CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Bundled Payment Models
Where We Have Been and Where We Are Going: BPCI

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

"The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures…while preserving or enhancing the quality of care** furnished to individuals under such titles"

Section 3021 of Affordable Care Act

Three scenarios for success

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

The Case for Bundled Payments

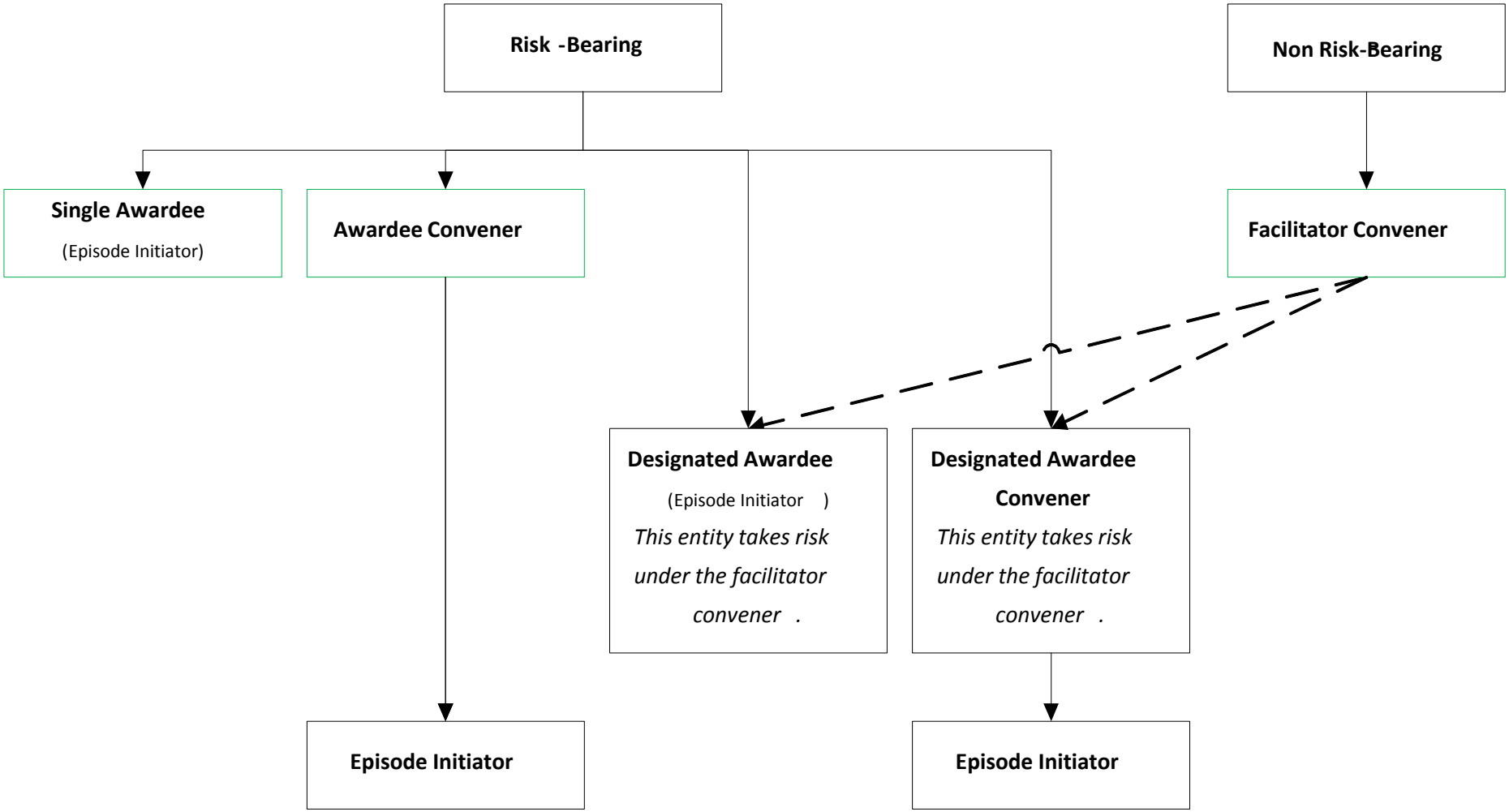
- Single bundled payment makes providers jointly accountable for patient outcomes and aligns hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
  - Opportunity to reduce costs from duplicative testing and services
  - Potential to streamline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

- Valuable synergies with ACOs, Medicare's Shared Savings Program, and other payment reform initiatives
- Improvements identified via these model tests may spill over to private payers

Bundled Payments for Care Improvement (BPCI)

- The bundled payment model provides a single payment for an episode of care
  - Incentivizes providers to take **accountability for both cost and quality** of care
  - **Four Models – encompassing all DRGs (Model 1) or 48 targeted clinical conditions (Models 2, 3, and 4)**
    - Model 1: Acute care hospital stay only
    - Model 2: Retrospective acute care hospital stay plus post-acute care
    - Model 3: Retrospective post-acute care only
    - Model 4: Prospective acute care hospital stay only
  - Conclusion of BPCI
    - Model 1: completed December 31, 2016
    - Models 2, 3, 4: close out September 30, 2018

Description of Participant Roles in BPCI



Bundled Payments for Care Improvement: Models Overview

Model 1

- Bundled payment model for the acute inpatient hospital stay only
- 0 Participants: completed December 31, 2016

Model 2

- Retrospective bundled payment model consisting of an inpatient hospital stay followed by post-acute care
- 577 Participants: 177 Awardees and 400 Episode Initiators

Model 3

- Retrospective bundled payment models for post-acute care only
- 779 Participants: 104 Awardees and 675 Episode Initiators

Model 4

- Prospectively administered bundled payment models for the acute inpatient hospital stay only
- 5 participants: 5 Awardees and 0 Episode Initiator

As of January 1, 2017

BPCI Provider Types

Provider Type	Model 2	Model 3	Model 4	TOTAL
Acute Care Hospital	335	0	5	340
Physician Group Practice	204	48	0	252
Home Health Agency	0	81	0	81
Inpatient Rehab Facility	0	9	0	9
Long Term Care Hospital	0	0	0	0
Skilled Nursing Facility	0	620	0	620
TOTAL	539	758	5	1302

As of January 1, 2017

Trigger Clinical Conditions

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 Pricing – Models 2 & 3

- Baseline and Target Prices
  - Baseline prices are derived from episodes initiated during period from July 1, 2009 – June 30, 2012, updated quarterly and trended to 2012 using an annual national MS-DRG-specific growth rate
  - Target prices for each performance period are calculated by applying a national MS-DRG-specific growth rate to the baseline price and then applying the discount percentage, which ranges from 2-3% depending on model, episode length and discount
    - Target prices include direct adjustments for key payment policies including the Hospital Readmissions Reduction and Hospital Value-Based Purchasing programs
    - Target amounts are calculated as the target price times the number of episode cases for each MS-DRG

BPCI Models 2 & 3 – Net Payment Reconciliation Amount (NPRA)

- NPRA = Performance period target amount – adjusted aggregate fee-for-service payment
  - Calculated first at the MS-DRG level and then aggregated to clinical episode and episode initiator levels
- If NPRA > 0, CMS will issue payment to the awardee
- If NPRA < 0, CMS will send a demand letter to the awardee

Gainsharing of Savings Through Fraud and Abuse Waivers

- In a healthcare context, gainsharing arrangements often been found to violate the Civil Money Penalties Law and/or the Anti-Kickback Statute
- Waiver of Fraud and Abuse permits gainsharing of certain funds in BPCI under specific and limited circumstances
  - Approximately 50% of Awardees gainshare
- What funds are gainshared in BPCI?
  - Positive **"NPRA" dollars**
    - We set a **target price** for each Bundled Episode, and reconcile that against the FFS payments made to providers who furnished services to beneficiaries in Models 2 and 3
    - When our participants provide all services at a lower cost than the target price, they are eligible to gainshare, or keep the remainder, provided they meet quality performance targets
  - Funds derived from **Internal Cost Savings**
    - Actual, verifiable cost savings attributable to care redesign
    - E.g., MJRLE – bulk purchasing of a particular implant

Other BPCI Waivers

- Payment policy waivers
  - 3-Day Hospital Stay Requirement for SNF Payment (Model 2)
  - Telehealth (Models 2, 3)
  - Post-Discharge Home Visit (Models 2, 3)

- Waivers of Certain Fraud and Abuse laws
  - Available to Models 2-4
  - **Require adherence to strict requirements** in order to engage in specified gainsharing, incentive payment, and patient engagement incentive arrangements

BPCI Evaluation

- *JAMA* Article: Dummit, et al., Association between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes.
  - Objective: To evaluate whether BPCI was associated with a greater reduction in Medicare payments without loss of quality of care for lower extremity joint (primarily hip and knee) replacement episodes initiated in BPCI-participating hospitals that are accountable for total episode payments (for the hospitalization and Medicare-covered services during the 90 days after discharge).
  - Conclusion: In first 21 months of BPCI, Medicare payments declined more for lower extremity joint replacement episodes provided in BPCI-participating hospitals than for those provided in comparison hospitals, without a significant change in quality outcomes.
  - Published online September 19, 2016. doi:10.1001/jama.2016.12717; available http://jama.jamanetwork.com/article.aspx?articleid=2553001

BPCI Evaluation

- Second Annual Evaluation Report (Models 2-4) was released in September 2016
  - Available at: https://innovation.cms.gov/Data-and-Reports/index.html
  - Quantitative analyses reflects experience of Phase 2 participants during the first year (October 2013 – September 2014)
  - Qualitative analyses reflects participants' experience through June 2015
  - Future evaluation reports will have greater ability to detect changes in payment and quality due to larger sample sizes and the recent growth in participation of the initiative, which generally is not reflected in this report.

BPCI Model 2 Evaluation Highlights

- 11 out of the 15 clinical episode groups analyzed showed potential savings to Medicare
- Orthopedic surgery episodes showed statistically significant savings of $864 per episode while showing improved quality as indicated by beneficiary surveys
- Cardiovascular surgery episodes hospitals did not show any savings yet but quality of care was preserved
- Statistically significant decrease in institutional PAC use for BPCI orthopedic surgery and cardiovascular surgery episodes relative to comparison populations among those who received any PAC

BPCI Model 3 Evaluation Highlights

- Standardized SNF payments and SNF days for SNF-initiated BPCI episodes declined relative to comparison group across almost all clinical episode groups
  - Did not result in statistically significant declines in total episode payments
- Quality generally was maintained or improved relative to comparison group

Thank you!

Questions?