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CENTER FOR MEDICARE & MEDICAID INNOVATION

CMS Innovation Center Bundled Payment Models

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The CMS Innovation Center Statute

"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"

Three scenarios for success from Statute:

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

CMS Innovation Center all-inclusive portfolio

Accountable Care
- ACO investment Model
- Comprehensive ESRD Care Model
- Medicare Health Care Quality Demonstration
- Next Generation ACO Model
- Vermont All-Payer ACO Model

Episode-based Payment Initiatives
- *BPCI Advanced*
- BPCI Models 2-4
- Comprehensive Care for Joint Replacement Model
- Oncology Care Model

Primary Care Transformation
- Comprehensive Primary Care Plus
- *Direct Contracting Model (3 voluntary model options)*
- Graduate Nurse Education Demonstration
- Independence at Home Demonstration
- *Primary Care First*
- Transforming Clinical Practice Initiative

Initiatives Focused on the Medicare-Medicaid Enrollees
- Medicaid Innovation Accelerator Program
- Financial Alignment Initiative for Medicare-Medicaid Enrollees
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Phase Two
- *Integrated Care for Kids Model*
- *Maternal Opioid Misuse Model*

Initiatives to Accelerate the Development & Testing of Payment and Service Delivery Models
- Accountable Health Communities Model
- *Artificial Intelligence Health Outcomes Challenge*
- *Emergency Triage, Treat, and Transport Model*
- Frontier Community Health Integration Project Demonstration
- *Home Health Value-Based Purchasing Proposed Model*
- *International Pricing Index Proposed Model*
- Maryland All-Payer Model
- Maryland Total Cost of Care Model
- *Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration*
- *Medicare Advantage Value-Based Insurance Design Model*
- Medicare Care Choices Model
- Medicare Intravenous Immune Globulin Demonstration
- Part D Enhanced Medication Therapy Management Model
- *Part D Payment Modernization Model*
- Pennsylvania Rural Health Model
- Rural Community Hospital Demonstration

Initiatives to Speed the Adoption of Best Practices
- Health Care Payment Learning and Action Network
- Medicare Diabetes Prevention Program Expanded Model
- Million Hearts
- Million Hearts: Cardiovascular Disease Risk Reduction Program
- Partnership for Patients

Blue text - Announced in 2018-2019

CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

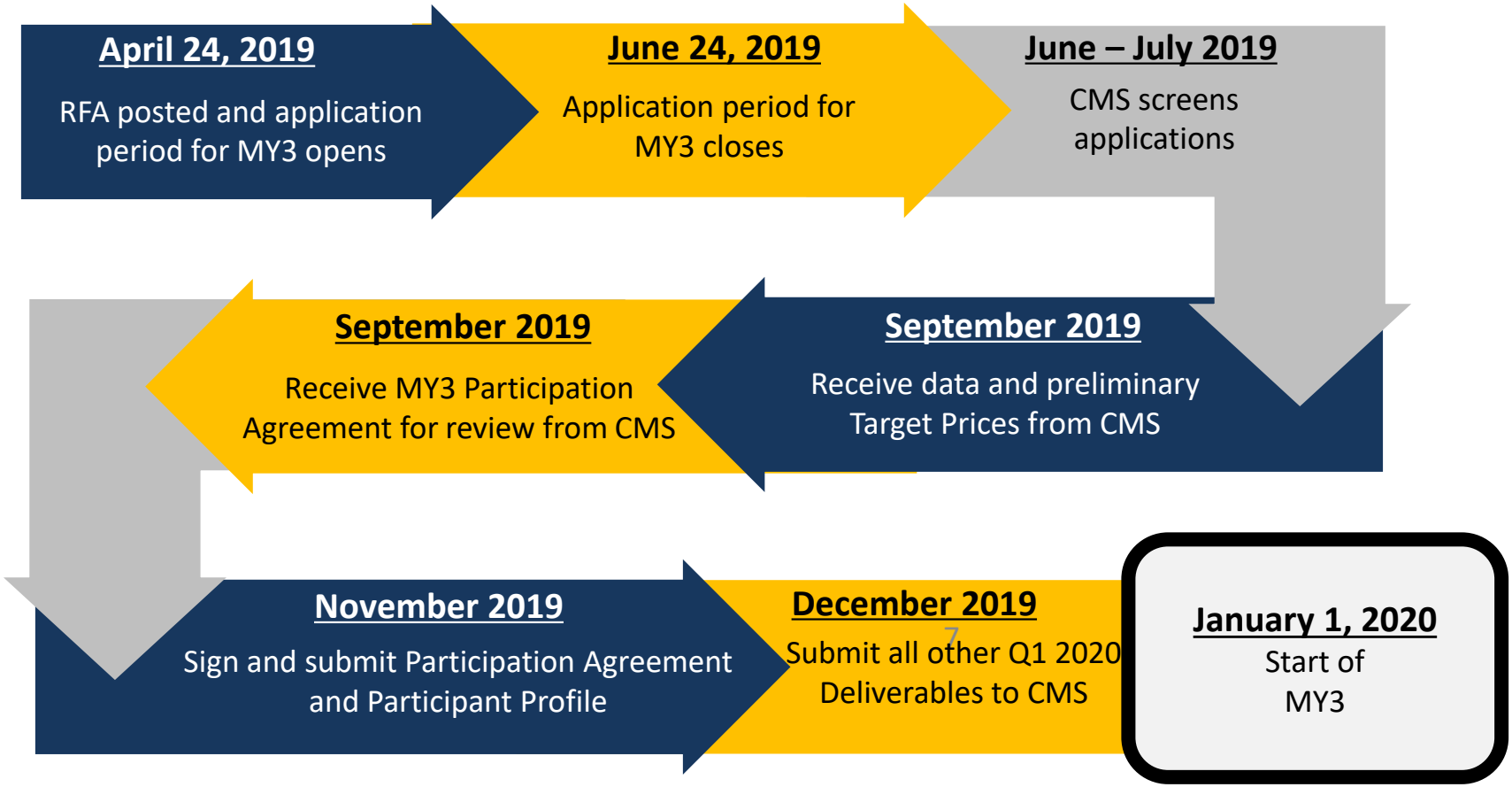
BPCI Advanced Model Overview

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

Objectives of BPCI Advanced

1. Financial Accountability
2. Care Redesign
3. Data Analysis and Feedback
4. Health Care Provider Engagement
5. Patient and Caregiver Engagement

Application Roadmap – Model Year 3 (MY3)



Two Categories of Participants

Convener Participant

- Brings together downstream Episode Initiators (EIs)
- Facilitates coordination
- Bears and apportions financial risks

Non-Convener Participant

- Is the Episode Initiator (EI)
- Bears financial risk only for itself, and
- Does not bear risk on behalf of downstream EIs

Who can be an Episode Initiator (EI)?

Physician Group Practices (PGPs)

Acute Care Hospitals (ACHs)

Quality Measures, Continued

For the first two Model Years, the amount by which any **Positive** Total Reconciliation Amount or **Negative** Total Reconciliation Amount may be adjusted by the CQS Adjustment Amount is capped at 10 percent.

Model Years 1 & 2 will include **claims-based measures.**

Additional measures with varying reporting mechanisms may be added in Model Year 3 and beyond.

Quality Measures, Continued

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

33 Inpatient Clinical Episodes

Spine, Bone, and Joint

- Back and 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 and femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- **Major joint replacement of the lower extremity (MJRLE)****
- Major joint replacement of the upper extremity
- Double joint replacement of the lower extremity

Kidney

- Renal failure

Infectious Disease

- Cellulitis
- Sepsis
- Urinary tract infection

Neurological

- **Seizures***
- Stroke

***New Clinical Episode in MY3**

****This is a multi-setting Clinical Episode category. Total Knee Arthroplasty (TKA) procedures can trigger episodes in both inpatient and outpatient settings.**

33 Inpatient Clinical Episodes

(Continued)

Cardiac

- **Transcatheter Aortic Valve Replacement***
- Acute myocardial infarction
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft
- Congestive heart failure

Pulmonary

- Simple pneumonia and respiratory infections
- COPD, bronchitis, asthma

Gastrointestinal

- **Bariatric Surgery***
- **Inflammatory Bowel Disease***
- Major bowel procedure
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis

***New Clinical Episode in MY3**

4 Outpatient Clinical Episodes

- **Major joint replacement of the lower extremity (MJRLE)****
- Percutaneous Coronary Intervention
- Cardiac Defibrillator
- Back and Neck, except Spinal Fusion

****This is a multi-setting Clinical Episode category. Total Knee Arthroplasty (TKA) procedures can trigger episodes in both inpatient and outpatient settings.**

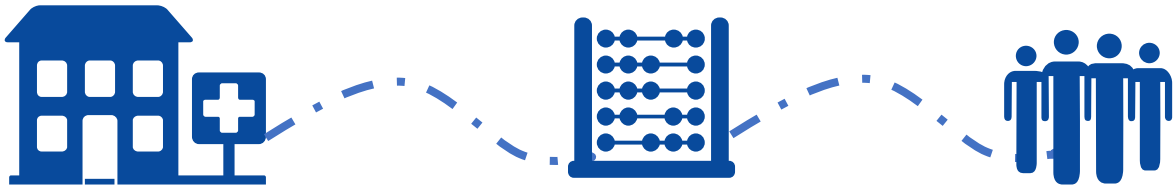
ACH's Benchmark Price

To determine the EI-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. ACH's characteristics
3. Projected trends in spending among ACH's peer group
4. Historical Medicare FFS expenditures specific to the ACHs Baseline Period

PGP's Benchmark Price

BPCI Advanced will base the PGP's Benchmark Prices on the Benchmark Prices for the ACHs where its Anchor Stays or Anchor Procedures occur. CMS will adjust each ACH-specific Benchmark Price to calculate a PGP-ACH-specific Benchmark Price that accounts for the PGP's historical spending patterns and the PGP's patient case mix, each relative to the ACH.



Target Price Calculations

- 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

Frequency of Reconciliation

- Semi-Annually with two “True-Ups” to allow for claims run-out
- Clinical Episodes will be reconciled based on the Performance Period in which the Clinical Episode ends

- **First Performance Period of a Model Year:** Clinical Episodes that end during the period of January 1 – June 30
- **Second Performance Period of a Model Year:** Clinical Episodes that end during the period of July 1 – December 31

What have we learned about success in bundled payments?

- Maximize CMS Data
- PAC Collaboration
- Care Standardization
- Clinical Coordinators
- Committed Leadership
- Episode Variety
- Time

BPCI Advanced Participation First Quarter 2019

- There are currently 1,086 Participants in the Model
  - 834 Convener Participants
  - 252 Non-Convener Participants
  - 1,041 Episode Initiators in the Model
    - 593 ACHs
    - 448 PGPs

Comprehensive Care for Joint Replacement (CJR) Model

The CJR model started on **April 1, 2016** and is currently in its fourth performance year. It is scheduled to run for 5 years in total; ending December 31, 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 was implemented in **67** metropolitan statistical areas (MSAs) All participant hospitals in these selected MSAs are acute care hospitals paid under the IPPS
- Initial Evaluation Results for PY 1 are available on the CJR website

CJR Target Pricing

At the beginning of each model performance year, CJR hospitals receive separate episode target prices for **MS-DRGs 469 and 470**. Each MS-DRG has a separate price for episodes with and without fracture. Target prices are adjusted for quality.

Target prices blend of hospital specific and regional data

100% regional data in model years 4 & 5 (2019-2020)

CJR Pay-for-Performance Methodology uses 2 quality measures:

- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0166)

CJR also financially incentivizes a voluntary patient-reported outcome (PRO) and risk variable data collection initiative

- Successful submission of PRO data can result in 2 additional points being added to the quality score

CJR Participation Changes

- Participation was mandatory for all participants for model years 1 & 2
- CJR model participation requirements changes were proposed and finalized in a final rule effective January 1, 2018
- Rural and low volume providers and providers in **33 of the 67 CJR geographic areas** were able to voluntarily opt into the model between January 1st and January 31, 2018

488 total number of participating hospitals as of January 15, 2019

402 of these 489 hospitals are located in the 34 **mandatory** MSAs

86 of these 489 providers are located in the **voluntary** MSAs

Evaluation of the CJR Model Year 1 Performance

- Results from the first performance year of the CJR model are promising and indicate that a mandatory episode based payment approach for LEJR episodes can achieve per episode payment reductions while maintaining quality for both planned LEJR episodes and those due to fracture.

GROSS REDUCTIONS IN SPENDING

Reductions in total episode payments were largely driven by reductions in the use of more intensive post-acute care settings and shorter lengths of stay.

$910	**Total Payments (per episode)**
$455	Skilled Nursing Facility Payments
$350	Inpatient Rehabilitation Facility Payments
$83	Part B Payments
$109	Readmissions Payments

Utilization

Among elective episodes, fewer patients are being discharged to inpatient rehabilitation facilities (IRF), and a relative larger proportion are being discharged directly home with home health agency services.

Among fracture episodes, utilization analyses suggest the substitution of SNF for IRF care.

Both elective and fracture patients are spending fewer days in SNF.

The shift to less intense post-acute care did not impact readmission rates, emergency department visits, and mortality.

Oncology Care Model (OCM) Overview

- Test innovative payment strategies that promote high-quality and high-value cancer care
  - Real-time monthly payments (MEOS) that pay for enhanced services
  - Potential for a retrospective performance-based payment based on quality and savings

OCM Overview contd.

Episode-based

Payment model targets chemotherapy and related care during a 6-month period that begins with receipt of chemotherapy treatment

Emphasizes practice transformation

Physician practices are required to implement "practice redesign activities" to improve the quality of care they deliver

Multi-payer model

Includes Medicare fee-for-service and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the practice's population

Timeline: July 1, 2016-June 30, 2021

OCM Scope

- ~25% of Medicare FFS chemotherapy-related cancer care
  - 176 practices
  - ~ 7,000 practitioners
  - ~ 200,000 unique beneficiaries per year
  - ~ 260,000 episodes of care per year
- 10 commercial payers participating

Transforming Cancer Care: Practice Redesign

1. **Provide Enhanced Services**
   - 24/7 access to clinician with real-time access to medical records
   - Patient navigation
   - 13-point care plan
   - Use of nationally recognized clinical guidelines
2. **Use certified electronic health record technology (CEHRT)**
3. **Utilize data for continuous quality improvement**

Improving Care for Cancer Patients

- Care transformation
  - “Enables us to do what we’ve always wanted to”
- Improving care coordination, symptom management, palliative care, and end of life care
- Recognizing depression and distress in cancer patients
- Addressing financial toxicity
- Improving education and communication with patients and other providers

Evaluation Findings: Performance Period 1*

Utilization/cost and quality: early promise but no measureable impacts yet

- Hospitalizations/ED visits
- Use of chemotherapy
- Total Medicare spending
- Surveys
- End of life care

*Performance period 1 included 6-month episodes that began July 1, 2016, through January 1, 2017.

Lessons Learned: OCM Design

- Payment methodology
  - Low- vs. high-risk cancers
  - Coding practices, e.g., Z51
  - Attribution
  - MEOS submission window
  - Clinical and staging data
- Quality measures
- Two-sided risk arrangement

Innovation Center – 2019 Looking Forward

We are focused on:

- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS
- Portfolio analysis and launch new models to round out portfolio

Value Considerations for Model Development and Testing

Focus Areas

Patients as Consumers

Payment for Outcomes

Providers as Navigators

Prevention of Disease

Priority will be given to proposed models that meet the following criteria:

QUALITY

✓ Reduce avoidable events by at least 10% and/or mortality by at least 2%

COST

✓ Reduce expenditures by $10 billion/year upon expanding nationally

BENEFICIARY CHOICE

✓ Empower beneficiaries by increasing choice and access

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