The Bundled Payments for Care Improvement (BPCI) initiative was developed by the Center for Medicare and Medicaid Innovation. The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care for beneficiaries.

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations voluntarily enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare.

In **Model 1**, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continues to pay physicians separately for their services under the Medicare Physician Fee Schedule. The first Awardees in Model 1 began in April 2013.

**Models 2** and **Model 3** involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. In **Model 2**, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. In **Model 3**, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. Under these retrospective payment models, Medicare continues to make fee-for-service (FFS) payments; the total expenditures for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate expenditures compared to the target price.

In **Model 4**, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment. The first Awardees in Models 2, 3, and 4 began in October 2013.

The Bundled Payments for Care Improvement initiative includes two phases for Models 2, 3, and 4. Phase 1, also referred to as the “preparation” period, is the initial period of the initiative during which CMS and participants prepare for implementation and assumption of financial risk. Phase 1 participant’s transition to Phase 2, also referred to as the “risk-bearing” period, upon execution of an agreement with CMS.

As of October 1, 2015, the BPCI initiative has 1618 participants. The breakdown of participants by provider type is as follows: acute care hospitals (415), skilled nursing facilities (723), physician group practices (305), home health agencies (103), inpatient rehabilitation facilities (9), and long-term care hospitals (1).

### Mandatory Medicare Bundled Payment Initiative for Hip and Knee Replacements

The Centers for Medicare & Medicaid Services (CMS) finalized the Comprehensive Care for Joint Replacement (CJR) model, set to begin on April 1, 2016, which will hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for hip and knee replacements and/or other major leg procedures from surgery through recovery. Through this **mandatory payment model**, hospitals in 67 geographic areas will receive additional payments if quality and spending performance are strong or, if not, potentially have to repay Medicare for a portion of the spending for care surrounding a lower extremity joint replacement (LEJR) procedure.

These procedures are among the most common that Medicare beneficiaries receive, and the price varies significantly. In 2014, more than 400,000 Medicare beneficiaries received a hip or knee replacement, costing more than $7 billion for the hospitalizations alone.

The average Medicare payment for surgery, hospitalization and recovery ranges from $16,500 to $33,000 across geographic area, CMS said in a news release announcing the initiative.
How the CJR Model works:

- Under this model, the hospital in which the hip or knee replacement and/or other major leg procedure takes place will be accountable for the costs and quality of related care from the time of the surgery through 90 days after hospital discharge, which is called an “episode” of care.
- Depending on the hospital’s quality and cost performance during the episode, the hospital will either earn a financial reward or, beginning with the second performance year, be required to repay Medicare for a portion of the spending above an established target. This payment structure gives hospitals an incentive to work with physicians, home health agencies, skilled nursing facilities, and other providers to make sure beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications.
- By “bundling” payments for an episode of care, hospitals, physicians, and other providers have an incentive to work together to deliver more effective and efficient care.
- This model is being tested in 67 geographic areas throughout the country, and nearly all hospitals in those geographic areas are required to participate.
- Patients can continue to choose their doctor, hospital, skilled nursing facility, home health agency, and other provider, but now with the CJR model, their providers receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications.
- In year 2 of the CJR model (2017) - waiver for beneficiaries who are eligible for discharge to a medically necessary SNF stay after less than a 3 day hospitalization. Qualifying SNFs must have an overall Three Stars or better in the Five Star Quality Rating System for at least 7 of the 12 preceding months. The list of qualifying SNFs will be posted quarterly on the CMS website.

The CJR model final rule can be viewed at https://www.federalregister.gov.

Additional Documentation Limits for Medicare Providers

The Centers for Medicare & Medicaid Services (CMS) has modified the additional documentation request (ADR) limits for the Recovery Auditor program for providers. The revised limits will be effective January 1, 2016. Each provider’s annual limit will be based on the number of Medicare claims paid in the previous year that are associated with their 6-digit National Provider Identifier (NPI) number.

1. The annual ADR Limit will be one-half of one percent (0.5%) of the provider’s total number of paid Medicare claims from the previous year.

2. ADR letters are sent on a 45-day cycle. The annual ADR Limit will be divided by eight to establish the ADR cycle limit, which is the maximum number of claims that can be included in a single 45-day period. Although the Recovery Auditors may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days.

3. ADR limits will be diversified across all claim types of a facility, based on the Types of Bill (TOB) that the provider was paid for in the previous year.

4. CMS will adjust a provider’s ADR limit based on the provider’s compliance with Medicare rules. Providers with low denial rates will have ADR limits decreased, while providers with high denial rates will have their ADR limits increase.

5. CMS reserves the right to establish a different record limit when directing the Recovery Auditors to conduct reviews of specific topics or providers.

Fundamental Elements to Prevent Influenza Transmission

Annually, influenza causes severe illness and deaths in the United States. It is the 6th leading cause of death among US adults and accounts for more than 200,000 hospitalizations per year. The Centers for Disease Control and Prevention (CDC) estimates that each year on average 5-20% of the population will get the flu.

Preventing transmission of influenza virus and other infectious agents within healthcare settings requires a multi-faceted approach. Spread of influenza virus can occur among patients, Health Care Personnel (HCP) and visitors; in addition, HCP may acquire influenza from persons in their household or community. The core prevention strategies include:

- Administration of influenza vaccine
- Implementation of respiratory hygiene and cough etiquette
- Appropriate management of ill HCP
- Adherence to infection control precautions for all patient care activities and aerosol-generating procedures
- Implementing environmental and engineering infection control measures.

CDC reports that successful implementation of many, if not all, of these strategies is dependent on the presence of clear administrative policies and organizational leadership that promote and facilitate adherence to these recommendations among the various people within the healthcare setting, including patients, visitors, and HCP. This guidance should be implemented in the context of a comprehensive infection prevention program to prevent transmission of all infectious agents among patients and HCP.
Question:
We have a resident that is being discharged on the 7th day of the COT and the RUG is going from an RH to an RM. Can I combine the COT with the Discharge MDS?

Answer:
Yes you can combine the COT with the Discharge MDS but if the 7th day of the COT is on the day of discharge you have the choice of completing the COT or not completing the COT. If the RUG is going down like yours is from an RH to an RM you do not want to complete the COT since you have the choice. If the RUG was going up then you would want to complete the COT.

Question:
I had a 30 day MDS that was transmitted and accepted but we discovered that I entered the therapy minutes wrong. What can I do to fix this? Also I have never modified an MDS so could you walk me through it?

Answer:
Yes, you would modify the assessment. Open the assessment then it will ask you if you want to modify this assessment then answer yes. Go to the section X and answer the questions after you fix the section, then resubmit the MDS.

Question:
We have a resident that was receiving therapy on a Medicare Part A stay. Therapy discharged them and I completed an EOT with day 1 after therapy as the ARD day. I am still getting a rehab RUG. I thought we wouldn't get a rehab RUG on an EOT. What am I doing wrong?

Answer:
The EOT will give you a rehab RUG and a nursing RUG but the facility would bill the nursing RUG from Section Z0150. The EOT will give the rehab RUG because you have rehab minutes and days under Section O.