

# Medicare and the Transition to Value-Based Care

## Part 3: What are bundled-payment programs?

Whether you're a **field sales rep**, an **account executive**, a **medical liaison**, or **customer service manager**, you are expected to know a great deal about the health care delivery system—and it can be complicated. This five-part series introduces key elements that make up our health care system and the transition from fee-for-service to value-based care (also called value-based payment).

In this third part, you'll learn what bundled-payment programs are and get an introduction to the Bundled Payments for Care Improvement (BCPI) program, the BPCI Advanced program, and the Comprehensive Care for Joint Replacement (CJR) program.



### What are bundled-payment programs?

Bundled-payment programs are two value-based programs designed to incentivize providers to deliver value-focused care. What makes these programs unique is that they hold providers financially accountable for the cost and quality of care for a particular “episode.” **An episode of care is the entire course of treatment for a specific condition or medical event and includes all inpatient and outpatient care.**

In a traditional fee-for-service payment model, providers are reimbursed in a siloed manner (figure 1). Physicians are paid for the services they deliver,

hospitals for the services they deliver, and so on. Bundling, on the other hand, is a payment system in which a group of providers (e.g., hospitals, physicians, and post-acute care providers) are given a lump sum to cover the cost of care for an entire episode.

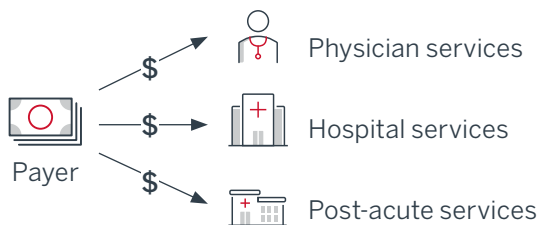
Bundled payments reduce overall costs by paying the group of providers responsible for an entire episode of care less than the sum of what the payer would have given to each individual provider under a fee-for-service model. This means that providers from all sites of care must coordinate and reduce the overall cost.

Participating health care providers can realize either a gain or loss through bundled-payment programs. The incentive for providers to participate comes in the form of gainsharing: if providers can efficiently deliver care for less than the target amount, they all share in the savings. On the other hand, bundled payments also expose providers to downside risk: if providers' costs exceed the target amount, then they are financially responsible to cover the difference. This system incentivizes the entire group of providers to coordinate on total cost of care across an entire episode.

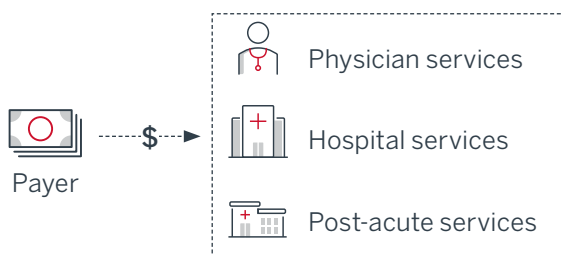
While there are only two active programs under the bundled payment umbrella, there have been three programs in total. **Bundled Payments for Care Improvement (BPCI)**, was the first iteration that CMS implemented. However, that program is now inactive and **BPCI Advanced** has taken its place. The other active program is **Comprehensive Care for Joint Replacement (CJR)**.

Figure 1: Bundled payments are fundamentally different from FFS

**Individual fee-for-service payments reinforce siloed care delivery**



**Lump-sum bundled payment drives integration through shared accountability**



**What is the Bundled Payments for Care Improvement program?**

The Bundled Payments for Care Improvement (BPCI) program was launched in 2013. It is now inactive and was replaced with BPCI Advanced in 2018.<sup>1</sup>

While it was active, the BPCI program was voluntary and providers were given much flexibility. They had choices on what episodes of care to bundle and could select from up to 48 conditions. Providers could also select from four different payment models, which included a variety of combinations of pre-acute, acute, and post-acute care services. They could also choose the method through which they received payment—either prospective or retrospective. **Several trends emerged from this original program that clearly revealed providers' hesitations and priorities.**

First, even though providers had many conditions to choose from, an overwhelming majority chose just a few bundles—primarily lower extremity joint replacements, congestive heart failure, and coronary artery bypass grafting.

Second, while providers were drawn to BPCI for its potential gainsharing, it's important to note that the first phase of BPCI was "upside only." This means providers were rewarded for keeping costs below target, but they were not penalized if they exceeded the target. When the CMS first introduced downside financial risk to BPCI in 2015, the number of participants significantly dropped off.

**PROGRAM IN BRIEF**

**Bundled Payment for Care Improvement (BPCI) program**

- The BPCI program sought voluntary participation in four bundled payment models; this program is now inactive.
- Participating hospitals selected one of four bundled payment models per condition.
  - **Models 1–3** provided retrospective reimbursement.
  - **Models 2 and 3** included post-episode reconciliation.
  - **Model 4** offered a single prospective payment.
- In phase I (through October 2015), providers were not required to take on downside financial risk. Beginning in phase II, providers were held financially responsible for spending above target limit.

## What is the Bundled Payment for Care Improvement Advanced program?

BPCI Advanced was introduced in 2018 and replaced the original BPCI.<sup>2</sup> While there are some similarities between the two programs—for example, BPCI Advanced enables participants to opt in and is voluntary—the differences between the two programs have grabbed attention.

A few of the most significant differences include:

- The original BPCI program allowed acute-care hospitals, physician groups, and post-acute care facilities to initiate episodes. BPCI Advanced allows only acute-care hospitals and physician groups to initiate episodes of care. This eliminates the bundles that were just for post-acute care. It also limits post-acute care providers to convener-only roles, which significantly impacts how post-acute care providers participate.
- The original BPCI program had 48 episodes of care, which were all inpatient-based. BPCI Advanced has 29 inpatient episodes and 3 outpatient episodes to choose from. The addition of outpatient episodes opens up an entirely new avenue for taking on episodic risk.
- BPCI episodes were acute care plus 30, 60, or 90 days of post-acute care. BPCI Advanced episodes are acute care plus 90 days of post-acute care only.
- The original BPCI program had no downside risk to providers. BPCI Advanced includes downside risk for all providers that participate.

Another unique quality of BPCI Advanced is that it also qualifies as an Advanced Alternative Payment Model. This is important for physicians who want to participate in the Alternative Payment Model (APM) track of MACRA.

► For more information on MACRA and APMs, see Part 5 of this series: **What is MACRA?**

### PROGRAM IN BRIEF

#### Bundled Payment for Care Improvement (BPCI) Advanced program

- All participants must use certified EHR.
- Participants bear more than a normal risk—up to 20% of the target price for each episode.
- Payment is tied to quality measures, including all-cause readmission and advanced care plan.



**Episodes included:** 29 inpatient episodes and 3 outpatient episodes; spans 90 days post-discharge or procedure.



**Eligible clinicians:** Hospitals and physician groups may initiate episodes; post-acute providers may participate.



**Payments mechanics:** Users retrospective reconciliation to adjust payments; participants take on total financial risk from the outset.

## What is the Comprehensive Care for Joint Replacement program?

Introduced in 2016, the Comprehensive Care for Joint Replacement (CJR) program was the first mandatory bundled-payment program. It focused on total hip and total knee replacements.<sup>3</sup> This program included all related Medicare Part A and Part B services for 90 days post-discharge, and it was mandatory in 67 Metropolitan Statistical Areas (MSAs). Like the original BPCI program, CJR didn't originally carry any downside risk, though downside risk was later incorporated in 2017.



[Click here for more data](#) about Metropolitan Statistical Areas (MSAs) that are participating in the Comprehensive Care for Joint Replacement Model, focusing on hip and knee replacements.

#### What is a Metropolitan Statistical Area?

- U.S. Office of Management and Budget (OMB) defines metropolitan statistical areas (MSAs). They're used by the Census Bureau and other federal government agencies for statistical purposes.<sup>4</sup>
- An MSA is a geographical region with a relatively high population density at its core and close economic ties throughout the area.
- Current MSA delineations were announced by OMB effective September 2018.

After the initial success of CJR-generated savings, CMS proposed to expand their suite of mandatory bundled-payment programs to include cardiac-focused bundles. With the change in administration in 2017, however, the expansion was canceled and the CJR was scaled back. So, at present, **CJR focuses on joint-related episodes of care, includes downside risk, and is mandatory in only 34 of the original 67 MSAs.**

#### PROGRAM IN BRIEF

##### Comprehensive Care for Joint Replacement (CJR) program



CJR focuses on joints. The average expenditure varies from \$16,500 to \$33,000 by MSA.



The program covers a comprehensive care episode. It includes all related Part A and Part B services for 90 days post-discharge.



CJR has been implemented in all 67 MSAs. Participation is mandatory in 34 of the 67 MSAs. Participation is voluntary for all rural and low-volume providers, as well as for providers located in the remaining 33 of the 67 MSAs.



Payment is provided as a retrospective bundle. CMS makes FFS payment to each provider separately and conducts annual reconciliation process.

## Let's recap what we've learned:



- Bundled payments reduce overall costs by paying the group of providers responsible for an entire episode of care less than the sum of what the payer would have given to each individual provider under a fee-for-service model.
- While P4P programs hold providers accountable for quality and outcomes within the hospital, bundled-payment programs hold them responsible for quality, outcomes, and cost for physicians and post-acute care as well.

▶ [Click here](#) to move to Part 4 of this series:  
**What are shared-savings programs?**

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### ENDNOTES

1. "Bundled Payments for Care Improvement (BPCI) Initiative," Centers for Medicare and Medicaid Services, <https://innovation.cms.gov/initiatives/bundled-payments>
2. "BPCI Advanced," Centers for Medicare and Medicaid Services, <https://innovation.cms.gov/initiatives/bpci-advanced>
3. "Comprehensive Care for Joint Replacement Model," Centers for Medicare and Medicaid Services, <https://innovation.cms.gov/initiatives/cjr>
4. "About (Metropolitan and Micropolitan)," United States Census Bureau, <https://www.census.gov/programs-surveys/metro-micro/about.html>



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