FAQs: Bundled Payment Models

Q1: What are bundled payment models?

In bundled payment models, Medicare establishes a total budget for all services provided to a beneficiary throughout a given episode of care. If the episode's spending on services is below budget, then the providers may share in Medicare savings; alternatively, if providers' costs exceed the budget, then the providers may incur losses. In some cases, bundled payment models can span across multiple health care settings. Some of Medicare's bundled payment models are voluntary and others are mandatory for hospitals in selected areas of the country. Recently, CMS reduced the number of mandatory models that were originally scheduled to begin in 2018.

CMS is running a range of bundled payments models in Medicare that vary by key design features, including levels of financial risk, up-front payments for infrastructure costs, and beneficiary involvement. To learn more about each model and compare key features, see our Bundled Payment Side-by-Side comparison tool.

Q2: What are the different types of bundled payment models in Medicare?

Bundled Payments for Care Improvement (BPCI) Initiative

BPCI offers four different voluntary Medicare bundled payment models, numbered 1-4 (**Table 1**). Each model includes a different set of services for an episode of care. All episodes in BPCI models are triggered by a hospitalization. In models 1-3, CMS reconciles participants' spending against the "target price" after the episode of care, and in Model 4, CMS makes a prospective payment based on the "target price."

Table 1. Bundled Payments for Care Improvement (BPCI) Initiative Models: First Two Years

Model	Services Included in Bundled	Number of Episodes	CMS Spending Reconciliation
Model 1	• Inpatient hospital services	240,960	Retrospective
Model 2	• Inpatient hospital services • Physician care • Post-acute care • Readmissions	242,000	Retrospective
Model 3	• Post-acute care • Readmissions	35,000	Retrospective
Model 4	• Inpatient hospital services • Physician care • Readmissions	7,682	Prospective

Comprehensive Care for Joint Replacement (CJR)

The CJR model effectively bundles payment for lower extremity joint (hip and/or knee) replacement episodes across all inpatient hospital services, physician services, post-acute care services, and any readmissions or other related services through 90 days after the initial hospital discharge. Participants gain financially if actual expenditures for an episode (determined retrospectively) are below the "target price." Originally, the CJR model was mandatory for hospitals in 67 geographic areas, but CMS recently reduced the number of mandatory areas to 34, allowing voluntary participation among hospitals in the remaining 33 areas, as well as for small and/or rural hospitals in all 67 areas.

Oncology Care Model (OCM)

The OCM is a voluntary model in which oncology practices receive monthly care management fees and are eligible for bonus payments if they lower overall Medicare spending and meet quality goals for episodes of chemotherapy and related care. CMS offers multiple risk/reward options to participating practices. Commercial insurers are also participating.

Episode Payment Models (EPM)

CMS recently canceled all three EPMs, originally scheduled to start in 2018. These three mandatory bundled payment models were the acute myocardial infarction (AMI) model, the coronary artery bypass graft (CABG) model, and the surgical hip and femur fracture treatment (SHFFT) model. The bundled payments for each of these models included all inpatient hospital services, physician services, post-acute care services, and other related services through 90 days after the initial hospital discharge.

Cardiac Rehabilitation (CR) Incentive Payment Model

CMS recently canceled the CR Incentive Payment model, originally scheduled to start in 2018. This model was a mandatory, bonus-only bundled payment model for hospitals in 90 geographic areas. It was designed for CMS to make added payments to hospitals based on the number of cardiac rehabilitation sessions that applicable Medicare patients receive after discharge.

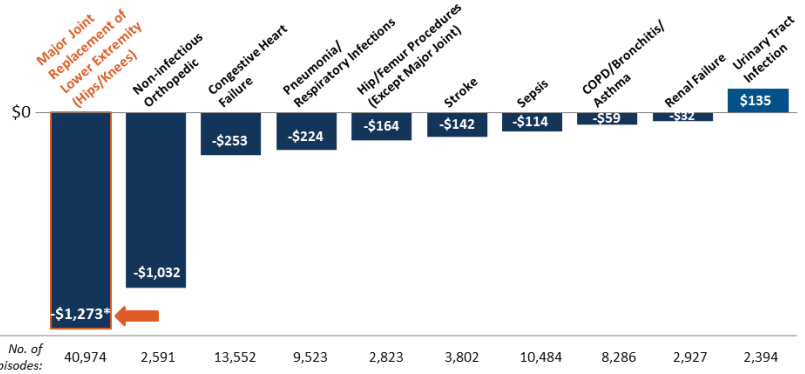
Q3: What is the evidence on savings for Medicare bundled payment models?

BPCI Model 1, which focused on Medicare hospital admissions in its bundle, achieved modest net savings ($10 million across two years), attributable mostly to discounted Medicare payments to hospitals. Notably, Medicare spending on care following hospitalizations was higher for the test episodes than the comparison group. Most hospital participants ultimately withdrew and the model has ended.

Figure 1

Major joint replacements of lower extremity (hips/knees) was the only clinical group that achieved statistically significant Medicare savings per episode in BPCI Model 2

Difference in Medicare spending per episode, relative to comparison group, among the 10 clinical groups with the highest number of episodes):



NOTES: *Statistically significant difference from comparison group ($p < 0.05$). Services included in BPCI Model 2 bundle: inpatient care, physician care, post-acute care, and all related services. Of the 23 clinical groups that had enough episodes for statistical analysis, the only group with statistically significant results was Major Joint Replacement of the Lower Extremity.
SOURCE: KFF analysis of results shown in The Lewin Group, *CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report*, October 2017.

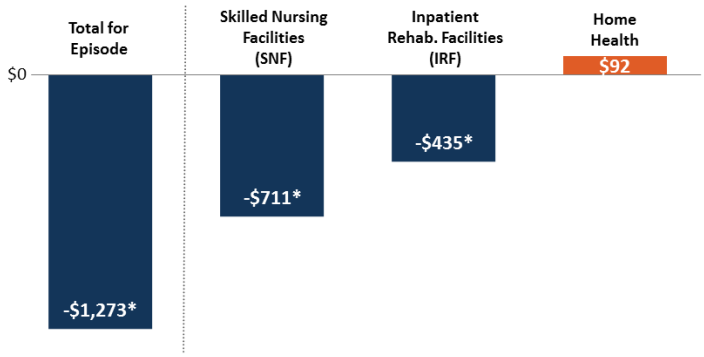
Of the other BPCI models, the most prevalent is BPCI Model 2, which spans across hospitals, physicians, and post-acute providers. In its first two years, this model generated statistically significant Medicare savings per episode for one clinical category—hip/knee replacement (technically, major joint replacement of the lower extremity)—among the 23 categories that had enough episodes for statistical analysis (**Figure 1**). Medicare savings in the hip/knee replacement category was $1,273 per episode, relative to a comparison group. While the other 22 clinical categories did not have statistically different spending from their comparison groups, among the 10 clinical categories with the highest number or episodes, spending generally trended lower than their comparison groups, per episode.

Further analysis of the hip/knee replacement episodes shows that BPCI participants had lower Medicare spending for facility-based post-acute care, such as skilled nursing facility (SNF) care, but not for home health care, which is typically less expensive (**Figure 2**).

Figure 2

For major lower joint replacements (hips/knees) episodes within BPCI Model 2, Medicare spending for post-acute care declined for facility-based care (SNFs and IRFs), but not for home health care

Difference in BPCI participants' Medicare spending for major lower joint replacements relative to comparison group, per episode, years 1 and 2:



NOTES: *Statistically significant difference from comparison group ($p < 0.05$). Services included in BPCI Model 2 payments: inpatient care, physician care, post-acute care, and all related services.
SOURCE: KFF analysis of results shown in The Lewin Group, *CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report*, October 2017.

For the newer model, the CJR model, which was mandatory for 800 hospitals and focused on hip and knee replacements, Medicare spending results are limited. Analysis of CMS data shows that in the first year of the program, about half of the hospitals received "reconciliation payments" indicating that they received added payments from Medicare because their spending was below their target benchmark in 2016. Reconciliation payments totaled $37.6 million, averaging $1,134 per episode. No spending information is available for hospitals that did not receive reconciliation payments.

Notably, episode-based spending results, including those reported for the CJR model and BPCI, do not account for changes in the number of episodes per participating provider. Therefore, any changes in the overall volume of episodes could have additional spending effects on Medicare. For specific results and more details about each model, see the Bundled Payment Side-by-Side comparison tool.

Q4: What is the evidence on quality for Medicare bundled payment models?

Quality results varied by clinical episode and model, but generally did not reveal major differences between the BPCI models and comparison groups. However, in BPCI Model 3, evaluation results showed increased rates of unplanned readmissions, emergency department use, and mortality (though greater patient complexity may have biased mortality results somewhat) for SNF-based BPCI participants relative to comparison groups. In contrast, for other measures, including functional improvement and patient-reported experience, these BPCI participants showed either greater improvement or no statistical differences.

For the CJR model, quality results are limited. CMS data show that in the first year of the program, among the hospitals that received any reconciliation payments for lower episode spending, 39 percent were classified as "excellent"; 53 percent as "good"; 8 percent as "acceptable"; and none as "below acceptable." In general, these classifications were based on CMS analysis of medical complications and patient-reported assessments for each hospital. No quality information is available for hospitals that did not receive reconciliation payments.

For further details on quality results by model, see the Bundled Payment Side-by-Side comparison tool.

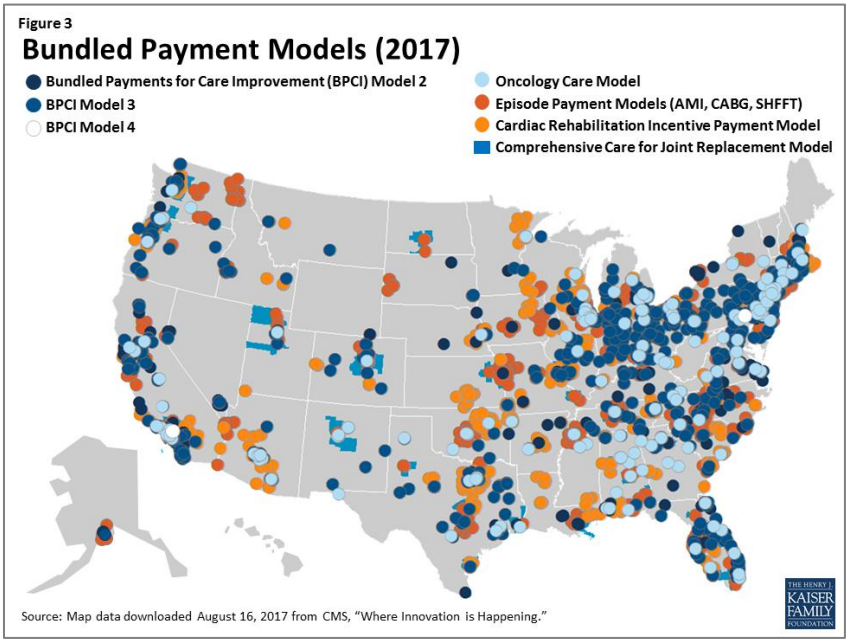
Q5: Are doctors in Medicare bundled payment models eligible for automatic bonuses under MACRA?

In 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA), which changed the Medicare payment system for physician services. In this law, physicians and other health professionals who are affiliated with "advanced alternative payment models" (APMs) are eligible for automatic 5-percent bonuses on their Medicare payments, starting in 2019. Two bundled payment models—namely, the Comprehensive Care for Joint Replacement (CJR) model and the Oncology Care Model (OCM)—qualify as advanced APMs, either in full or in part. Several other models (specifically, the AMI model, CABG model, and SHFFT model) would have qualified as advanced APMs in 2018, but CMS recently canceled them before they began.

Q6: Where are Medicare bundled payment models located?

For 2017, CMS reports that 987 hospitals/practices and another 1,019 "episode initiator" organizations are participating in Medicare bundled payment models in almost all states and the District of Columbia (**Figure 3**). Bundled payment models are more prevalent in the eastern half of the country, but are also concentrated along the west coast, with others located in Alaska and throughout the Midwest.

Figure 3



Q7: How many Medicare beneficiaries have received care in bundled payment models?

BPCI Model 1 accounted for over 240,000 beneficiary episodes among participating hospitals during its first two years. Models 2-4, for which only first year results are available, accounted for about 61,000 episodes, with the majority (74%) initiated under Model 2. Although beneficiary episodes are not an exact match to the number of beneficiaries receiving care in bundled payment models, it is likely a close estimate. To learn more about the number of beneficiaries in other models and how bundled payment models compare, see the Bundled Payment Side-by-Side comparison tool.

Q8: What are the start and end dates for the Medicare bundled payment models?

BPCI started in 2013. Model 1 concluded in December 2016, but the other three BPCI models were extended into 2018. The other ongoing models—the CJR model and the OCM—will be active at least through 2020. The Episode Payment Models (AMI, CABG, and SHFFT models) and the Cardiac Rehabilitation Incentive Payment model were slated to begin in 2018, but CMS recently canceled them before they started.