National Bundled Payment Summit 2016
CMS Keynote

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CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people

Public and Private sectors

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

As of **January 01, 2016**, the **30% goal was achieved one year ahead of schedule.**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

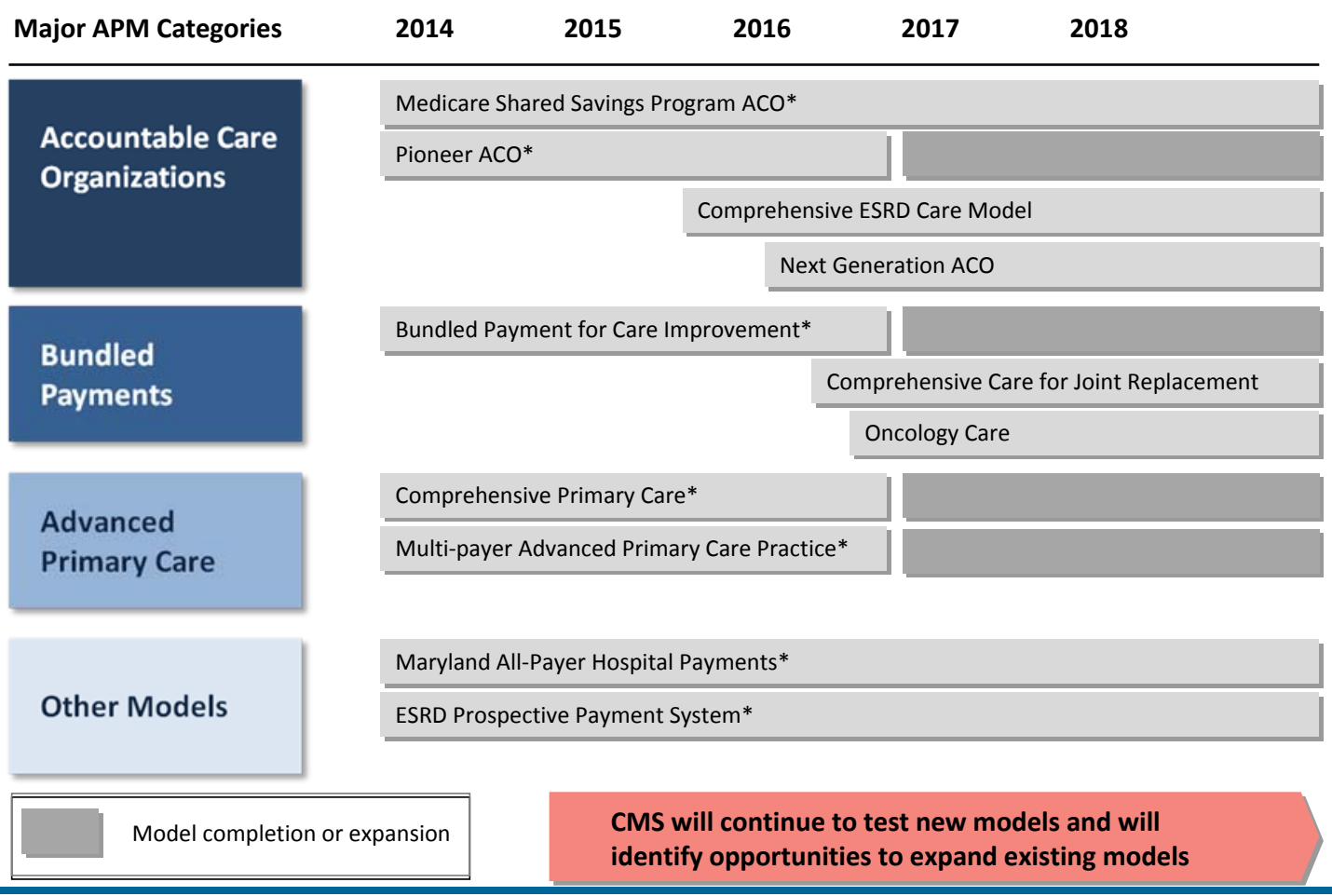
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality



* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011

The Case for Bundled Payments

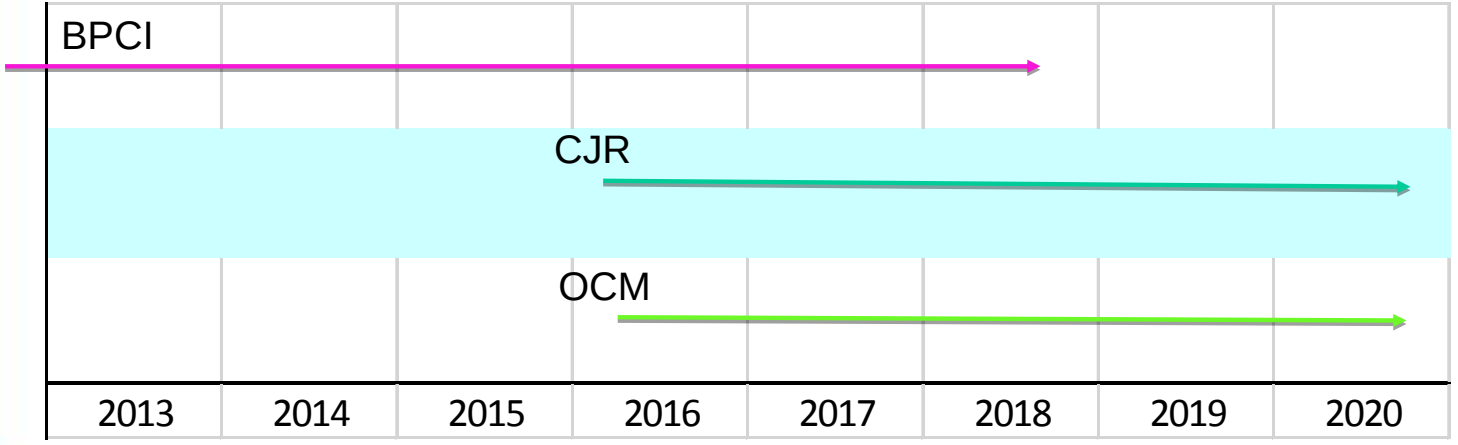
- Large opportunity to reduce costs from waste and variation
- Gainsharing incentives align hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
- Improvements “spillover” to private payers
- Strategies learned in bundled payments lay the foundation for success in a value driven market
- Adoption of bundled payments is accelerating across both private and public payers
- Valuable synergies with ACOs, Medicare’s Shared Savings Program and other payment reform initiatives

CMMI: Episode-Based Payment Models

- Bundled Payments for Care Improvement (BPCI)
- Comprehensive Care for Joint Replacement (CJR)
- Oncology Care Model (OCM)

CMMI: Episode-Based Payment Models

CMS is testing multiple episode-based payment models that, while diverse in their structure and clinical focus, all incentivize higher quality, more efficient, coordinated care for beneficiaries



Bundled Payments for Care Improvement (BPCI)

Rationale for BPCI Episode Parameters

- Broad bundles to strongly incentivize care coordination and care for the whole beneficiary, despite the specific clinical episode
- Allow flexibility for providers to select clinical conditions, risk tracks, and episode lengths with greatest opportunity for improvement
- Enable episodes that have a sufficient number of beneficiaries to demonstrate meaningful results
- Assure enough simplicity to allow rapid analysis and implementation of episode definitions
- Achieve episodes that balance financial risk and opportunity
- Build on lessons from prior initiatives and CMS demonstrations

Bundled Payments for Care Improvement: Models Overview

Model 1	Bundled payment models for the acute inpatient hospital stay only (1 Awardee; 10 Awardees completed their period of performance 3/31/2016)
Model 2	Retrospective bundled payment model for hospitals, physicians, and post-acute providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care (649 Awardees or Episode Initiators)
Model 3	Retrospective bundled payment models for post-acute care where the bundle does not include the acute inpatient hospital stay (862 Awardees or Episode Initiators)
Model 4	Prospectively administered bundled payment models for hospitals and physicians for the acute inpatient hospital stay only (10 Awardees)

BPCI Provider Types

Provider Type	Model 2	Model 3	Model 4	TOTAL
Acute Care Hospital	375	0	9	384
Physician Group Practice	234	49	0	283
Home Health Agency	0	99	0	99
Inpatient Rehab Facility	0	9	0	9
Long Term Care Hospital	0	1	0	1
Skilled Nursing Facility	0	681	0	681
TOTAL	609	839	9	1457

BPCI: 48 Clinical Episodes

Acute myocardial infarction	Major bowel procedure
AICD generator or lead	Major cardiovascular procedure
Amputation	Major joint replacement of the lower extremity
Atherosclerosis	Major joint replacement of the upper extremity
Back & neck except spinal fusion	Medical non-infectious orthopedic
Coronary artery bypass graft	Medical peripheral vascular disorders
Cardiac arrhythmia	Nutritional and metabolic disorders
Cardiac defibrillator	Other knee procedures
Cardiac valve	Other respiratory
Cellulitis	Other vascular surgery
Cervical spinal fusion	Pacemaker
Chest pain	Pacemaker device replacement or revision
Combined anterior posterior spinal fusion	Percutaneous coronary intervention
Complex non-cervical spinal fusion	Red blood cell disorders
Congestive heart failure	Removal of orthopedic devices
Chronic obstructive pulmonary disease, bronchitis, asthma	Renal failure
Diabetes	Revision of the hip or knee
Double joint replacement of the lower extremity	Sepsis
Esophagitis, gastroenteritis and other digestive disorders	Simple pneumonia and respiratory infections
Fractures of the femur and hip or pelvis	Spinal fusion (non-cervical)
Gastrointestinal hemorrhage	Stroke
Gastrointestinal obstruction	Syncope & collapse
Hip & femur procedures except major joint	Transient ischemia
Lower extremity and humerus procedure except hip, foot, femur	Urinary tract infection

BPCI: Most Prevalent Clinical Episodes in Models 2-4

The five most prevalent Clinical Episodes make up 21.8% of the Clinical Episodes currently being tested in BPCI.

Most Prevalent Clinical Episodes in Models 2-4	Number of Episodes	Percent of Total Episodes
Major joint replacement of the lower extremity	865	6.7%
Simple pneumonia and respiratory infections	551	4.2%
Congestive heart failure	515	4.0%
Chronic obstructive pulmonary disease, bronchitis, asthma	464	3.6%
Hip & femur procedures except major joint	431	3.3%
Total	2826	21.8%

BPCI: Waivers

- Fraud and abuse waivers

  Waivers of certain fraud and abuse authorities are available in Phase 2 of Models 2-4 for specified gainsharing, incentive payment, and patient engagement incentive arrangements, narrowly crafted based on the model policies and taking into consideration the provisions of the Awardee Agreement

- Payment policy waivers

  3-Day Hospital Stay Requirement for SNF Payment (Model 2)

  Telehealth (Models 2, 3)

  Post-Discharge Home Visit (Models 2, 3)

Comprehensive Care for Joint Replacement (CJR)

CJR: Overview

CJR Model began **April 1, 2016, runs through December 31, 2020**

Model participation is required in 67 metropolitan statistical areas (MSAs) and includes **almost 800 acute care hospitals**

Participant **hospitals receive prospective episode target prices** that reflect expected spending for a LEJR episode. Providers and suppliers continue to be paid via Medicare FFS and actual spending will be compared to target price after a performance year

No downside risk in Year 1, **two-sided risk years 2-5**

Payment tied to quality using quality composite score

CJR: Episodes

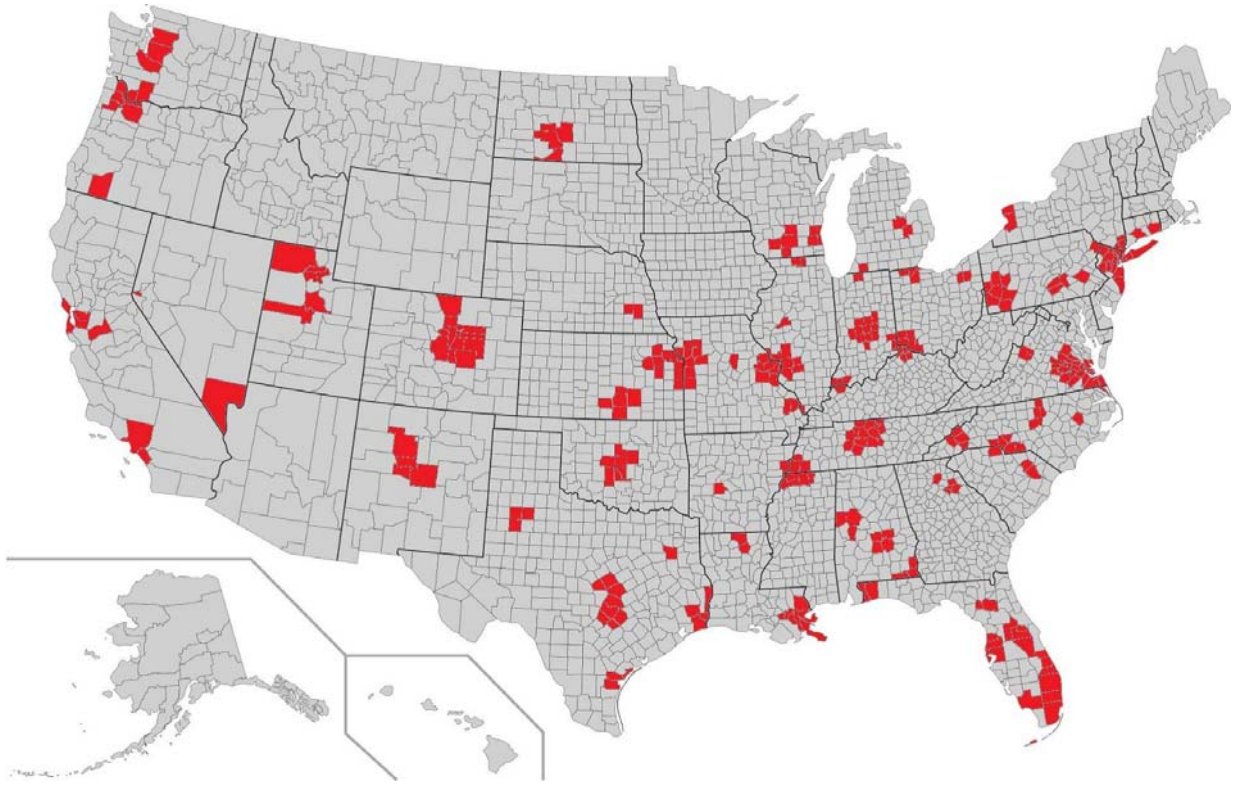
Episodes are triggered by hospitalizations of eligible Medicare Fee-for-Service beneficiaries discharged with diagnoses:

- **MS-DRG 469:** Major joint replacement or reattachment of lower extremity with major complications or comorbidities
- **MS-DRG 470**: Major joint replacement or reattachment of lower extremity without major complications or comorbidities

Episodes include:

- Hospitalization and 90 days post-discharge
- All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode

CJR: Participants



CJR: Payment

Retrospective, two-sided risk model with hospitals bearing financial responsibility

- Providers and suppliers continue to be paid via Medicare FFS
- After a performance year, actual episode spending will be compared to the episode target prices
  - If aggregate target prices are greater than actual episode spending, hospitals may receive a reconciliation payment
  - If aggregate target prices are less than actual episode spending, hospitals will be responsible for making a payment to Medicare

Responsibility for repaying Medicare begins in Year 2, with no downside responsibility in Year 1

CJR: Quality

Hospitals are assigned a composite quality score each year based on their performance and improvement on the following 2 quality measures:

- Hospital Level Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0166)

Participant hospitals who successfully submit voluntary THA/TKA patient-reported outcomes and limited risk variable data receive additional points for their composite quality score.

CJR: Waivers

Waivers provide additional flexibilities for hospitals participating in CJR to increase LEJR episode quality, decrease episode spending, and to provide better, more coordinated care for beneficiaries.

3 Medicare Program Rule Waivers

- Post-discharge home visits
- Telehealth
- Skilled Nursing Facility (SNF) 3-Day Stay Rule

Consistent with applicable law, participant hospitals may have certain financial arrangements with collaborators to support their efforts to improve quality and reduce costs.

Oncology Care Model (OCM)

Oncology Care Model

- The Innovation Center's Oncology Care Model (OCM) focuses on an episode of cancer care, specifically a chemotherapy episode of care
- The goals of OCM are to utilize appropriately aligned financial incentives to improve:
    1) Care coordination
    2) Appropriateness of care
    3) Access for beneficiaries undergoing chemotherapy
- Financial incentives encourage participating practices to work collaboratively to comprehensively address the complex care needs of beneficiaries receiving chemotherapy treatment, and encourage the use of services that improve health outcomes.
- Begins July 1, 2016.

OCM: Participants & Practice Requirements

Episode-based payment model targets chemotherapy and related care during a 6-month period following the initiation of chemotherapy treatment

Physician practices that are Medicare providers and furnish chemotherapy. Practices are required to engage in practice transformation to improve the quality of care they deliver.

Practice Requirements

- Provide the core functions of patient navigation;
- Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan outlined in the Institute of Medicine report, “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis”*;
- Provide 24 hours a day, 7 days a week patient access to an appropriate clinician who has real-time access to practice’s medical records; and
- Treat patients with therapies consistent with nationally recognized clinical guidelines.
- Use data to drive continuous quality improvement.
- Use certified electronic health record technology

OCM: Payers

Multi-Payer Model

OCM is multi-payer model that includes Medicare fee-for-service (OCM-FFS) as well as commercial payers (OCM-OP) working together to transform care for all patients living with cancer

Payer Agreement

CMS invited other payers to participate in OCM by entering into a Memorandum of Understanding (MOU) with CMS.

Consistent but Not Identical Approach

There are differences between OCM-FFS and other payers in certain areas, such as specific payment amounts and episode definition. However, the approach to practice transformation is consistent across all payers in OCM.

OCM: Episode Definition

Types of cancer

- OCM includes nearly all cancer types

Episode initiation

- Episodes initiate when a beneficiary starts chemotherapy
- The Innovation Center has devised a list of chemotherapy drugs that trigger OCM episodes, including endocrine therapies but excluding topical formulations of drugs

Included services

- All Medicare A and B services that Medicare FFS beneficiaries receive during episode
- Certain (limited) Part D expenditures will also be included

Episode duration

- OCM episodes extend six months after a beneficiary's chemotherapy initiation.
- Beneficiaries may initiate multiple episodes during the five-year model performance period

OCM: Two-Part Payment Approach

During OCM, participating practices will be paid Medicare FFS payments plus:

(1) Per-beneficiary-per-month (PBPM) payment

- $160 PBPM payment for enhanced services required by OCM that is paid during the chemotherapy episode
- OCM practices are eligible for the PBPM monthly for each month of the 6-month episode, unless beneficiary enters hospice

(2) Performance-based payment

- Incentive to lower the total cost of care and improve quality of care for beneficiaries over the 6-month episode period
- Retrospective payment that is calculated based on the practice's historical Medicare expenditures and achievement on selected quality measures

OCM: Risk Arrangement Options

One-Sided

- Participants are NOT responsible for Medicare expenditures that exceed target price
- 5-year model duration
- Medicare discount = 4%
- *Must qualify for performance-based payment by end of Year 3*

Two-Sided

- Participants are responsible for Medicare expenditures that exceed target price
- Option to take downside risk, beginning in Year 3 (one-sided risk for Years 1 and 2)
- Medicare discount = 2.75%
- *Must qualify for performance-based payment by end of Year 3*

OCM: Quality Measures

OCM Measure #	Measure Description	Source
OCM-1	Risk Adjusted proportion of patients with all-cause hospital admissions	Claims
OCM-2	Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission	Claims
OCM-3	Proportion of patients who died who were admitted to hospice for 3 days or more	Claims
OCM-4	Pain assessment and management	Practice
OCM-5	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Practice
OCM-6	Patient-reported experience of care	Survey
OCM-7	Prostate cancer: Adjuvant hormonal therapy for high-risk beneficiaries	Practice
OCM-8	Timeliness of adjuvant chemotherapy for colon cancer	Practice
OCM-9	Timeliness of combination chemotherapy for hormone receptor negative breast cancer	Practice
OCM-10	Trastuzumab received by patients with AJCC stage I (T1c) to III Her2/neu positive breast cancer	Practice
OCM-11	Hormonal therapy for stage IC-IIIC estrogen receptor/progesterone receptor positive breast cancer	Practice
OCM-12	Documentation of current medication	Practice

Questions?

Thank you!

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