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Update on CMS Bundled Payment Policies

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

Key characteristics

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

Key characteristics

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

Focusing on efforts to accelerate the move from a healthcare system that pays for volume to one that pays for value & encourages provider innovation

> *We recognize that the best ideas don't come from Washington, so it's important that we hear from the front lines of our healthcare system about how we can improve care.*

FOCUS AREAS

- Empower beneficiaries as consumers
- Provide price transparency
- Increase price & competition to drive quality
- Reduce costs
- Improve outcomes

Source: Verma S. Feedback on New Direction Request for Information (RFI) Released, CMS Innovation Center's Market-Driven Reforms to Focus on Patient-Centered Care CMS Press Release 2018 April 23.

CMS Innovation Center New Direction Request for Information

The CMS Innovation Center released an RFI that seeks broad input related to a new direction for the CMS Innovation Center that will promote **patient-centered care** and **test market-driven reforms** that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, and improve outcomes.

The administration plans to launch models in several focus areas:

1. Expanded Opportunities for Participation in Advanced APMs
2. Consumer-Directed Care & Market-Based Innovation Models
3. Physician Specialty Models
    - Physician-Focused Payment Model Technical Advisory Committee (PTAC) Recommended Models
4. Prescription Drug Models
5. Medicare Advantage (MA) Innovation Models
6. State-Based and Local Innovation, including Medicaid-focused Models
7. Mental and Behavioral Health Models
8. Program Integrity

Guiding Principles

- Choice and competition in the marketplace
- Provider choice and incentives
- Patient-centered care
- Benefit design and price transparency
- Transparent model design and evaluation
- Small scale testing

Comprehensive Care for Joint Replacement (CJR)

Comprehensive Care for Joint Replacement (CJR)

- Bundled payment for LEJR episode of care.
- Discharging hospital is financially accountable entity.
- Implemented through rulemaking in 2015.
- Five performance years: 2016-2020.
- Mandatory participation for PY1 & PY2.
- One-time opt in for 33 of 67 MSAs and rural/low volume providers.

Description of Episode

- Triggered by discharge from acute care hospital with MSDRG of 469 or 470.
- Includes 90 days Part A & Part B spending.
- Certain clinical exclusions for services clinically unrelated (e.g. hemophilia clotting factor, trauma, and cancer).

Participants

- As of February 1, 2018, 462 Hospitals:
  - 387 Mandatory
  - 86 opted in to model (11 rural/low volume)

Pricing and Payment Details

- Prospective target prices with 3% discount; discount can reduce to 1.5% with excellent quality results.
- Initial and Final reconciliations for each PY.
- Downside risk begins in PY2.
- Target pricing shifts from hospital-based to regional throughout PYs.
- Stop-gain and Stop-loss limits:
  - PY1 (5% stop-gain only) & PY2 (5%), PY3 (10%), PY4 & PY5 (20%)
  - MDHs/RRCs/SCHs 3% stop-loss in PY2, 5% for PY3-PY5

Quality

- Composite Quality Score (CQS) includes:
  - Capped at 20 points, used to assign provider a quality category (below acceptable, acceptable, good, excellent).
  - Performance points for THA/TKA complications measure.
  - Performance points for HCAHPS survey measure.
  - Additional quality improvement points earned by improvement in either measure.
  - If applicable, 2 additional points for successful data submission of patient reported outcomes and limited risk variable data.
- CQS impacts financial results – better quality means increased opportunity for reconciliation payments.

Reconciliation

- There was no downside risk for participants in performance year 1; downside risk phased in beginning with 5% in PY2, 10% in PY3 and 20% in PY4 & PY5

- Each CJR performance year is reconciled 2 months after the close of the performance year and then again 14 months later to allow for claim run out and updated data files.

- Initial Reconciliation Reports for Performance Year (PY) 1 were distributed to CJR participants at the end of April 2017; 382 providers who had actual episode spending below the target price and who achieved a minimum composite quality score earned initial reconciliation payments; a final reconciliation on PY 1 and an initial reconciliation of PY 2 will occur beginning June 2018.

- Financial arrangements to allow gainsharing are permitted under the model.

Interim Final Rule with Comment (IFC)

The December 1, 2017 final rule and interim final rule with comment also finalized several technical refinements and clarifications including:

- Codification of CJR Model-related Evaluation Participation
- Clarification of CJR Reconciliation Following Hospital Reorganization Events
- Adjustment to the Pricing Calculation for the CJR Telehealth HCPCS Codes to Include the Facility Practice Expense (PE) Values
- Clarification of Use of Amended Composite Quality Score Methodology During CJR Model Performance Year 1 Subsequent Reconciliation
- Change to the criteria for the Affiliated Practitioner List to broaden the CJR Advanced Alternative Payment Model (APM) track to additional eligible clinicians.

IFC, continued

- This policy will apply for **performance years 2 through 5**.
- For CJR hospital located in areas for which a waiver under section 1135 of the SSA invoked by Secretary of HHS if also located in major disaster area under Stafford Act or National Emergencies Act.
- For non-fracture episodes with a date of admission to the anchor hospitalization on or within 30 days before the date that the emergency period begins, actual episode payments are capped at the target price determined for those episodes under§510.300.
- For fracture episodes with a date of admission to the anchor hospitalization on or within 30 days **before *or after*** the date that the emergency period begins, actual episode payments are capped at the target price determined under §510.300.

TKA

- We anticipate engaging in rulemaking this year to address the removal of total knee replacements from the Inpatient Only List.
- Knee replacements can be done outpatient and CJR only has inpatient episodes.
- More to come.

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The CMS Oncology Care Model

Oncology Care Model Background

- The Innovation Center also focuses on specialty care, including improving the quality of oncology care.
- In 2016, more than 1.6 million new cases of cancer were diagnosed, and cancer was responsible for the death of an estimated 600,000 Americans. A significant proportion of those diagnosed are over 65 years old and Medicare beneficiaries.
- According to the NIH, based on growth and the aging of the U.S. population, medical expenditures for cancer in the year 2020 are projected to reach at least $158 billion (in 2010 dollars) – an increase of 27 percent over 2010.
- The Innovation Center is pursuing the opportunity to further its goals of improved quality of care at the same or lower cost through an oncology payment model.

OCM Overview

- Five-year model (2016-2021) to test innovative payment strategies that promote high-quality and high-value cancer care

- Real-time monthly payments (MEOS) that pay for enhanced services for beneficiaries combined with usual Medicare FFS payments and the potential for a retrospective performance-based payment based on quality and savings

OCM Overview

Episode-based

Payment model targets chemotherapy and related care during a 6-month period that begins with receipt of chemotherapy treatment

Emphasizes practice transformation

Physician practices are required to implement practice redesign activities to improve the quality of care they deliver

Multi-payer model

Includes Medicare fee-for-service and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the practice's population

Timeline: July 1, 2016-June 30, 2021

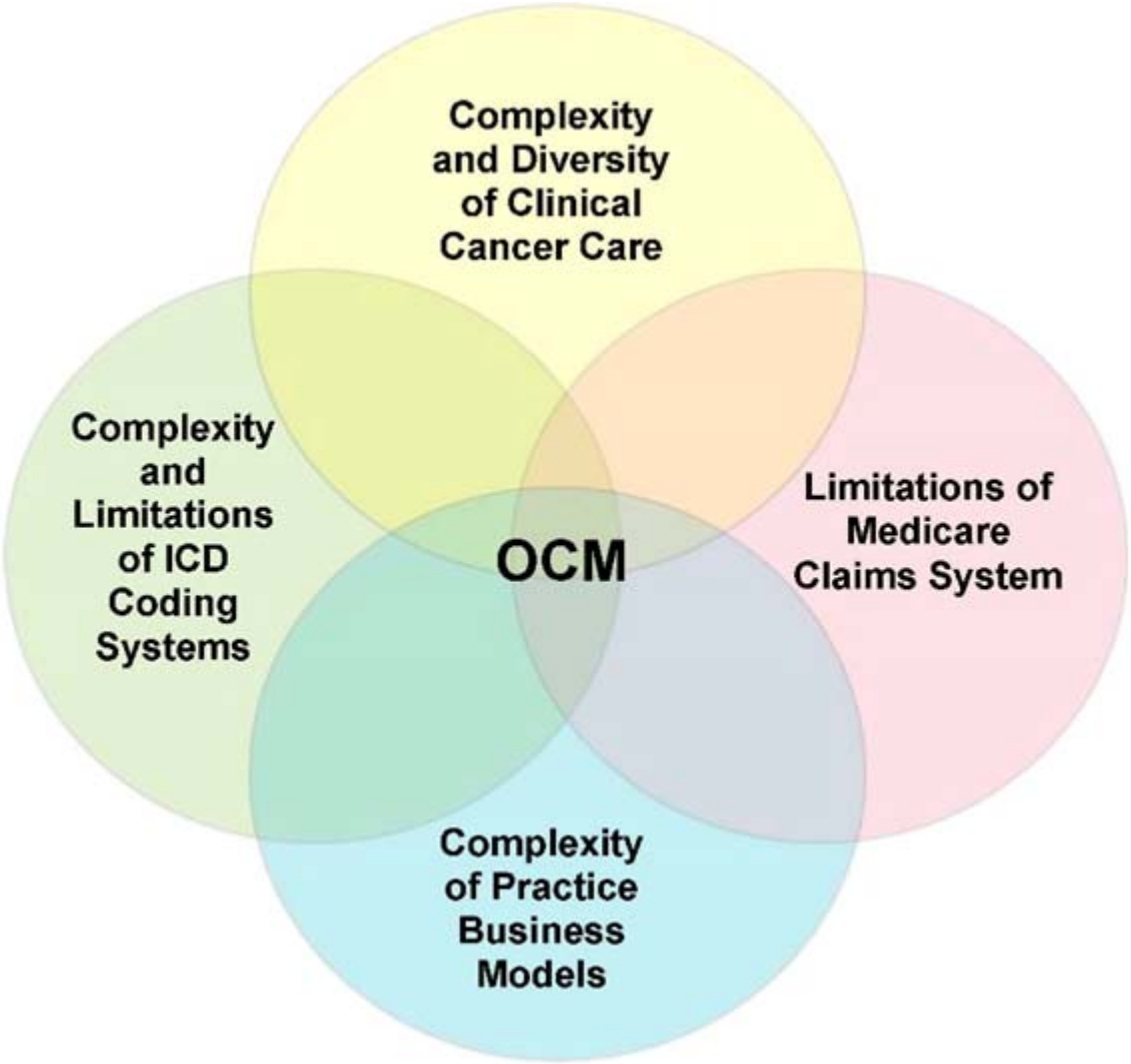
OCM Scope

- ~25% of Medicare FFS chemotherapy-related cancer care
  - 187 practices
  - >6,500 practitioners
  - >150,000 unique beneficiaries per year
  - Approx. 200,000 episodes of care per year
- 14 commercial payers participating

Geographic Diversity

Source: Centers for Medicare & Medicaid Services

Challenges in Developing a Medicare APM in Oncology



Transforming Cancer Care: Practice Redesign Activities

1) **Provide Enhanced Services**

- Provide OCM Beneficiaries with 24/7 access to an appropriate clinician who has real-time access to the Practice's medical records
- Provide the core functions of patient navigation to OCM Beneficiaries
- Document a care plan for each OCM Beneficiary that contains the 13 components in the Institute of Medicine Care Management Plan
- Treat OCM Beneficiaries with therapies that are consistent with nationally recognized clinical guidelines

Practice Redesign Activities (cont.)

2) **Use certified electronic health record technology (CEHRT)**

   OCM Practices must use CEHRT in a manner sufficient to meet the requirements of an "eligible alternative payment entity" under the MACRA rule implementing the Quality Payment Program.

3) **Utilize data for continuous quality improvement**

   Practices must collect and report clinical and quality data to the Innovation Center. In addition, the Innovation Center will provide participating practices with feedback reports for practices to use to continuously improve OCM patient care management.

OCM-FFS Episode Definition

Types of cancer

- OCM-FFS includes nearly all cancer types (see Cancer Code List on website)

Episode initiation

- Episodes initiate when a beneficiary receives a qualifying chemotherapy drug
- The list of qualifying chemotherapy drugs that trigger OCM-FFS episodes includes endocrine therapies but excludes topical formulations of drugs

Included services

- All Medicare A and B services that Medicare FFS beneficiaries receive during the episode
- Certain Part D expenditures are also included: the Low Income Cost Sharing Subsidy (LICS) amount and 80 percent of the Gross Drug Cost above the Catastrophic (GDCA) threshold

Episode duration

- OCM-FFS episodes extend six months after a beneficiary's triggering chemotherapy claim
- Beneficiaries may initiate multiple episodes during the five-year model

OCM-FFS Two-Part Payment Approach

During OCM, participating practices continue to be paid Medicare FFS payments

Additionally, OCM has a two-part payment approach:

(1) Monthly Enhanced Oncology Services (MEOS) Payment

- Provides OCM practices with financial resources to aid in effectively managing and coordinating care for Medicare FFS beneficiaries
- The $160 payment for OCM enhanced services can be billed for OCM FFS beneficiaries for each month of their 6-month episodes, unless they enter hospice or die

(2) Performance-Based Payment (PBP)

- The potential for a PBP encourages OCM practices to improve care for beneficiaries and lower the total cost of care during the 6-month episodes
- The PBP is calculated retrospectively on a semi-annual basis based on the practice's achievement on quality measures and reductions in Medicare expenditures below a target price

OCM-FFS Performance-Based Payment

1) CMS calculates **benchmark** episode expenditures for OCM practices
    - Based on historical data
    - Risk-adjusted and adjusted for geographic variation
    - Trended to the applicable performance period
    - Includes a novel therapies adjustment
2) A discount is applied to the benchmark to determine a **target price** for OCM-FFS episodes
    - Example: Benchmark = $30,000 → Discount = 4% → Target Price = $28,800
3) If **actual** OCM-FFS episode Medicare expenditures are **below target** price, the practice could receive a performance-based payment
    - Example: Actual = $25,000 → Performance-based payment up to $3,800
4) The amount of the performance-based payment is adjusted based on the participant's achievement on a range of **quality measures**

OCM-FFS Risk Adjustment

Benchmark prices are risk-adjusted for factors that affect episodic expenditures and that are available in Medicare claims data

- Age
- Sex
- Dual eligibility for Medicaid and Medicare
- Selected non-cancer comorbidities
- Receipt of selected cancer-directed surgeries
- Receipt of bone marrow transplant
- Receipt of radiation therapy
- Type of chemotherapy drugs used during episode (for breast, prostate, and bladder cancers only)
- Institutional status
- Participation in a clinical trial
- History of prior chemotherapy use
- Episode length
- Hospital referral region

Over time, the risk adjustment methodology may incorporate additional factors not captured in claims data, such as cancer staging.

OCM-FFS Novel Therapies Adjustment

- Potential adjustment based on the percentage of each practice's average episode expenditures for novel therapies compared to the percentage for practices that are not part of OCM
  - Includes oncology drugs that received FDA approval after 12/31/14
  - Use of the novel therapy must be consistent with the FDA-approved indications for inclusion in the adjustment
  - Oncology drugs are considered "new" for 2 years from FDA approval for that specific indication
- The novel therapies adjustment may lead to a higher benchmark only (i.e., it will never lower a benchmark)
- In the future, CMS may modify this adjustment to incorporate value of the novel therapies

OCM-FFS Risk Arrangement Options

One-Sided

- OCM practices are NOT responsible for Medicare expenditures that exceed the target price
- Medicare discount = 4%
- *Must qualify for performance-based payment by mid-2019 to remain in one-sided risk*

Two-Sided

- OCM practices are responsible for Medicare expenditures that exceed target price
- Option to take two-sided risk began in 2017
- Medicare discount = 2.75%

Early Experiences/Lessons Learned

- Practice eligibility criteria
- Identifying OCM beneficiaries and episodes
- Estimating out-of-pocket costs
- Technology
  - OCM Data Registry/Reporting Requirements
  - Practices' EMRs
- Quality measures

Experiences/Lessons (2)

- Methodology
  - Low- vs. high-risk cancers
  - Coding practices: Z51
- Quality improvement
  - OCM Learning System
  - Practices' Use of Data

Improving Care for Cancer Patients

- Care transformation
  - "Enables us to do what we've always wanted to"
- Improving care coordination, symptom management, palliative care, and end of life care
- Recognizing depression and distress in cancer patients
- Addressing financial toxicity
- Improving communication with patients and other providers

Bundled Payments for Care Improvement (BPCI)

What is included in a “Bundled Payment”?

The Case for "Bundled Payments"

- A single bundled payment makes providers jointly accountable for patient outcomes and aligns hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
  - ✓ Opportunity to reduce costs from duplicative testing and services
  - ✓ Potential to streamline care delivery
  - ✓ Emphasis is on quality of care rather than quantity of services

BPCI - Retrospective Payment

- Providers continue to bill Medicare
- Medicare continues to pay the claims submitted by providers
- Medicare sets a Target Price for each clinical episode based on historical costs minus a CMS discount
- After the end of the episode, the total cost of services is compared to the Target Price
  - **If payments for an episode of care are less than the Target Price**

    →Medicare pays the savings to the Participant
  - **If payments for an episode of care are more than the Target Price**

    →The Participant pays Medicare the difference

BPCI: Models Overview & Participation as of April 1, 2018

Model 1	• Retrospective bundled payment model for the acute inpatient hospital stay and readmissions during the length of the episode 1101 Participants: 226 Awardees and 875 Episode Initiators **Model ended on 12/31/16**
Model 2	• Retrospective bundled payment model consisting of an inpatient hospital stay, professional services, readmissions, and post-acute care during the length of the episode • **453 Participants: 140 Awardees and 313 Episode Initiators**
Model 3	• Retrospective bundled payment model for post-acute care, professional services and readmissions during the length of the episode • **646 Participants: 84 Awardees and 562 Episode Initiators**
Model 4	• Prospectively administered bundled payment model for the acute inpatient hospital stay, professional services and readmissions that occur within 30 days of discharge • **2 participants: 2 Awardees**

Models 2, 3, 4 will end on September 30, 2018

BPCI Provider Types – As of April 1, 2018

Provider Type	Model 2	Model 3	Model 4	TOTAL
Acute Care Hospital	271	0	2	273
Physician Group Practice	153	41	0	194
Home Health Agency	0	46	0	46
Inpatient Rehab Facility	0	9	0	9
Long Term Care Hospital	0	0	0	0
Skilled Nursing Facility	0	536	0	536
TOTAL	**424**	**632**	**2**	**1058**

Top 5 BPCI Clinical Episodes – Q2 2017

Clinical Episodes (CE)	# of Cases *[% of Total CE]*
1. Major joint replacement of the lower extremity - MJRLE	29,485 *[35.4%]*
2. Sepsis	8,541 *[10.3%]*
3. Congestive heart failure	7,303 *[8.8%]*
4. Chronic obstructive pulmonary disease, bronchitis, asthma	4,430 *[5.3%]*
5. Simple pneumonia and respiratory infections	4,073 *[4.9%]*
Total # of CE - Top 5	**53,832** **65% of all Clinical Episodes**

BPCI Impact

- **Medicare Beneficiaries**

  During the last 4 years over **1.5 million** beneficiaries have received care in a clinical episode under the Bundle Payments for Care Improvement (BPCI) initiative

  During Q2 2017- **83,272** beneficiaries participated in BPCI.

BPCI Evaluation Results

- First Annual Report released in February 2015
- Second Annual Report released September 2016
- Third Annual Report released October 2017
  - •Quantitative analyses reflect experience of participants during the first two years (2013 Q4 – 2015Q2).
  - •First time an annual report is reporting results for individual clinical episodes and not episode groups.

Reports available on the BPCI website:
https://innovation.cms.gov/initiatives/Bundled-Payments/index.html

- **Fourth Annual Report - Target release date Summer 2018**

BPCI Results – Payment Outcomes

Medicare FFS payments for hospital stay + 90 days post-discharge

- **Statistically significant changes for 3 out of 37 bundles evaluated**
  - •MJRLE under Model 2 ACHs - 4.5% decline ($1,273)
  - •MJRLE under Model 3 SNFs - 7.1% decline ($2,568)
  - •CHF under Model 3 HHAs - 3.6% decline ($970)

- **Payment reductions were primarily achieved by reducing institutional PAC Quality**
  - •Model 2 showed no systemic impact on quality
  - •Model 3 had mixed quality results

BPCI Care Redesign

Awardees are implementing interventions related to:

- **Patient Engagement and Education**
  - ✓ Pre-surgery classes
  - ✓ Setting expectations before surgery
- **Risk Management**
  - ✓ PT assessment prior to surgery for risk stratification
  - ✓ IT systems/software for tracking patients during the episode
- **Care Coordination**
  - ✓ Nurse Navigators
  - ✓ Follow-up with phone calls/home visits after discharge home
- **Redesign of Care Pathways**
  - ✓ PT on the day of surgery
  - ✓ Medication reconciliation at admission/discharge
  - ✓ Early discharge planning
- **Enhancements in Care Delivery**
  - ✓ Standardization of implant devices
- **Reducing SNF length of stay**
- **Reducing Readmissions**

BPCI Care Redesign

- **Awardees have identified these challenges when implementing changes in BPCI:**
  - Managing patient expectations related to PAC use
  - Increasing care standardization
  - Accurately identifying patients who are in BPCI episodes

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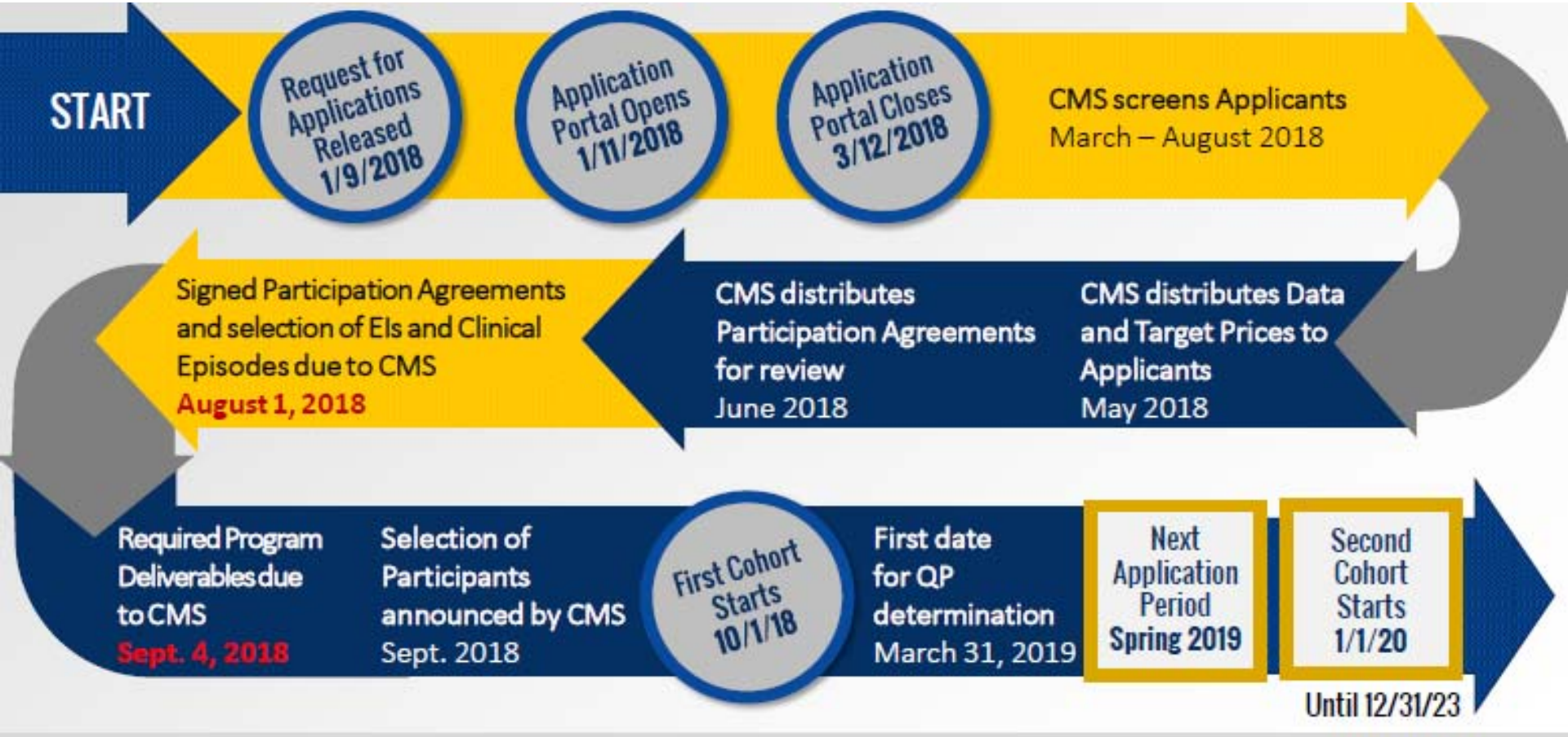
Bundled Payments for Care Improvement Advanced | BPCI Advanced

BPCI Advanced Model Overview

- Voluntary bundled payment model
- Single retrospective payment and one risk track with a 90-day episode period
- 29 Inpatient Clinical Episodes
- 3 Outpatient Clinical Episodes
- Qualifies as Advanced Alternative Payment Model (Advanced APM)
- Payment is tied to performance on quality measures
- Preliminary Target Prices provided prospectively

BPCI Advanced Timeline



Who can participate as a Convener Participant?

Entities that are either Medicare-enrolled or not Medicare-enrolled providers or suppliers

- **Brings together downstream Episode Initiators (EIs)**
- **Facilitates coordination**
- **Bears and apportions financial risks**

Who can Participate as a Non-Convener Participant?

- Is the Episode Initiator (EI)
- Bears financial risk only for itself, and
- Does not bear risk on behalf of downstream EIs

Physician Group Practices (PGPs)

Acute Care Hospitals (ACHs)

Who can be an Episode Initiator (EI)?

Physician Group Practices (PGPs)

Acute Care Hospitals (ACHs)

Precedence Rules for EIs

1.  Attending PGP

2.  Operating PGP

3.  ACHs

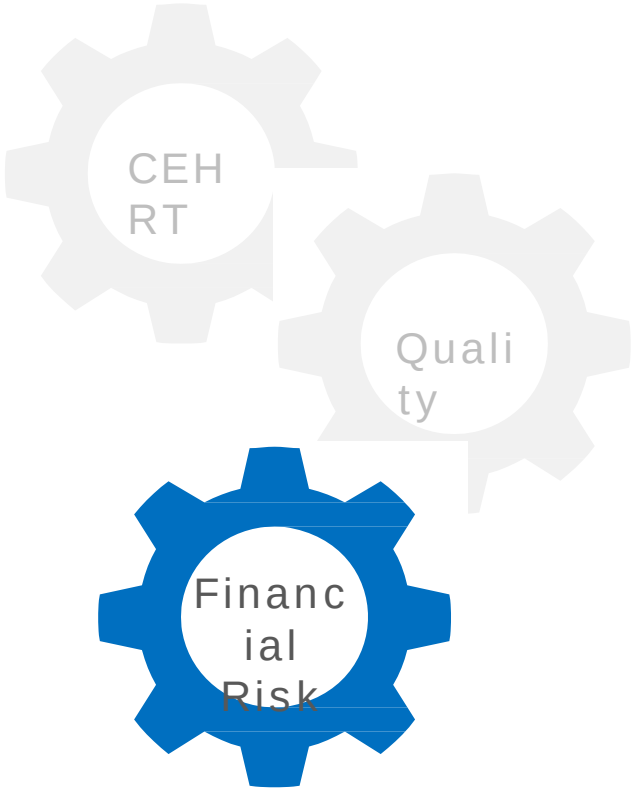
BPCI Advanced will not use time-based precedence rules.

Advanced Alternative Payment Model (Advanced APM)

BPCI Advanced will be an Advanced APM as of the first day of the Model Performance Period: October 1, 2018

- Eligible clinicians who meet the patient count or payment thresholds under the Model may become Qualified APM Participants (QPs) and be eligible to receive the 5% APM Incentive Payment.

- **The first date for QP determination will be March 31, 2019.**

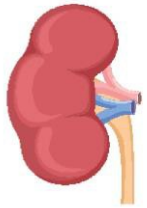


29 Inpatient (IP) Clinical Episodes

Spine, Bone, and Joint Episodes

- Back & neck except spinal fusion
- Spinal fusion (non-cervical)
- Cervical spinal fusion
- Combined anterior posterior spinal fusion
- Fractures of the femur and hip or pelvis
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Double joint replacement of the lower extremity

Kidney

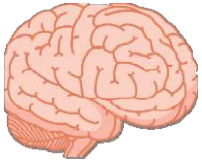


- Renal failure

Infectious Diseases

- Cellulitis
- Sepsis
- Urinary tract infection

Neurology



- Stroke

29 Inpatient (IP) Clinical Episodes, Continued

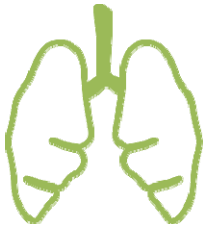
Cardiac Episodes

- Acute myocardial infarction
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft
- Congestive heart failure

Pulmonary Episodes

•Simple pneumonia and respiratory infections

•COPD, bronchitis, asthma

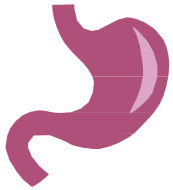


Gastrointestinal Episodes

•Major bowel procedure

•Gastrointestinal hemorrhage

•Gastrointestinal obstruction



•Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis (New Episode for BPCI Advanced)

3 Outpatient (OP) Clinical Episodes

- Percutaneous Coronary Intervention (PCI)

- Cardiac Defibrillator

- Back & Neck Except Spinal Fusion

Services Included in the Clinical Episode

- IP or OP hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- Physicians' services
- Other hospital OP services
- IP hospital readmission services
- Long-term care hospital (LTCH) services
- Hospice services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs

Clinical Episode Length

IP Clinical Episode:

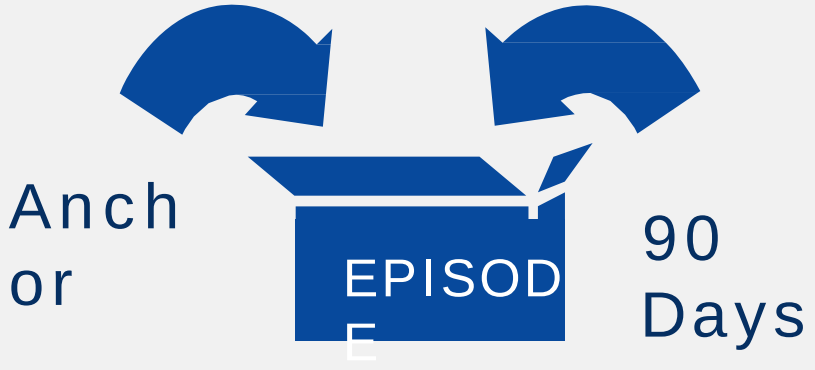
Anchor Stay

+ 90 days beginning the day of discharge

OP Clinical Episode:

Anchor Procedure

+ 90 days beginning on the day of completion of the outpatient procedure



Key Differences: BPCI vs. BPCI Advanced

BPCI	BPCI Advanced
48 Inpatient (IP) Clinical Episodes	29 IP and 3 OP Clinical Episodes
Not an Advanced APM since lacking CEHRT requirement and quality not tied to payment	Model is an Advanced APM
No quality measures required for payment purposes	Quality measures are reportable and performance on these measures will be tied to payment
Excludes cost of care associated with services according to 13 unique exclusion listings of "unrelated" care	Limited exclusions; Excludes the Part A & B costs associated with ACH readmissions qualifying based on a limited set of MS-DRGs
Model 3 includes PAC providers triggering episodes in the post-discharge period	No equivalent for Model 3; design is similar to Model 2 with PGPs and ACHs as EIs; PAC Providers, and other Medicare-enrolled, as well as non-Medicare-enrolled entities can participate as Convener Participants
Risk corridor of 20% of spending above the upper limit of the selected risk track	One risk track Risk is capped at +/-20%
Target Prices provided at reconciliation	Preliminary Target Prices provided prospectively, before the start of each Model Year

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

PTAC Background

The MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models (PFPMs) based on proposals submitted by individuals and stakeholders to the committee.

PTAC provides a unique opportunity for individuals and stakeholders to have a key role in the development of new Alternative Payment Models (APMs) and to ensure that proposals recommended to the Secretary meet the established criteria and are well-developed.

The MACRA final rule with comment period published on November 4, 2016 establishes 10 criteria and defines a PFPM as an APM in which:

- Medicare is a payer,
- Eligible clinicians that are eligible professionals (EPs) who are participants and play a core role in implementing the APM's payment methodology, and
- Targets are the quality and costs of services that EPs participating in the APM provide, order, or can significantly influence.

PTAC Proposal Status (June 2018)

- 38 letters of interest received
- 24 proposals submitted
- 3 submitters withdrew proposals before the PTAC's public meeting or vote

- 15 proposals already reviewed and voted on by PTAC during prior public meetings
- 4 public meetings held to date:
  - April 2017
  - September 2017
  - December 2017
  - March 2018

- The Secretary's Response to PTAC Recommendations and Comments for:
  - 3 proposals voted on during the April 2017 public meeting are posted on the CMS website

- For updates and announcements, please subscribe to the PTAC email listserv or email PTAC@hhs.gov