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

Bundled Payment Models at the CMS Innovation Center

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Strategic Goals of the CMS

The CMS strategy will be built on one main goal:

PUT PATIENTS FIRST

1. Empower Patients and Doctors to make decisions about their health care.
2. Usher in a new era of state flexibility and local leadership.
3. Support innovative approaches to improve quality, accessibility, and affordability.
4. Improve the CMS customer experience.

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

We are assessing the portfolio to ensure alignment with CMS' strategy

Focus Areas	Current CMS Innovation Center Portfolio (under review)*
Pay Providers	**Test and expand alternative payment models** ▪ **Accountable Care** – ACO Investment Model – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Comprehensive ESRD Care Initiative – Next Generation ACO ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) & CPC+ – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices – Frontier Community Health Integration Project – Medicare Diabetes Prevention Program Expanded Model ▪ **Bundled payment models** – Bundled Payments for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ **Initiatives Focused on the Medicaid** – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program ▪ **Dual Eligible (Medicare-Medicaid Enrollees)** – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Medicare-Medicaid ACO Model ▪ **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design Model – Part D Enhanced Medication Therapy Management
Deliver Care	**Support providers and states to improve the delivery of care** ▪ **Learning and Diffusion** – Partnership for Patients – Transforming Clinical Practice ▪ **Health Care Innovation Awards** ▪ **Accountable Health Communities** ▪ **State Innovation Models Initiative** – SIM Round 1 & SIM Round 2 – Maryland All-Payer Model – Pennsylvania Rural Health Model – Vermont All-Payer ACO Model ▪ **Million Hearts Cardiovascular Risk Reduction Model**
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** ▪ **Information to providers in Innovation Center models** ▪ **Shared decision-making required by many models**

* Many Innovation Center models test innovations across multiple focus areas

Innovation Center’s Major Areas of Impact

>18 million	**Beneficiaries touched**	Innovation Center models impact over 18M beneficiaries and individuals[1,2] **in all 50 states**
>207,000	**Providers participating**	Over 200,000 providers and provider groups[2] **across the nation** are participating in Innovation Center models
>30%	**Medicare FFS payments in APMs**	CMS reached their goal of tying greater than 30% of **Medicare fee-for-service payments to alternative payment models (APMs)**

[1] Includes CMS beneficiaries (i.e., individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage) and individuals with private insurance, including in multi-payer models
[2] Figures as of September 30, 2016

Source: Center for Medicare and Medicaid Innovation
-Report to Congress, December 2016

Bundled Payments for Care Improvement (BPCI)

The bundled payment model provides a single payment for an episode of care and 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

Timeline for BPCI

- Model 1: Started January 2013 - Completed December 31, 2016
- Models 2, 3, 4: Started October 2013 - Close out September 30, 2018

BPCI: Models Overview & Participation as of April 2017

1295 Participants: 276 Awardees and 1019 Episode Initiators

Model	Description
Model 1	• Retrospective bundled payment model for the acute inpatient hospital stay and readmissions during the length of the episode • Model ended on 12/31/16
Model 2	• Retrospective bundled payment model consisting of an inpatient hospital stay, professional services, readmissions, and post-acute care during the length of the episode • **557 Participants: 175 Awardees and 382 Episode Initiators**
Model 3	• Retrospective bundled payment model for post-acute care, professional services and readmissions during the length of the episode • **735 Participants: 98 Awardees and 637 Episode Initiators**
Model 4	• Prospectively administered bundled payment model for the acute inpatient hospital stay, professional services and readmissions that occur within 30 days of discharge • **3 participants: 3 Awardees**

BPCI Provider Types as of April 2017

Provider Type	Model 2	Model 3	Model 4	TOTAL
Acute Care Hospital	327	0	3	330
Physician Group Practice	192	48	0	240
Home Health Agency	0	78	0	78
Inpatient Rehab Facility	0	9	0	9
Long Term Care Hospital	0	0	0	0
Skilled Nursing Facility	0	582	0	582
TOTAL	**519**	**717**	**3**	**1239**

BPCI Impact

Beneficiaries

- Between October 2014 and September 2016 **876,287 Medicare beneficiaries** received care in a clinical episode under BPCI.

Geographical Reach

- 49 states & DC
  (except Montana)

Top 5 BPCI Clinical Episodes Q2 2014 - Q2 2016 for Models 2 and 3

Clinical Episode	Total M2-3 Cases	Total M2 Cases	Total M3 Cases
Major joint replacement of the lower extremity - MJRLE	182,511	168,372	14,139
Sepsis	63,715	58,215	5,500
Congestive heart failure	52,987	45,890	7,097
Simple pneumonia and respiratory infections	44,364	39,652	4,712
Chronic obstructive pulmonary disease, bronchitis, asthma	33,522	31,133	2,389
Total Top 5 Clinical Episodes **Total # of Clinical Episodes**	**377,099** **630,792** **60% of all CE**	**343,262** **566,033**	**33,837** **64,770**

BPCI Evaluation

- First Annual Report released in February 2015
- Second Annual Report released September 2016
- ***Third Annual Report anticipated to be released Fall 2017***
  - Quantitative analyses reflect experience of participants during the first two years (2013 Q4 – 2015 Q3).
  - First time an annual report is reporting results for individual clinical episodes and not episode groups.

Released Reports available on the BPCI website:
https://innovation.cms.gov/initiatives/Bundled-Payments/index.html

BPCI Evaluation to Date

- Orthopedic surgery episodes showed **statistically significant savings of $864 per episode.**
- Savings were mainly achieved by lowering utilization of institutional PACs.
- Quality was generally maintained or improved relative to comparison group.

The Future is…BPCI Advanced

The Innovation Center is considering a new Voluntary Bundled Payment Model that would be designed to be an Advanced Alternative Payment Model. Participants would be required to use CEHRT.

- Model would provide payment for covered services based on quality measures comparable to those in the quality performance category under MIPS.
- Participating APM entities would be required to bear risk for monetary losses of more than a nominal amount.

Comprehensive Care for Joint Replacement Model (CJR): Description

- The CJR model **started on April 1, 2016** and is currently in its second performance year. It is scheduled to run for 5 years in total; ending December 2020.
- CJR is an episode-based payment model for lower extremity joint replacement (LEJR) procedures for Medicare fee-for-service beneficiaries.
- CJR episodes include:
  - Hospitalization for LEJR procedure assigned MS-DRG 469 or 470 and 90 days post-discharge.
  - All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode.

CJR Model: Participants

- The CJR model was implemented in **67** metropolitan statistical areas (MSAs).
- Participant hospitals in these selected MSAs are **all acute care hospitals paid under the IPPS** that are not currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes.
- **Approximately 800 hospitals are required to participate in the CJR model.**
- Initial Reconciliation Reports for Performance Year 1 (PY 1) were distributed to CJR participants at the end of April 2017; a final reconciliation on PY 1 will occur in April of 2018.
- Many participants in CJR are actively engaged in improving care management and coordination; the CJR Connect online collaboration tool is the most actively used of all Innovation Center models and webinars on care redesign and improvement are widely attended.

Advancing Care Coordination through Episode Payment Models: Description

- The three new mandatory participation episode payment models (EPMs) implemented through notice and comment rulemaking cover bundles for heart attacks, coronary bypass and surgical hip and knee procedures. Like CJR, the episodes will all begin with inpatient admissions and will extend 90 days beyond discharge.
- The original EPM final rule, which established the EPMs, was published January 3, 2017 but was delayed for additional review. The original start date of July 1, 2017 was changed to **January 1, 2018 in a final rule published May 19, 2017. CMS intends to engage in additional rulemaking on these models.**
- A Cardiac Rehabilitation Incentive Payment model designed to incentivize the use of the cardiac rehabilitation benefit under Medicare was also established and is currently set to begin January 1, 2018. **CMS intends to engage in additional rulemaking on this model as well.**
- All of the EPMs were designed to offer an Advanced APM track to model participants so that clinicians assisting in care for the beneficiaries in these models will have an opportunity to participate in an Advanced APM.

Oncology Care Model (OCM) - Description

Episode-based payment model for cancer care

- Six-month episodes of care triggered by chemotherapy
- Multi-payer model
- Practice redesign activities to drive practice transformation

Overarching Aims

- Improve the health outcomes for patients with cancer
- Improve quality of cancer care
- Reduce spending for cancer treatment

Oncology Care Model (OCM) - Description

Model Launch: July 1, 2016 with 5 year duration

- Participants
  - **Practices: 190 Payers: 16**

Two-pronged payment approach

- PBPM: Monthly Enhanced Oncology Services (MEOS) Payments $160
- Performance Based Payments

Quality Measures

- 12 total quality measures; 8 reported to registry

Risk Arrangements:

- One-sided risk with 4% discount
- Two-sided risk with 2.75% discount; Advanced APM
- Stop-loss/stop-gain set at 20% of benchmark amount
- First reconciliation results: February 2018

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

- MACRA established the PTAC to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee. The PTAC is a federal advisory committee that provides independent advice to the Secretary. This committee provides a unique opportunity for stakeholders to participate in the development of new models and to help determine priorities for the physician community
- Based on feedback and input from PTAC, CMS intends to create new specialty models best suited to Physician Group Practices (PGPs) needs.
- CMS is working with organized medicine and other interested parties to evaluate and expand the availability of MIPS APMs and Advanced APMs through the Innovation Center and the PTAC process.
- CMS intends to offer new APM opportunities later this year and also looks forward to learning from the PTAC about even more model ideas.
- For more information on PTAC: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee
- APM Design Toolkit (resource for designing APMs): https://qpp.cms.gov/docs/QPP_How_to_Design_an_APM.pdf

Thank you!

Questions?

Questions regarding BPCI can be directed to: BundledM234@cms.hhs.gov
Questions regarding CJR can be directed to: CJR@cms.hhs.gov
Questions regarding EPM can be directed to: EPMrule@cms.hhs.gov
Questions regarding OCM can be directed to: OCMsupport@cms.hhs.gov