The Bundled Payments for Care Improvement Initiative (BPCI) was developed by the CMS Innovation Center to test innovative payment and service delivery models that have the potential to reduce healthcare expenditures while preserving or enhancing the quality of care for beneficiaries of the following programs:

- Medicare
- Medicaid
- Children's Health Insurance Program (CHIP)

**Background**

Traditionally, Medicare makes separate payments to providers for each service they perform for beneficiaries during a single illness or course of treatment. This approach can:

- Result in fragmented care with minimal coordination across providers and health care settings
- Reward the quantity of services offered by providers rather than the quality of care furnished.

Under BPCI, organizations enter into payment arrangements that include financial and performance accountability for episode of care. Bundled payments can align incentives for providers allowing them to work closely together across all specialties and settings.

**BPCI Payment Models**

There are four different models under BPCI:

<table>
<thead>
<tr>
<th>Model 1: Retrospective Acute Care Hospital Stay Only</th>
<th>Model 2: Retrospective Acute Care Hospital Stay Plus Post-Acute Care</th>
<th>Model 3: Retrospective Post-Acute Care Only</th>
<th>Model 4: Acute Care Hospital Stay Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs, hospital plus post-acute period</td>
<td>Selected DRGs, post-acute period only</td>
<td>Selected DRGs, hospital plus readmissions</td>
</tr>
<tr>
<td>Services included in the bundle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Part A services paid as part of the MS-DRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
</tr>
<tr>
<td>Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
</table>
**Medical Severity-Diagnosis Related Groups (MS-DRGs)**

- There are 48 different episodes from which participants could choose.
- Only services provided to a beneficiary who is receiving treatment related to the MS-DRG chosen by the Awardee can be paid under the BPCI Model payment initiative.
- MS-DRGs (episodes) included in BPCI episode: [http://innovation.cms.gov/initiatives/Bundled-Payments/index.html](http://innovation.cms.gov/initiatives/Bundled-Payments/index.html)

### J15 BPCI Model 2: 3-Day Hospital Qualifying Stay Waiver Awardees and MS-DRGs

<table>
<thead>
<tr>
<th>Awardee</th>
<th>Episode Initiator</th>
<th>City</th>
<th>State</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aultman Hospital</td>
<td>Aultman Hospital</td>
<td>Canton</td>
<td>OH</td>
<td>Stroke (61-66)</td>
</tr>
<tr>
<td>The Cleveland Clinic Health System</td>
<td>Euclid Hospital</td>
<td>Euclid</td>
<td>OH</td>
<td>Major joint replacement of the lower extremity (469, 470)</td>
</tr>
<tr>
<td>Mercy St. Vincent Medical Center</td>
<td>Mercy St. Vincent Medical Center</td>
<td>Toledo</td>
<td>OH</td>
<td>Coronary Artery Bypass Graft (231-236)</td>
</tr>
</tbody>
</table>

**BPCI Model 2**

- An episode can be initiated by admission to a Model 2 episode-initiating IPPS hospital. It can also be admission to an IPPS hospital where the operating or attending physician is a member of a Model 2 physician group practice. It must result in a discharge assigned to a selected MS-DRG.
- An episode of care includes both the acute inpatient hospital stay and post acute care. Services include physician and non-physician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and Part B covered services such as clinical laboratory services, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).
- Awardee ends the episode either 30, 60 or 90 days after discharge.

**Qualifying for Use of the 3-day Hospital Qualifying Stay Waiver – Model 2**

- Awardee is responsible for the episode-initiating hospital or physician member of the episode-initiating physician group practice has been approved by CMS to use the 3-day stay waiver.
- Majority of the Awardee’s identified SNF partners as reported to CMS must have in effect a quality rating of 3-5 stars under CMS’ 5-Star Quality Rating System for at least 7 out of the last 12 months.
- CMS monitors the use of the waiver to ensure that discharges to a SNF are medically appropriate and that the majority of the Model 2 beneficiaries are discharged to a SNF rated 3-stars or better.
- Beneficiary must have been discharged from a Model 2 episode-initiating hospital or an IPPS hospital where he/she was treated by a physician member of a Model 2 episode-initiating physician group practice;
- Beneficiary’s discharge MS-DRG must be included in a Model 2 episode selected by the episode-initiating hospital or episode-initiating physician group practice; and
• Beneficiary must have been discharged from an IPPS hospital within 30 days of the initiation of SNF services.

**Skilled Nursing Facilities (SNFs): Submitting claims for patients who qualify for use of the 3-day Hospital Qualifying Stay Waiver – Model 2**

Effective October 27, 2014 enter demonstration code “62” in Form Locator 63 - Treatment Authorization Code on the UB-04 claim form or electronic equivalent when all of the qualifications are met.

• **Note:** If the beneficiary’s hospitalization meets the prerequisite hospital stay requirement of at least 3 consecutive days for Part A coverage of “extended care” services in a SNF (absent the waiver), do not report demonstration code 62.

**Reference**

• **MLN Matters article MM8792:** Affordable Care Act (ACA) Bundled Payments for Care Improvement (BPCI) Initiative: Provider Education Regarding New Demonstration Codes for Skilled Nursing Facility (SNF) Claims and Payment of SNF Claims for BPCI Model 2 Beneficiaries Who Have Not Met the 3-day Hospital Stay Requirement  

• **CMS website:** Bundled Payments for Care Improvement (BPCI) Initiative  

**Questions and Answers**

**Question 1:** We are a skilled nursing facility in the vicinity of Euclid Hospital (part of the Cleveland Clinic Health System). As we understand it, Euclid Hospital has the ability to discharge patients who undergo knee replacements to nursing homes prior to the patient meeting the traditional 3-day hospital qualifying stay. Is it true that the 3-day hospital stay can be waived for knee replacement patients discharged from Euclid Hospital to ANY nursing facility? If we accept a knee replacement patient from Euclid hospital, and the 3-day hospital qualifying stay was waived, do we need to enter a “62” on the UB-04 in order for our claim to be properly paid?

**Answer 1:** The patient can be discharged to any SNF in the service area of Euclid Hospital as long as the facility has maintained at least a 3 star rating for at least 7 out of the last 12 months. The patient’s discharge MS-DRG from Euclid Hospital must be either 469 or 470, as knee replacement is the episode chosen by Euclid Hospital for this initiative. When billing for a qualifying beneficiary, for dates of service on or after October 27, 2014, the SNF would use “62” in Form Locator 63.

**Question 2:** I have accessed the CMS website link for BPCI and see that many of our surrounding hospitals are in Phase 1. What is the difference between Phase 1 and Phase 2? Is it only the Phase 2 that may qualify for the 3 day hospital stay waiver? And, it would only be if the diagnosis is for the specified episode(s)? Is there a way to be notified when an organization moves from Phase 1 to Phase 2?
Answer 2: Phase 1 is the initial period of the initiative when the awardee prepares to implement and assume the financial risk associated with the initiative. Phase 2 is the implementation phase at which point the awardee becomes accountable for both the cost and quality of care. All awardees are scheduled to be transitioned to Phase 2 by January 2015.

An awardee would have to be in Phase 2 and have an agreement with CMS to participate in a waiver program available under Model 2.

The CMS Innovation Center notifies the public via press releases of changes in the programs. A link to the BPCI Model 2 page of the CMS Innovation Center website provides more detail on the initiative: http://innovation.cms.gov/initiatives/bundled-payments/