DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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200 Independence Avenue, SW
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FACT SHEET

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Contact: CMS Media Relations Group
(202) 690-6145

Bundled Payments for Care Improvement Initiative

OVERVIEW

The Affordable Care Act provides a number of new tools and resources to help improve health care and lower costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare & Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the Bundled Payments initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. Through the Bundled Payments initiative, providers have great flexibility in selecting conditions to bundle, developing the health care delivery structure, and determining how payments will be allocated among participating providers.

BACKGROUND

Medicare currently makes separate payments to providers for the services they furnish to beneficiaries for a single illness or course of treatment, leading to fragmented care with minimal coordination across providers and health care settings. Payment is based on how much a provider does, not how well the provider does in treating the patient. Under the Bundled Payment initiative, CMS would link payments for multiple services patients receive during an episode of care. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality

of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together.

Research has shown that bundled payments can align incentives for providers – hospitals, post acute care providers, doctors, and other practitioners– to partner closely across all specialties and settings that a patient may encounter to improve the patient's experience of care during a hospital stay in an acute care hospital, and during post-discharge recovery.

The Bundled Payments for Care Improvement Initiative is one more step in an effort across the Department of Health and Human Services (HHS) to help all Americans enjoy better health, improve the quality of health care, and reduce costs by replacing fragmented care with care that is coordinated and that is guided by the patient's needs and wishes. Other recent activities by CMS and HHS to promote improvement in the health care delivery system include:

- Creating user-friendly tools for patients and their caretakers to compare the quality of care offered by providers and suppliers in their communities. All quality information can now be found on the CMS Web site at:

  http://www.medicare.gov/quality-care-finder/index.html;

- Launching the Partnership for Patients to encourage hospitals, physicians and other providers to partner with the Department to focus on improving patient safety across all health care settings. The Partnership is expected to save 60,000 lives and more than $35 billion in health care costs, including up to $10 billion in Medicare costs, over the next three years. In the first few months, more than 4,000 organizations, including more than 2,000 hospitals, have taken the Partnership for Patients pledge. More information can be found at:

  http://www.healthcare.gov/center/programs/partnership/index.html; and

- Tying payment for services to the quality of care through Pay for Performance, starting with the payment systems for dialysis services and most recently for hospital inpatient care, and laying the groundwork for achieving similar results in other payment systems.

A brief summary of the Department's activities, *Lower Costs, Better Care: Reforming Our Health Care Delivery System*, including information about new initiatives authorized by the Affordable Care Act can be found at:

http://www.healthcare.gov/news/factsheets/deliverysystem07272011a.html

BUNDLED PAYMENTS FOR CARE IMPROVEMENT

The Centers for Medicare & Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the Bundled Payments Initiative. The Bundled Payments initiative is seeking applications for four broadly defined models of care, three of

which would involve a retrospective bundled payment arrangement, with a target price (target payment amount) for a defined episode of care.

Retrospective Payment Bundling

In these models, CMS and providers would set a target payment amount for a defined episode of care. Applicants would propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the Original Medicare fee-for-service (FFS) system, but at a negotiated discount. At the end of the episode, the total payments would be compared with the target price. Participating providers may then be able to share in those savings.

In Model 1, the episode of care would be defined as the inpatient stay in the general acute care hospital. Medicare will pay the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System (IPPS). Medicare will pay physicians separately for their services under the Medicare Physician Fee Schedule. Hospitals and physicians will be permitted to share gains arising from better coordination of care.

In Model 2, the episode of care would include the inpatient stay and post-acute care and would end, at the applicant's option, either a minimum of 30 or 90 days after discharge, while in Model 3, the episode of care would begin at discharge from the inpatient stay and would end no sooner than 30 days after discharge. In both Models 2 and 3, the bundle would include physicians' services, care by a post-acute provider, related readmissions, and other services proposed in the episode definition such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and Part B drugs. The target price will be discounted from an amount based on the applicant's historical fee-for-service payments for the episode. 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 participants to share among the participating providers.

Prospective Payment Bundling

Under Model 4, CMS would 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 would submit "no-pay" claims to Medicare and would be paid by the hospital out of the bundled payment.

A side-by-side comparison of key features of the four models can be found below.

Gainsharing Arrangements: In addition to streamlining care through the use of bundles, the proposals for this initiative may include gainsharing arrangements. Gainsharing refers to payments that may be made by hospitals and other providers to physicians and other practitioners as a result of collaborative efforts to improve quality and efficiency. These payments can further

align incentives for health care providers to coordinate care, improve quality and efficiency of care, and partner in the improvement of care delivery.

Additional Information about Applying for the Bundle Payments for Care Improvement initiative: Organizations are welcome and encouraged to apply for and participate in one or more models. Providers participating in Accountable Care Organizations wishing to use this opportunity to improve care coordination and the quality of care are welcome to do so. For more information on applicant eligibility, please review the "Conditions of Participation" section of the RFA.

Applicants will be required to identify the clinical condition(s) through MS-DRGs, define the time period for the episode of care, and identify the services included in the bundled payment, among other criteria. Applicants will also be required to plan and implement quality assurance and improvement activities as a condition of participation in this initiative and participate in CMS quality monitoring by reporting appropriate quality measures. During the demonstration, CMS will carefully monitor the program to ensure improved clinical quality, patient experience, and outcomes of care throughout participation in the initiative. Applicants will be required to propose strong patient protections that preserve beneficiary choice in seeking care from the provider of their choice.

To help facilitate health care innovation, recognize the diversity of provider organizations, and cultivate strong provider partnerships, applicants are asked to submit their own episode definitions and bundled payment proposals. CMS will provide historical Medicare claims data to potential applicants planning to apply for Models 2-4. The data are intended to enable potential applicants to develop well-defined episodes and discount proposals based on the experience of providers in the applicant's area. In order to be considered for receipt of data, applicants must submit a Research Study Protocol along with their letter of intent (LOI) and will later be expected to submit and comply with a Data Use Agreement (DUA). Both of these forms are available on the Bundled Payments for Care Improvement website.

Deadlines for Letters of Intent and Applications: Applicants for Model 1 must submit a nonbinding LOI by September 22, 2011 and a completed application by October 21, 2011. Applicants for Models 2-4, must submit a nonbinding LOI by November 4, 2011; applicants who wish to receive historical Medicare claims data must complete a Research Request Packet by November 4, 2011 as well. If approved to receive Medicare data, applicants must submit a DUA prior to receipt of data. Completed applications for Models 2-4 must be submitted by no later than by March 15, 2012.

For more information please refer to the RFA and application found at: www.innovations.cms.gov or email at BundledPayments@cms.hhs.gov.

APPENDIX

BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE

KEY FEATURES OF BUNDLED PAYMENT MODELS COMPARED

MODEL / FEATURE	MODEL 1 – Inpatient Stay Only	MODEL 2 – Inpatient Stay plus Post-discharge Services	MODEL 3 - Post-discharge Services Only	MODEL 4 – Inpatient Stay Only
Eligible Awardees	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Conveners of participating health care providers	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Post-acute providers • Conveners of participating health care providers	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Long-term care hospitals • Inpatient rehabilitation facilities • Skilled nursing facilities • Home health agency • Physician-hospital organizations • Conveners of participating health care providers	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Conveners of participating health care providers
Payment of Bundle and Target Price	Discounted IPPS payment; no separate target price	Retrospective comparison of target price and actual FFS payments	Retrospective comparison of target price and actual FFS payments	Prospectively set payment
Clinical Conditions Targeted	All MS-DRGs	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay
Types of Services Included in Bundle	Inpatient hospital services	• Inpatient hospital and physician services • Related post-acute care services • Related readmissions • Other services defined in the bundle	• Post-acute care services • Related readmissions • Other services defined in the bundle	• Inpatient hospital and physician services • Related readmissions
Expected Discount Provided to Medicare	To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. to 2% in Year 3	To be proposed by applicant; CMS requires minimum discount of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode	To be proposed by applicant	To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration
Payment from CMS to Providers	• Acute care hospital: IPPS payment less pre-determined discount • Physician: Traditional fee schedule payment (not included in episode	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment

	or subject to discount)			
Quality Measures	All Hospital IQR measures and additional measures to be proposed by applicants	To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs		

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