 470</th>
<th>MS-DRG 481</th>
<th>MS-DRG 192</th>
<th>MS-DRG 194</th>
<th>MS-DRG 291</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Readmission</td>
<td>Readmission</td>
<td>No Readmission</td>
<td>Readmission</td>
<td>No Readmission</td>
<td>Readmission</td>
</tr>
<tr>
<td>$12,301</td>
<td>$23,527</td>
<td>$29,803</td>
<td>$32,262</td>
<td>$14,977</td>
<td>$19,243</td>
</tr>
<tr>
<td>$18,128</td>
<td>$23,034</td>
<td>$5,514</td>
<td>$8,492</td>
<td>$12,075</td>
<td>$23,844</td>
</tr>
</tbody>
</table>

DRG 247: Percutaneous cardiovascular procedure with drug-eluting stent w/MCC
DRG 470: Major joint replacement or reattachment of lower extremity w/o MCC
DRG 481: Hip and femur procedures except major joint w/CC
DRG 192: Chronic obstructive pulmonary disease w/o CC/MCC
DRG 194: Simple pneumonia and pleurisy w/CC
DRG 291: Heart failure and shock w/MCC

Orthopedics Example: Bundling Changes Use of Acute and Post-Acute

Shared savings: 45% Physicians
45% Hospital
10% Visiting Nurse

A Closer Look at Model 3
Criteria for Beneficiary Inclusion in Episode in Model 3

• Beneficiary is:
  – Eligible for Part A and enrolled in Part B
  – 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

• Beneficiary must:
  – Not have end-stage renal disease (defined Medicare Benefit)
  – Not be enrolled in any managed care plan, e.g., Medicare Advantage, health care prepayment plans, cost-based health maintenance organizations)

Examples of Organizations That May Participate in Model 3

• Skilled nursing facilities
• Inpatient rehabilitation facilities
• Long-term care hospitals
• Home health agencies
• Physician group practices
• Conveners of health care providers
• Health systems
Entities That Can Initiate Episodes in Model 3

- Skilled nursing facilities (SNF)
- Inpatient rehabilitation facilities (IRF)
- Long-term care hospitals (LTCH)
- Home health agencies (HHA)
- Physician group practices (PGP)

Bundled Payment Components

- Defined population
- Defined period of time
- Quality of care
- Fixed price
### Defined Population

- **Defined population**
- **Defined period of time**
- **Quality of care**
- **Fixed price**

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### 48 Diagnostic Families: Orthopedics

<table>
<thead>
<tr>
<th>Orthopedics</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Major joint replacement of the lower extremity</td>
</tr>
<tr>
<td>- Hip &amp; femur procedures except major joint</td>
</tr>
<tr>
<td>- Spinal fusion (non-cervical)</td>
</tr>
<tr>
<td>- Revision of the hip or knee</td>
</tr>
<tr>
<td>- Lower extremity &amp; humerus procedure except hip, foot, femur</td>
</tr>
<tr>
<td>- Double joint replacement of the lower extremity</td>
</tr>
<tr>
<td>- Fractures femur and hip/pelvis</td>
</tr>
<tr>
<td>- Amputation for MSK/CT or endocrine/nutrition or circ disorder</td>
</tr>
<tr>
<td>- Back &amp; neck except spinal fusion</td>
</tr>
<tr>
<td>- Cervical spinal fusion</td>
</tr>
<tr>
<td>- Major joint upper extremity</td>
</tr>
<tr>
<td>- Combined anterior posterior spinal fusion</td>
</tr>
<tr>
<td>- Complex non-cervical spinal fusion w/spinal curv/malig/infxn/9+fusion</td>
</tr>
<tr>
<td>- Removal of devices (both hip/femur and other)</td>
</tr>
<tr>
<td>- Knee procedures w/ and w/o infection</td>
</tr>
<tr>
<td>- Medical non-infectious orthopedic problems (sprains, strains, back pain)</td>
</tr>
</tbody>
</table>
### 48 Diagnostic Families: Cardiology and Cardiothoracic Surgery

<table>
<thead>
<tr>
<th>Cardiology</th>
<th>Cardiothoracic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CHF</td>
<td>• Cardiac valve</td>
</tr>
<tr>
<td>• Percutaneous coronary intervention</td>
<td>• CABG</td>
</tr>
<tr>
<td>• Cardiac arrhythmia</td>
<td>• Major cardiovascular procedure</td>
</tr>
<tr>
<td>• AMI discharged alive</td>
<td></td>
</tr>
<tr>
<td>• Pacemaker</td>
<td></td>
</tr>
<tr>
<td>• Cardiac defibrillator</td>
<td></td>
</tr>
<tr>
<td>• Chest pain</td>
<td></td>
</tr>
<tr>
<td>• Transient ischemia</td>
<td></td>
</tr>
<tr>
<td>• Pacemaker device replacement or revision</td>
<td></td>
</tr>
<tr>
<td>• AICD generator or lead</td>
<td></td>
</tr>
</tbody>
</table>

### 48 Diagnostic Families: Internal, Pulmonary Medicine, Neurology, Other

<table>
<thead>
<tr>
<th>Internal Medicine</th>
<th>Neurology</th>
<th>Pulmonary Medicine</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• UTI</td>
<td>• Stroke w/ and w/o T-PA</td>
<td>• Simple pneumonia/Respiratory infections</td>
<td>• Sepsis</td>
</tr>
<tr>
<td>• Nutritional &amp; misc metabolic disorders</td>
<td>• Syncope &amp; collapse</td>
<td>• COPD, bronchitis/asthma</td>
<td>• Major bowel</td>
</tr>
<tr>
<td>• Peripheral vascular disorders (medical)</td>
<td></td>
<td>• Other respiratory</td>
<td>• Cellulitis</td>
</tr>
<tr>
<td>• Atherosclerosis</td>
<td></td>
<td></td>
<td>• GI hemorrhage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• GI obstruction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Renal failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Esophagitis, gastroenteritis &amp; misc digestive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Other vascular</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Red blood cell disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Diabetes</td>
</tr>
</tbody>
</table>
## Top Bundles for All Model 3 Participants

*Represents Participants & Conditions Moved Into Phase 2*

1. Congestive heart failure (94%)
2. COPD, bronchitis/asthma (79%)
3. Simple pneumonia & respiratory infections (77%)
4. UTI (75%)
5. Other respiratory (73%)
6. Acute myocardial infarction (AMI) (64%)
7. Cardiac arrhythmia (63%)
8. Cardiac defibrillator, Cardiac valve, Chest pain, Coronary artery bypass graft surgery, Medical peripheral vascular disorders, Other vascular surgery, Percutaneous coronary intervention, Stroke (63%)
9. Fractures femur and hip/pelvis (56%)
10. Sepsis (55%)

* 84 Model 3 awardees (55%) have moved into Phase 2  

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### Defined Period of Time

- Defined population
- Defined period of time
- Quality of care
- Fixed price
Start and End of Episode
Model 3

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

End of Episode
• 30, 60, or 90 days after the initiation of the episode

Length of Episodes for Model 3 Bundlers as of 6-2014

<table>
<thead>
<tr>
<th>Name of Episode</th>
<th>No. Participating</th>
<th>% Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day episodes</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>60-day episodes</td>
<td>53</td>
<td>3.0%</td>
</tr>
<tr>
<td>90-day episodes</td>
<td>1,729</td>
<td>97.0%</td>
</tr>
<tr>
<td>All Episodes Total</td>
<td>1,782</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: CMS.gov February 2014
Fixed Price

- Defined population
- Defined period of time
- Quality of care
- Fixed price

Payment Parameters

- **Payment from CMS to providers**: traditional FFS payments
- **Discount provided to Medicare defined by episode length**: 3% discount for episodes of 30, 60, or 90 days in length
- **Reconciliation**:
  - Medicare pays awardee difference between target price and actual cost of care for an episode if actual cost of care is less than target price
  - Awardee pays Medicare difference between target price and actual spending if actual cost of care exceeds target price
Included Services in Bundle:
Which Include Broad Clinical Episode Categories

- Physicians’ services
- Inpatient post-acute care services
- Inpatient hospital readmission services
- Long-term care hospital services
- Inpatient rehabilitation facility services
- Skilled nursing facility services
- Home health agency services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs (injectibles)
- **NOTE**: HOSPICE IS NOT INCLUDED
- Part D drugs not included
- Some exclusions to readmissions and other ICD-9 codes

Target Price and Reconciliation Process

**Set Target Price**
- Price is set based on baseline episode costs for each selected episode at DRG family level; then 3% discount applied
- May include low-volume adjustment

**Upfront FFS Payments**
- Medicare pays all Part A and Part B providers who serve patients identified as participating in the initiative using current FFS payment systems

**Quarterly Payment Reconciliation**
- Approximately six months after patient’s episode ends, actual expenditures are compared to target price:
  - If expenditures exceed target price, awardee pays difference to Medicare
  - If expenditures less than target price, Medicare pays difference to awardee
Target Price: SNF as episode initiator (Sample Case Study)

SNF Episodic Stats: (All) ; (All)

All DRG's

$2,066

$1,617

$552

$2,200

$17,914

Historic “bundled Price” = $25,144

Mandatory 3% savings = $754

Projected “target price” = $24,390 or less
Care Redesign is Integral to Bundling

• Care redesign includes all of the providers and suppliers of care who must work together to achieve goals

• Care redesign focuses on using evidence-based practices to redesign the care provided for a specific bundle that will measurably improve care, prevent readmissions and ED visits, and improve patient outcomes

• Pathways extend from the hospital into the post-acute settings, home health, assisted living, and home care
Risks and Rewards of participating in BPCI

**Rewards**
- Gain experience managing risk
- Capture gains from reducing hospitalizations and retain revenues from reducing length of stay
- Access valuable data during preparatory phase: learn more about your position in your market

**Risks**
- Insufficient bandwidth to successfully execute bundled payment initiative
- Insufficient scale or inadequate management of readmissions leads to making payments to CMS
- Acuity level of referrals increases relative to baseline
Keys to Managing Downside Risk in BPCI

- Robust care redesign that targets readmissions
- Selection of diagnostic families for bundling
- Achieving sufficient scale
- Stratify patients by risk to customize intensity of interventions

Bundling Market Dynamics
Which Bundler Owns the Clinical Episode/Patient?

Reminder: Four Models of BPCI

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<tr>
<td>Related post-acute care services</td>
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<td></td>
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<td>Awardees as of June 2014</td>
<td>21</td>
<td>148</td>
<td>152</td>
<td>22</td>
</tr>
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</table>
**Precedence Rules: Which Entity Owns the Bundle?**

- Model 4 always trumps Model 2 and 3
- Across model types, the clinical episode that enters risk first always trumps later start dates
- Within a given model type, a Physician Group Practice (PGP) always trumps a non-PGP
- Model 2 trumps Model 3 (in almost all cases)

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**Alternative Value Based Models**

- CMS has set a goal of 50% of Medicare FFS payments paid through alternative value-based models by 2018
- Both ACOs and Bundlers are alternative models
- Primary Risk Takers (ACOs and Bundlers) control the downstream flow of risk
PAC Risk Managers

- PAC providers are being organized and managed by PAC risk managers who will determine payment to PAC providers.

Post Acute Providers with competencies in episode management will become the sought-after partner.

- Requires Investment of time, energy and resources:
  - clinical processes
  - operational processes
  - data processes
  - partnership processes
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