Bundled Care Payment Initiatives

and BPCI Advanced

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Speaker Disclosure

I have no relevant financial relationships or affiliations to disclose.

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Speaker Disclosure

• Current appointment as a “Quality Payment Program Clinical Champion” for the Centers for Medicare & Medicaid Services

• Recently appointed member of the Technical Expert Panel (TEP) for the project entitled “Development of Inpatient Outcome Measures for the Merit-based Incentive Payment System”

• Rural Quality Advisory Panel for the Rural Quality Improvement Technical Assistance (RQITA) Program (funded by the Federal Office of Rural Health Policy)

• Co-Chair, National Quality Forum Technical Advisory Panel – Primary Care and Chronic Illness Safety Standing Committee

All are volunteer positions.
Objectives

• Describe the concepts of bundled payment.

• Discuss variation in cost and quality for episodes of care

• Describe the Bundled Payment for Care Improvement Advanced initiative of CMMI

• Review the evidence of impact of bundled payments
Moving from volume to value......

Increasing assumed risk by provider

Increasing coordination/integration required

Current State: Payments for Reporting

Incremental FFS payments for value

Bundled payments for acute episode

Bundled payments for chronic care/disease carve-outs

Accountability for Population Health

From.... ..get paid more for doing more (i.e., FFS)

To.... ..profiting by keeping your population of patients healthy, delivering high-quality care, and doing so at less cost
Fee-for-service Payment is Inflationary
FFS: Getting What You Pay For

“Fee-For-Service” pays for volume, so that is exactly what we get: **LOTS OF VOLUME**
(visits, tests, procedures, duplication of services)
FFS: not only rewarding volume, but rewarding volume of highly priced services

• **FFS payment provides a financial incentive to:**
  • Provide more of those services which are paid most handsomely – e.g., cardiology, orthopedics
  • Introduce new services that generate higher fees than longer-standing services

• **FFS payment provides a financial disincentive to:**
  • Deliver services that generate comparatively lower remuneration – e.g., primary care, psychiatry
  • Provide services for which there is no FFS compensation – e.g., patient outreach, care coordination, treatment plan development, e-visits, web visits
FFS: No Financial Incentive for Quality

- Physicians get paid the same amount for one patient regardless of whether they provide excellent care or poor quality care.

  Providers may actually be paid more for poor quality due to the need for “rework.”
What is a Bundled Payment?

• Bundled payments offer reimbursement for all of the services needed by specific patient for a particular condition or treatment. Creates incentive for provider coordination of efforts.
  
  **Primary goal:** reduce costs by reducing cost variation, including through reduction in avoidable complications

• Generally includes payments for all of the providers and the care settings that may be required, but does not include services that are unrelated.
  
  • Example: hip replacement surgery bundle
    Include: the surgery, pre and post-operative appointments, rehabilitation and the treatment of any complications associated with the procedure.
Concept of Bundled Payments
A Clinical “Episode”

- One fixed payment that is then distributed to all of the caregivers and facilities.
- Profit is driven by keeping costs low (efficiency) while providing high quality care!
Pros/Cons of Bundled Payments

• Pros:
  • provide a strong incentive to reduce costs – including both volume and price
  • provide an incentive to improve quality and reduce costly complications associated with the procedures
  • “strong” evidence of success at reducing costs in the Medicare population

• Cons:
  • impact limited to specific procedures/ treatment of specific conditions
  • does not provide an incentive to reduce the volume of procedures (only the costs associated with each procedure)
  • administratively challenging to administer
Opportunities with Bundled Payment

• Large opportunity to reduce costs from waste and variation
• Gainsharing incentives align hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
  • Improvements “spillover” to private payers
• Strategies learned in bundled payments lay the foundation for success in a value driven market
• Adoption of bundled payments is accelerating across both private and public payers
• Valuable synergies with ACOs, Medicare’s Shared Savings Program and other payment reform initiatives
Bundled Payment Models

Concept: Establish a total budget for all services provided to a patient for an episode of care (starting with a hospitalization), rather than individual provider/setting payments; providers can share in savings if episodes are below budget

- 6,000+ participants in four BPCI models serving 130,000 Medicare beneficiaries

- Model 1: lower cost growth during hospital stays, but not post-discharge; models 2-4: results based on small samples and limited timeframe (2013-2014)

Focus of services for each BPCI model

<table>
<thead>
<tr>
<th>Model</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td>Inpatient hospital services</td>
</tr>
<tr>
<td>Model 2</td>
<td>Inpatient hospital, physician, post-acute services</td>
</tr>
<tr>
<td>Model 3</td>
<td>Post-acute services</td>
</tr>
<tr>
<td>Model 4</td>
<td>Inpatient hospital, physician services</td>
</tr>
</tbody>
</table>
Bundled Payments for Care Improvement (BPCI) Initiative: General Information

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 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.

Select anywhere on the map below to view the interactive version
CMMI has Identified Multiple Episodes

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute myocardial infarction</td>
<td>Major bowel procedure</td>
</tr>
<tr>
<td>AICD generator or lead</td>
<td>Major cardiovascular procedure</td>
</tr>
<tr>
<td>Amputation</td>
<td>Major joint replacement of the lower extremity</td>
</tr>
<tr>
<td>Atherosclerosis</td>
<td>Major joint replacement of the upper extremity</td>
</tr>
<tr>
<td>Back &amp; neck except spinal fusion</td>
<td>Medical non-infectious orthopedic</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>Medical peripheral vascular disorders</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>Nutritional and metabolic disorders</td>
</tr>
<tr>
<td>Cardiac defibrillator</td>
<td>Other knee procedures</td>
</tr>
<tr>
<td>Cardiac valve</td>
<td>Other respiratory</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Other vascular surgery</td>
</tr>
<tr>
<td>Cervical spinal fusion</td>
<td>Pacemaker</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Pacemaker device replacement or revision</td>
</tr>
<tr>
<td>Combined anterior posterior spinal fusion</td>
<td>Percutaneous coronary intervention</td>
</tr>
<tr>
<td>Complex non-cervical spinal fusion</td>
<td>Red blood cell disorders</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>Removal of orthopedic devices</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Revision of the hip or knee</td>
</tr>
<tr>
<td>Double joint replacement of the lower extremity</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
<td>Simple pneumonia and respiratory infections</td>
</tr>
<tr>
<td>Fractures of the femur and hip or pelvis</td>
<td>Spinal fusion (non-cervical)</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>Stroke</td>
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<tr>
<td>Gastrointestinal obstruction</td>
<td>Syncope &amp; collapse</td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
<td>Transient ischemia</td>
</tr>
<tr>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
<td>Urinary tract infection</td>
</tr>
</tbody>
</table>
Geographic Variation in Medicare Services

Joseph P. Newhouse, Ph.D., and Alan M. Garber, M.D., Ph.D.
“...a substantial part of the variation across HRRs stems from spending on post-acute care, meaning the use of home health services, skilled nursing facilities, rehabilitation facilities, long-term care hospitals, and hospices.”
“At the hospital level, the highest payment quartile of hospitals had a mean total episode payment of $54,399 compared with $45,487 for the lowest payment quartile (16.4% difference, \( P < .001 \)). The highest payment quartile hospitals compared with the lowest payment quartile hospitals had 14.6% higher index hospitalization payments ($34,992 vs $30,531, \( P < .001 \)), 33.9% higher professional payments ($8060 vs $6021, \( P < .001 \)), 29.6% higher post-acute care payments ($7663 vs $5912, \( P < .001 \)), and 35.1% higher readmission payments ($3576 vs $2646, \( P = .06 \)).”
“Participation in Medicare’s ACE Demonstration Program was not associated with a change in 30-day episode-based Medicare payments or 30-day mortality for cardiac or orthopedic surgery, but it was associated with lower total 30-day post-acute care payments.”

In the first 21 months of the BPCI initiative, Medicare payments declined more for lower extremity joint replacement episodes provided in BPCI-participating hospitals than in comparison hospitals, without a significant change in quality outcomes.

We identified participating hospitals and used national Medicare claims data to assess their characteristics and previous spending patterns. These hospitals are mostly large, nonprofit, teaching hospitals in the Northeast, and they have selectively enrolled in the bundled payment initiative covering patient conditions with high clinical volumes. We found no significant differences in episode-based spending between participating and nonparticipating hospitals. Postacute care explains the largest variation in overall episode-based spending, signaling an opportunity to align incentives across providers.
EXHIBIT 4

Percentage Of Variation In Total Thirty-Day Episode-Based Spending Explained By Components Of Care For Phase 1 And Phase 2 Hospitals, 2011

- Outpatient
- Index admission
- Provider pmt.
- Readmission
- Postacute care

“Patterns of participation and dropout in the BPCI program suggest that for voluntary alternative payment models to have a broad effect on quality and costs of health care, barriers to participation and strategies for retention need to be addressed.”

CMS History with Bundled Payments

Timeline of Recent Bundled Payment Programs

April 2013
BPCI\(^1\), a voluntary bundled payment program, begins

April 2016
CJR begins in 67 markets across the country

December 20, 2016
CMS finalizes rule for three new EPM\(^3\) bundles for hip and cardiac episodes

January 9, 2018
CMS announces BPCI Advanced, a new voluntary program

July 2015
CMS announces CJR\(^2\), a mandatory orthopedic bundle

July 25, 2016
CMS proposes three new EPM\(^3\) bundles for hip and cardiac episodes

August 15, 2017
CMS proposes to cancel the EPMs and scale back CJR; finalizes cancellation in November

Tom Price, MD
Secretary of DHHS
CMS makes it official: Two mandatory bundled-pay models canceled

By Virgil Dickson | November 30, 2017

The CMS has finalized its decision to toss two mandatory bundled-payment models and cut down the number of providers required to participate in a third.

Only 34 geographic areas will be required to participate in the Comprehensive Care for Joint Replacement Model, or CJR, according to a rulemaking released Thursday. Initially, 67 geographic areas were supposed to participate.

Up to 470 hospitals are expected to continue to operate under the model. That includes the CMS' estimate that 60 to 80 hospitals will voluntarily participate in CJR. Originally, 800 acute-care hospitals would have participated under the program.
Bundles are Back

HHS Nominee Alex Azar Signals Openness to Mandatory Payment Models

January 9, 2018 by Heather Landi

During a Senate Finance Committee hearing on his nomination, Alex Azar, President Donald Trump’s nominee for U.S. Department of Health and Human Services (HHS) Secretary, made comments indicating his openness to mandatory bundled payment models, which would represent, if Azar is confirmed, a potential shift in the Trump Administration’s policy.

Azar is a former pharmaceutical industry executive at Eli Lilly and Company, where he oversaw the company’s U.S. operations Beginning in 2016 until he left the company in January of this year. He has been the U.S. Deputy Secretary for Operations and Strategy and has asked to stay at the company as a non-employee operating officer of morning consult.

HHS Nominee Azar Says He Backs Mandatory Pilot Payment Programs

His stance contrasts with Trump administration’s push for voluntary payment programs in shift to value-based care

In contrast with Trump administration, Azar backs mandatory bundled payments

Written by Emily Rappleye (Twitter | Google+) | January 10, 2018 | Print | Email
BPCI Advanced

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

Advanced Alternative Payment Model (Advanced APM) Criteria

Participants will be financially at risk for up to 20% of the final Target Price
# Quality Measures

<table>
<thead>
<tr>
<th>Quality measures for:</th>
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<tbody>
<tr>
<td><strong>All Clinical Episodes</strong></td>
<td>All-cause Hospital Readmission Measure</td>
</tr>
<tr>
<td></td>
<td>(National Quality Forum [NQF] #1789)</td>
</tr>
<tr>
<td></td>
<td>Care Plan</td>
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<tr>
<td></td>
<td>(NQF #0326)</td>
</tr>
<tr>
<td><strong>Specific Clinical Episodes</strong></td>
<td>Perioperative Care: Selection of Prophylactic Antibiotic: First</td>
</tr>
<tr>
<td></td>
<td>or Second Generation Cephalosporin</td>
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<td></td>
<td>(NQF #0268)</td>
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<tr>
<td></td>
<td>Hospital-Level Risk-Standardized Complication Rate (RSCR)</td>
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<tr>
<td></td>
<td>Following Elective Primary Total Hip Arthroplasty (THA) and/or</td>
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<td></td>
<td>Total Knee Arthroplasty (TKA)</td>
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<tr>
<td></td>
<td>(NQF #1550)</td>
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<tr>
<td></td>
<td>Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate</td>
</tr>
<tr>
<td></td>
<td>(RSMR) Following Coronary Artery Bypass Graft Surgery</td>
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<tr>
<td></td>
<td>(NQF #2558)</td>
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<tr>
<td></td>
<td>Excess Days in Acute Care after Hospitalization for Acute</td>
</tr>
<tr>
<td></td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td></td>
<td>(NQF #2881)</td>
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<tr>
<td></td>
<td>AHRQ Patient Safety Indicators</td>
</tr>
<tr>
<td></td>
<td>(PSI 90)</td>
</tr>
</tbody>
</table>
Inpatient 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

[Images of medical tools and organs]
Inpatient Episodes

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

Gastrointestinal Episodes
- Major bowel procedure
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis (New Episode for BPCI Advanced)

Pulmonary Episodes
- Simple pneumonia and respiratory infections
- COPD, bronchitis, asthma
Outpatient Episodes

- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator
- Back & Neck Except Spinal Fusion
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
What’s included in an 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
How is the target price set?

To determine the Episode Initiator specific Benchmark Price for an ACH, CMS will use risk adjustment models to account for the following contributors to variation in the standardized spending amounts for the applicable Clinical Episode:

1. Patient case-mix
2. Patterns of spending relative to the ACHs peer group over time
3. Historic Medicare FFS expenditures efficiency in resource use specific to the ACHs Baseline Period
How is the target price set?

\[
\text{Target Price (TP)} = \text{Benchmark Price (BP)} \times (1 - \text{CMS Discount})
\]

- CMS Discount = 3% for all Clinical Episodes
- Preliminary Target Prices will be provided prospectively
- Final Target Price will be set retrospectively at the time of Reconciliation by replacing the historic Patient Case Mix Adjustment with the realized value in the Performance Period

Retrospective reconciliation based on comparing actual Medicare FFS expenditures to the final Target Price
CMS Will Get Their Cut No Matter What

Reconciliation or Repayment Calculated Based on Actual Cost Compared to Target Price

Episodic Spending in BPCI Advanced

Target Price

Negative Reconciliation Amount

Positive Reconciliation Amount

Episode 1

Episode 2

Positive Reconciliation Amount

Amount by which all expenditures are less than the Target Price for an Episode

Negative Reconciliation Amount

Amount by which all expenditures exceed the Target Price for an Episode

No More Phased-In Financial Risk

Unlike earlier bundles, participants will take on total financial risk from the outset of the program
### Episode Costs – OU Physicians

**Measurement Period:** 06/01/16 to 05/31/17

<table>
<thead>
<tr>
<th>Episode-Based Cost Measures</th>
<th>Percent Difference Between Your TIN's Average Risk-Adjusted Episode Cost and National</th>
<th>Percent Difference Between Your TIN's Average Risk-Adjusted Episode Cost and National</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
<td><strong>Name</strong></td>
<td><strong>Less Cost to Medicare</strong></td>
</tr>
<tr>
<td>Procedural</td>
<td>Elective Outpatient PCI</td>
<td>10%</td>
</tr>
<tr>
<td>Procedural</td>
<td>Knee Arthroplasty</td>
<td>9%</td>
</tr>
<tr>
<td>Procedural</td>
<td>Revascularization For Lower Extremity Chronic Critical Limb Ischemia</td>
<td>6%</td>
</tr>
<tr>
<td>Procedural</td>
<td>Routine Cataract Removal with IOL Implantation</td>
<td>-</td>
</tr>
<tr>
<td>Procedural</td>
<td>Screening/Surveillance Colonoscopy</td>
<td>27%</td>
</tr>
<tr>
<td>Acute IP Medical Condition</td>
<td>Intracranial Hemorrhage Or Cerebral Infarction</td>
<td>10%</td>
</tr>
<tr>
<td>Acute IP Medical Condition</td>
<td>Simple Pneumonia with Hospitalization</td>
<td>-2%</td>
</tr>
<tr>
<td>Acute IP Medical Condition</td>
<td>STEMI with PCI</td>
<td>-</td>
</tr>
</tbody>
</table>

**National Average**
Does bundled payment work?
Although the past decade has witnessed a fair amount of experimentation with performance-based payment models, primarily P4P programs, we still know very little about how best to design and implement VBP programs to achieve stated goals and what constitutes a successful program. The published evidence regarding improvements in performance from the P4P experiments of the past decade is mixed (i.e., positive and null effects); where observed, improvements were typically modest.
We included 89,605 beneficiaries undergoing lumbar fusion, including 36% seen by a preparatory hospital and 7% from a risk-bearing hospital.

Relative to non-participants, risk-bearing hospitals had a slightly increased fusion procedure volume from 2012 to 2013 (3.4% increase versus 1.6% decrease, \( p = 0.119 \)), did not reduce 90-day episode of care costs (0.4% decrease versus 2.9% decrease, \( p = 0.044 \)), increased 90-day readmission rate (+2.7% versus -10.7% percent, \( p = 0.043 \)), and increased repeat surgery rates (+30.6% versus +7.1% percentage points, \( P = 0.043 \)).
Compared with nonsavings hospitals, savings hospitals were larger (mean No. of hospital beds, 301 for savings hospitals vs 230 for nonsavings hospitals; P < .001) (Table) and had higher volume (mean annual Medicare joint replacement volume, 216.9 for savings hospitals vs 133.3 for nonsavings hospitals; P < .001). Savings hospitals were more likely to be nonprofit (70% for savings hospitals vs 53% for nonsavings hospitals; P < .001), teaching (62% for savings hospitals vs 52% for nonsavings hospitals; P = .004), and integrated with a post–acute care facility (55.8% for savings hospitals vs 40% for nonsavings hospitals; P < .001) than nonsavings hospitals.

A greater proportion of nonsavings hospitals were low volume (2% for savings hospitals vs 23% for nonsavings hospitals; P < .001) and safety-net hospitals (22% for savings hospitals vs 37% for nonsavings hospitals; P < .001).

High Caesarean section rates. Too many babies in the NICU. There are indications that maternity and newborn care in this country is far from ideal. Some payers are betting that bundled payments for obstetricians will create incentives to make changes and reduce low-value care.

“....because pregnancy, labor, and birth account for seven of the top 20 most expensive hospitalized conditions.”
The Ethics of Bundled Payments in Total Joint Replacement: "Cherry Picking" and "Lemon Dropping"

“......This article considers the ethics of patient selection to improve outcomes; specifically, screening patients by body mass index to determine eligibility for total joint replacement. I argue that this type of screening is not ethically defensible, and that the bundled payment program as structured is likely to lead to unfair restrictions on who receives total joint replacements.”
Closing Thoughts
Closing Thoughts

• There is substantial, non-evidence-based variation in the costs and quality of care

• There is substantial waste in healthcare – particularly unnecessary testing and interventions that do not alter patient outcomes

• In the next lecture – rates of growth in healthcare spending are not sustainable
If you are going to participate in a bundle, you need to understand your costs!

Hospitals and clinicians entering bundled payment programs for CABG (and other episodes) should work to understand local sources of variation, with a focus on patients with multiple readmissions, inpatient evaluation and management services, and post-discharge care.

1. **While some aspects of payment reform have slowed, MACRA and increased scrutiny of health care costs are here to stay.**

2. **Focusing on episodes of care can help align stakeholders around efforts to reduce unwarranted care variation and costs.**

3. **Now is the time to build infrastructure and increase alignment between hospitals and physicians**
Value-based payment is here to stay!