



**HUSCH BLACKWELL**

**New Bundled-Payments:  
Opportunities and Risks**

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# Outline

- Provide a national perspective on the rapid expansion of bundled payment programs across all payer types
- Provide an overview of the program's highlights, including the extent to which mandated acute care hospitals will be at risk
- Prepare hospitals/health systems for the challenges and opportunities that accompany bundled payment implementation, whether mandated or not;
- Highlight critical success factors for participation in bundled payment initiatives and describe how to use bundled payments to facilitate care redesign and physician engagement within an organization and align incentives accordingly.



# Provide a national perspective on bundled payment

## September 25, 2017 – CMS Seeks New Direction for Center for Medicare and Medicaid Innovation

- On September 20, 2017, the Center for Medicare and Medicaid Innovation (“CMMI”) issued an informal Request for Information (“RFI”) seeking public feedback on **“a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes.”** CMMI’s RFI came a day after Seema Verma, administrator for CMS, announced in an op-ed for the Wall Street Journal that CMS was looking to make changes to CMMI.



# Provide a national perspective on bundled payment (cont.)

- CMMI was established through the Affordable Care Act in 2010 to examine new ways of delivering health care and paying health care providers to improve the quality of care provided to individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits, all while reducing program expenditures.
- CMMI works with stakeholders across the country, other Federal agencies, and CMS directly to test innovative payment and service delivery models. These payment and service delivery models are based on three core strategies: improving the way health care providers are paid, improving the way care is delivered, and increasing the availability of information to guide decision-making. While **CMMI has had mixed reviews since its inception, CMS is now determining what CMMI models should and should not continue.**
- As a part of this initiative, CMMI “will carefully evaluate how models developed consistent with the new directions can complement **what we are learning from the existing initiatives.**” Specifically, CMMI notes that it is interested in testing models in the following eight areas:...

# The Purpose Test

- The Bundled Payments for Care Improvement (BPCI) initiative is designed to test whether linking the payments for all providers involved in delivering an episode of care can reduce Medicare costs while maintaining or improving quality of care.
- The Centers for Medicare & Medicaid Services (CMS) launched the BPCI initiative under the authority of the Center for Medicare and Medicaid Innovation.



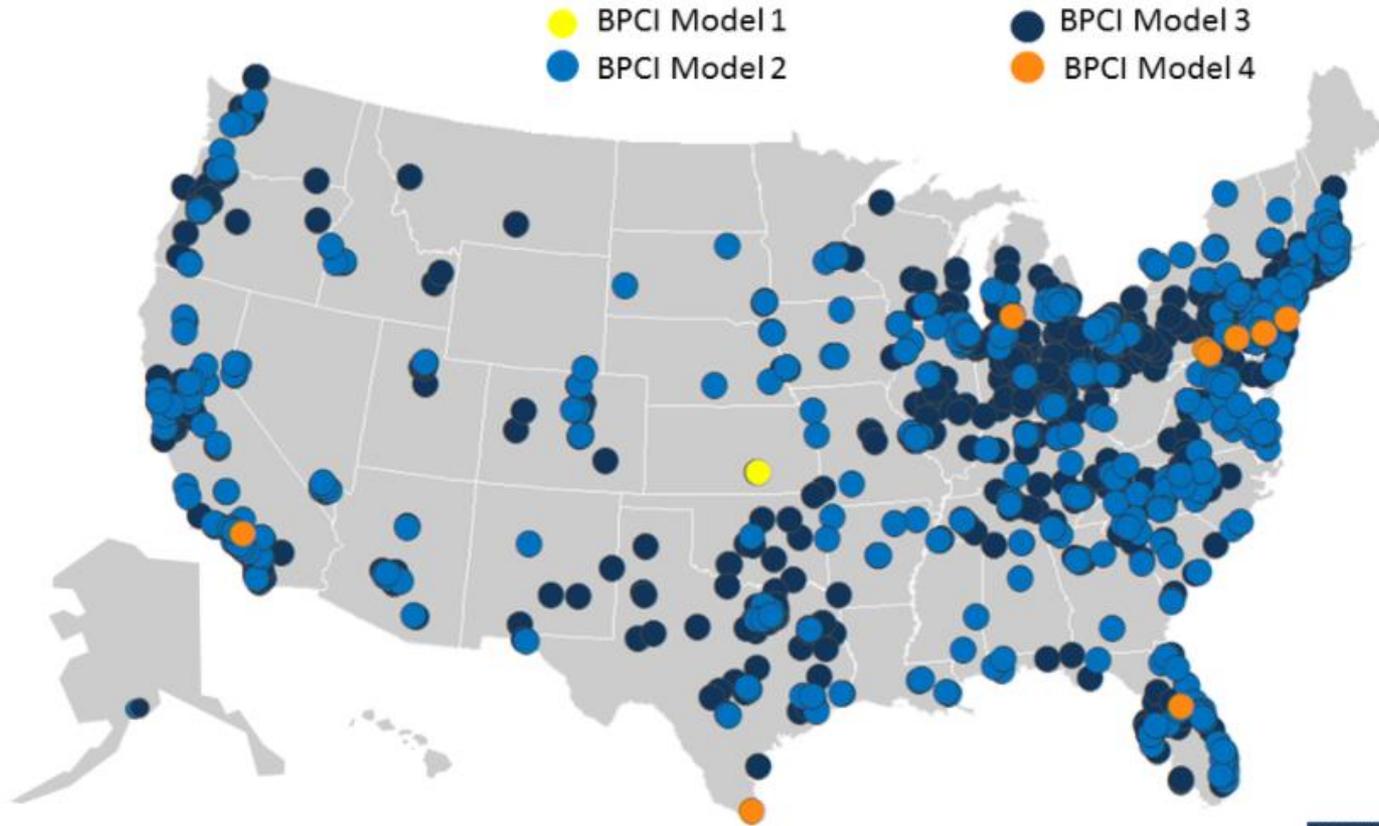
# BPCI

- The BPCI initiative is designed to reward Awardees for adopting practices that reduce Medicare payments for the bundle of services in the episode relative to a target price that CMS determines based on the provider's historical payments for the same type of episode.
- When Awardees' episode payments are below the target price, they may receive net payment reconciliation amounts (NPRA), which they can keep or share with their partnering providers.
- When Awardees' episode payments are above the target price, they may have to return amounts to CMS.
- Thus, Awardees have strong incentives to lower episode costs.



# BPCI

## Bundled Payments for Care Improvement (BPCI) Models



SOURCE: Map data downloaded October 7, 2016 from CMS: <https://innovation.cms.gov/initiatives/map/index.html>. Participant counts in this dataset are updated periodically. See Table 4 for official counts in most recently-available CMS documents and webpages.



# BPCI Models – Model 2

- **Model 2** has the most comprehensive bundle, which includes the triggering hospital stay (i.e., the anchor hospitalization), all concurrent professional services and post-discharge services, including hospital readmissions, delivered within the chosen episode length of 30, 60, or 90 days (with certain exclusions).
- Individual providers are paid on a fee-for-service basis and total episode payments are reconciled retrospectively against the established target price.



# BPCI Models - Model 3

- The **Model 3** bundle includes services after the anchor hospital discharge, including professional services and readmissions within the chosen episode length of 30, 60, or 90 days (with certain exclusions).
- The episode starts when a beneficiary is admitted to a participating skilled nursing facility (SNF), home health agency (HHA), inpatient rehabilitation facility (IRF), or long-term care hospital (LTCH) following a hospitalization for a chosen clinical episode, or when a beneficiary is admitted to a post-acute care (PAC) setting by a physician who is in a participating physician group practice (PGP).
- Individual providers are paid on a fee-for-service basis and total episode payments are reconciled retrospectively against the established target price.



# BPCI Models - Model 4

- The **Model 4** bundle includes the anchor hospitalization, all concurrent professional services, and any readmissions and associated professional services that occur within 30 days of discharge that are not explicitly excluded from the bundle.
- Awardees are paid a prospectively determined amount and they, in turn, pay the providers involved in the episode.

# Model 2 Characteristics

- **Participant Characteristics:** Episode-initiating hospitals differ from hospitals that did not participate.
- The majority (85%) of Model 2 episode-initiating hospitals were **not-for-profit**, compared with 59% of the non-participating hospitals.
- Nearly all (95%) BPCI hospitals were **in urban locations**, compared with 71% of non-participating hospitals.
- On average, BPCI hospitals **were also larger** (359 beds vs. 188 beds), **had greater teaching activity** (a resident-to-bed ratio of 0.18 vs. 0.06), and **had almost twice as many admissions** for the 48 BPCI clinical episodes in 2011 (4,060 vs. 2,140) compared with non-participating hospitals.
- BPCI hospitals were similar to non-participating hospitals in terms of chain status (49% vs. 52%) and disproportionate share percent (30% vs. 28%). The two groups differed in total Medicare inpatient days, with **a lower Medicare share for BPCI hospitals than non-participants** (37% vs. 41%).

# Model 2 Characteristics

- Hospital EIs tended to be located in CBSAs that had multiple competing providers, with none of them dominating the market, while markets without BPCI-participating hospitals tended to have fewer hospitals that had larger market shares. **BPCI hospitals were also located in more densely populated areas with higher median incomes**, compared with markets without BPCI participants.
- **Markets with BPCI-participating hospitals tended to have more primary care physicians, specialists, and nurse practitioners for their populations than markets without BPCI participants**, although BPCI markets tended to have fewer SNF beds. BPCI markets had higher Medicare Advantage penetration compared with non-BPCI markets (26.9% vs. 17.6%). The proportion of residents aged 65 years and over was similar between the two types of markets.

# Model 2 Characteristics

- **Model 2** Awardees reported several reasons for participating in BPCI, including to learn about payment reform, to pursue financial rewards, in response to urging of a Convener, to make quality improvements, and to align with existing expertise.
- Hospital EIs also indicated that they chose to participate under Model 2 instead of Model 4 because they believed that including PAC in the bundle increased their opportunities for reducing costs, and that maintaining FFS payments minimized their risk and their need for infrastructure changes.



# Model 3 Characteristics

- **Participant Characteristics:** SNFs and HHAs that are participating in BPCI as EIs under Model 3 differ from non-participating SNFs or HHAs that discharged Medicare beneficiaries in the same clinical episodes.
- Model 3 EIs were **more likely to be for-profit** than non-participating SNFs (83% vs. 69%).
- All of the participating SNFs were **in urban locations** (vs. 69% of non-participating SNFs) and fewer participating SNFs were part of a chain than non-participating SNFs (17% vs. 23%).
- Participating SNFs were more likely to be located in a CBSA with an IRF than non-participating SNFs (56% vs. 29%). Participating SNFs were larger than non-participants (148 beds vs. 110 beds). Participating SNFs were similar to non-participating SNFs in market share, five-star quality rating, and average market size.



# Model 3 Characteristics

- Market competition for SNFs and HHAs in CBSAs with BPCI-participating SNFs was higher than in CBSAs without BPCI-participating SNFs. **BPCI-participating SNFs were located in more densely populated areas, with higher average Medicare Advantage penetration and higher median household income, as well as more primary care physicians, specialists, and nurse practitioners for their populations compared with non-BPCI markets.**
- The majority of HHA Model 3 EIs (93%) were **for-profit entities**, compared with 79% of non-participating HHAs. Participating HHAs were likelier to be **part of a chain** than non-participants (86% vs 28%) and had more employed nurses, an indication that they were larger.

# Model 3 Characteristics

- Many Model 3 participants indicated that they have implemented care redesign activities related to risk assessment, care coordination, and patient engagement. During site visit interviews, participants spoke about some of the **barriers to implementing care redesign, such as difficulty obtaining information from hospitals to determine if the beneficiary was in a BPCI episode.**
- The care redesign strategies for Model 3 participants focused on **reducing costs by reducing PAC utilization and hospital readmissions.**

# Model 4 - Characteristics

- **Participant Characteristics:** Compared with non-participating hospitals, Model 4 EIs were **more likely to be non-profit** (65% vs. 59%) and located **in an urban area** (100% vs. 71%). Half of Model 4 EIs were part of a chain, which was similar to non-participating hospitals (52%). **Participating hospitals were larger** (427 beds vs. 188 beds) and **had more intensive teaching programs, as indicated by a higher average resident-to-bed ratio** (0.14 vs. 0.06) than non-participating hospitals.
- In addition, EIs had over twice as many BPCI episode admissions in 2011 than non-participating hospitals (4,516 vs. 2,140). EI hospitals averaged **a lower share of Medicare days** than non-participating hospitals (29% vs. 41%) and had similar Medicare disproportionate share percentages (29% vs. 28%).
- Coronary artery bypass graft and double joint replacement of the lower extremity were the next most common clinical episodes, which were each chosen by 45% of EIs during the first year of the initiative.

Provide an overview of the program's highlights, including risk

# Results - General

- From October 2013 through September 2014, the first full year of the active phase of the initiative, 94 Awardees, which include hospitals, physician groups, post-acute care (PAC) providers and other entities, entered into agreements with CMS to be held accountable for total Medicare episode payments. Across the three Models, 130 hospitals, 63 skilled nursing facilities (SNFs), 28 home health agencies (HHAs) and 4 physician group practices (PGPs) initiated almost 60,000 episodes of care under the initiative.
- BPCI-participating providers tended to be larger, operate in more affluent urban areas, have higher episode costs, and differed in other ways from providers that did not participate. Many indicated that commitment from their leadership and financial investment in consultants or other resources were key to implement BPCI changes.
- **Model 2 was the most widely adopted model**, accounting for approximately three-quarters of the episodes and half of provider participants. The majority of episode initiators **were acute care hospitals, which tended to be larger, urban and likelier to have teaching programs than non-participating hospitals.**

# General

## Impact of BPCI on Costs and Quality

- “For most clinical episodes, there were no statistically significant differences in the change in Medicare standardized allowed payments between BPCI participants and comparison providers, although many of the participants we interviewed indicated that they had implemented efforts intended to reduce total episode costs.”



# Results - Model 2

- The average Model 2 participant was in five clinical episodes. Almost three-quarters (74%) of Model 2 episode initiators participated in **major joint replacement** of the lower extremity. **Congestive heart failure** was chosen by 35% of episode-initiating hospitals, **chronic obstructive pulmonary disease** by 26%, and **pneumonia** by 20%.
- Average standardized allowed Medicare payments for the hospitalization and 90-days post-discharge were estimated to have declined \$864 more for orthopedic surgery episodes initiated at BPCI-participating hospitals than episodes initiated at comparison hospitals. **This was because of reduced use of institutional PAC following the hospitalization.** Beneficiaries who received their care at participating hospitals indicated that they had greater improvement in two mobility measures than beneficiaries from comparison hospitals.

# Results - Model 2

- For Model 2 orthopedic and cardiovascular surgery episodes participants' efforts to reduce episode spending are achieving expected results. For these episodes, which account for a large share of Model 2 episodes, **we saw a statistically significant shift from more expensive institutional PAC to less expensive home health care among beneficiaries discharged to any PAC setting.** This shift was the major contributor to the larger relative decline in total payments during the anchor stay and the 90-day PDP for orthopedic surgery episodes.
- The reduction in payments for orthopedic surgery episodes under Model 2 was achieved by changing the decision about where to obtain PAC... Beyond this decision, there was little evidence that EIs are affecting care after the hospital discharge.
- **There was not, however, a statistically significant decline in payments during the anchor stay and the 90-day PDP for cardiovascular surgery episodes.**



# Results - Model 2

- For cardiovascular surgery episodes, institutional PAC use declined more for BPCI than comparison populations among those with any PAC.
- Among **spinal surgery** episodes, average Medicare **payments increased** more for the hospitalization and the 90-day post-discharge period for the BPCI than comparison population.

# Results- Model 3

- SNFs were the most dominant participants under Model 3, followed by HHAs. Only 1 each inpatient rehabilitation facility, long-term care hospital, and PGP participated...
- The average Model 3 episode initiator participated in 19 clinical episodes, the most common of which was congestive heart failure, which was selected by 95% of episode initiators.
- Standardized SNF payments and SNF days for SNF-initiated BPCI episodes declined relative to the comparison group across almost all clinical episode groups. **However, this did not result in statistically significant declines in total episode payments.**
- Quality generally was maintained or improved, except in three isolated instances where BPCI participant quality outcomes declined relative to the comparison group.
- There was a statistically significant reduction in SNF length of stay for some Model 3 SNF-initiated episodes, although this did not reduce total episode payments.

# Results- Model 4

- Model 4 was the option with the lowest number of participants and 10 out of 20 episode initiators opted out of BPCI by the end of the study period.
- Orthopedic surgery and cardiovascular surgery clinical episode groups accounted for 81% of all Model 4 episodes. **For the orthopedic surgery clinical episode group, there were no statistically significant relative changes in Medicare standardized allowed payments, quality, or utilization.** Post-bundle payments and utilization increased and certain functional outcomes declined for the cardiovascular surgery clinical episode group relative to the comparison.



# Highlight critical success factors in bundled payment initiatives

# General - Impact of BPCI

- While we did not detect statistically significant changes in Medicare standardized allowed payments or quality between BPCI and comparison group episodes from the baseline to the intervention period for most clinical episodes groups, total standardized payments declined for clinical groups that constitute most of BPCI episodes.
- In this section, we highlight the key findings for the three clinical episode groups where we observed a statistically significant (at the 5% level) change in total payments.

# Orthopedic

- **Orthopedic surgery:** During the first year of BPCI, 82 hospitals (75% of Model 2 hospital EIs) participated in at least one orthopedic surgery episode. BPCI-participating hospitals initiated 18,936 orthopedic surgery episodes, of which approximately 90% were for **major joint replacement of the lower extremity**. PGP-initiated episodes were analyzed separately.
- Average Medicare payments for the anchor hospitalization and the 90-day post-discharge period (PDP) were estimated to have declined \$864 (**3%**) more for orthopedic surgery episodes initiated at BPCI hospitals than for orthopedic surgery episodes initiated at comparison hospitals. The larger reduction in Medicare payments for the BPCI population was primarily **due to reduced payments for institutional PAC**.
- The changes in Medicare payments for orthopedic surgery episodes were consistent with differential **changes in utilization** during the 90-day PDP.



# SNFs

- The average SNF length of stay (LOS) among beneficiaries with any SNF use was **1.3 days shorter** during the intervention period than the baseline period for beneficiaries discharged from BPCI-participating hospitals, a statistically significant decline relative to the LOS for those discharged from comparison hospitals, which remained virtually unchanged.
- Additionally, **there was a greater decline in institutional PAC (SNF, IRF, or LTCH) use** for the BPCI population than the comparison population. Among BPCI beneficiaries who received any PAC, the share that had institutional PAC use decreased from 64% to 57% between the baseline and intervention periods. This decline in institutional PAC use was 4.9 percentage points greater than the decline among beneficiaries in the comparison population (63.2% to 61.2%).

# Quality of Care

- Quality of care appeared comparable between orthopedic surgery patients with BPCI episodes and those with episodes at comparison hospitals. There were no statistically significant differences between the populations in hospital readmission rates and emergency department visits within 30 or 90 days of hospital discharge and mortality within 30 days of hospital discharge. Patient assessment measures for PAC users indicate similar improvements in multiple functional outcomes for BPCI and comparison episodes, **with one exception**. Among beneficiaries whose first PAC setting was an HHA, the proportion of BPCI beneficiaries with improvement in upper body dressing **declined** from 94.3% to 93.8%, and increased from 93.9% to 95% among comparison beneficiaries.

# Beneficiary Survey Results

- The beneficiary survey indicated that a greater proportion of BPCI respondents with a MJRLE episode that was initiated in a Model 2–participating hospital improved in two functional measures than comparison respondents. A larger share of the BPCI respondents (65.7%) reported improved ability to walk without resting than the comparison respondents (57.5%). Similarly, 65.4% of the BPCI respondents reported improved ability to walk up and down 12 stairs, compared with 57.9% of the comparison respondents.



# Orthopedic

- The change in orthopedic surgery episode payments among BPCI-participating hospitals from the baseline to the intervention period exhibited wide variation, although total episode payments declined for 89% of the BPCI hospitals. Total per-episode payments for the anchor hospitalization and services through the 90-day PDP for orthopedic surgery episodes declined \$2,137 at the average BPCI-participating hospital.
- **The change in total payments for episode initiators from the baseline to the intervention period ranged from a decline of \$7,867, to an increase of \$4,163.** BPCI hospitals with the greatest declines were likelier to have obtained the hospital 3-day waiver and be located in areas with fewer SNF beds per population. Given the importance of the shift away from institutional PAC to the greater decline in total episode payments for BPCI episodes relative to comparison provider episodes, these provider characteristics may be indicators of the hospitals' focus on controlling institutional PAC.

# Orthopedic

- Approximately 4.5% of all Model 2 orthopedic surgery episodes were initiated by PGPs and these episodes were similar to all Model 2 orthopedic surgery episodes in terms of payment, utilization, and quality of care. PGP-initiated episodes had statistically significant higher total payments for HHA services (\$2,523) in the intervention period than all Model 2 orthopedic surgery episodes (\$1,996) because more of the PGP-initiated episodes had HHA as the first PAC setting post-hospital discharge. Hospital readmission rates and emergency department visits within 90 days of the anchor hospitalization discharge and mortality within 30 days of the anchor hospitalization discharge were not statistically different between PGP and all Model 2 orthopedic surgery episodes.

# Cardiovascular surgery

- There was no statistically significant difference in the change in Medicare payments for the index hospitalization and the 90-day PDP between the BPCI and the comparison episodes. For a subset of episodes, however, there was a statistically significant difference between BPCI and comparison episode payments. For 30-day cardiovascular surgery episodes with PAC use, total payments for the episode was estimated to have declined \$4,149 more for BPCI episodes than for episodes initiated at comparison providers.



# The challenges and opportunities

# Model 2 Impact of BPCI:

- Institutional PAC use declined more in the BPCI episodes than in the episodes initiated by comparison providers. Among beneficiaries with a cardiovascular surgery episode who received any PAC, the share discharged to institutional PAC decreased from 55.1% to 44.2% in the BPCI episodes, which was statistically different from the 47.2% to 46.2% decline in episodes of comparison providers. For home health users, there was a statistically significant increase (1.5 visits) in the number of home health visits in BPCI episodes relative to those in comparison episodes.

# Model 2 Results

- “There were no statistically significant changes in hospital readmissions within the 30-day or 90-day post-discharge periods, or any of the assessment-based quality measures between the BPCI and comparison populations.
- ***Although emergency department use increased more for the BPCI than the comparison population during the 30-day post discharge period, there was no difference in the change during the 90-day period.”—What??***

# Model 2 Results

- ***There was, however, a statistically significant increase in mortality for beneficiaries with cardiovascular surgery episodes in BPCI-participating hospitals relative to comparison hospitals.*** This result was due to an increase in the mortality rate during the **30-days post-discharge** (1.6% to 1.9%) for beneficiaries in BPCI episodes at the same time that there was a decline in the mortality rate for beneficiaries with episodes in comparison hospitals (2.1% to 1.4%).—  
**What??**
- Because limited sample size did not allow us to match comparison and BPCI hospitals on baseline mortality rates, this outcome may be due to underlying provider differences not related to the initiative. (More recent results that incorporate an additional nine months of data did not indicate any statistically significant change in mortality.)

# Model 2- Spinal surgery

- During the first year of BPCI, 20 hospitals (18% of Model 2 hospital EIs) participated in at least one spinal surgery clinical episode and initiated 966 spinal surgery episodes.
- Average Medicare payments for the index hospitalization and the 90-day PDP were estimated to have increased \$3,477 more for spinal surgery episodes initiated at BPCI hospitals than for spinal surgery episodes in the comparison group.
- **Payments for the anchor stay increased for the BPCI episodes**, but there was no statistically significant difference in the change in Part A payments by setting or Part B payments by service relative to comparison episodes, with one exception.
- Part B payments for imaging and lab increased \$53 more in BPCI episodes than in comparison episodes.



# Model 2- Mortality

- Mortality rates within 30 days post discharge for beneficiaries with spinal surgery episodes at BPCI hospitals declined from the baseline to the intervention period. This change in mortality for BPCI episodes was statistically significantly different from the experience for comparison episodes. Again, however, this result should be viewed with caution because of differences in baseline mortality rates between comparison and BPCI-participating providers. (More recent results that incorporate an additional nine months of data did not indicate any statistically significant change in mortality.) There were no statistically significant changes in hospital readmissions, emergency department use, or any of the assessment-based quality measures.

# Model 3 - Impact of BPCI:

- For most clinical episode groups, there were no statistically significant differences between BPCI and comparison Model 3 episodes from the baseline to the intervention period in total Medicare standardized allowed payments during the qualifying inpatient stay and 90-day PDP or quality measures.
- There were, however, statistically significant declines in the SNF payments.
- There were no statistically significant differences in payment for HHA-initiated episodes, with the exception of a statistically significant decrease in the total amount of payments included in the pre-bundle period for non-surgical episodes.

# Model 3 - Impact

- Standardized payments for **SNF services declined** in Model 3 SNF-initiated episodes, relative to the comparison group across all clinical episode groups, except non-surgical respiratory. Changes in utilization were consistent with the decline in SNF payments.
- For all clinical episode groups, except non-surgical respiratory, the greater decline in the number of SNF days for episodes initiated by BPCI-participating SNF EIs was statistically significant relative to SNF days for episodes initiated in non-participating SNFs.

# Model 3 - Quality

- For Model 3 SNF EIs, quality outcomes were similar to those in the comparison group, with a few exceptions. For non-surgical cardiovascular clinical episodes, **there was a statistically significant increase in the unplanned readmission rate during the first 30 days of the episode**, equal to 7.0 percentage points, relative to the comparison group.
- Also, according to patient assessment data, there was a **statistically significant decline of 13.9 percentage points in the share of beneficiaries with improvement in self-care function** among those with orthopedic surgery episodes, relative to beneficiaries in comparison episodes.

# Describe how to use bundled payments in redesign

# Model 2 - Approach

- Awardees took different approaches with respect to how they related to their EIs.
- Some provided resources and guidance to their EIs. Others assumed full responsibility for care redesign, data analysis, and patient management. Facilitator Conveners (FCs), which do not bear risk under BPCI, typically served administrative and technical assistance functions on behalf of Awardees, although some indicated that they made recommendations about episode and waiver selection based on data analysis. According to FCs that we interviewed, their participation in BPCI was primarily motivated by a desire to increase their expertise with alternative payment models, with some citing an aversion to financial risk as the reason for joining as an FC rather than as an Awardee.

# Model 2 - Waiver Use

- Under BPCI, Awardees can request several waivers of Medicare requirements and certain requirements associated with furnishing telehealth and home visit services were waived for all participants. Based on an analysis of data that we received from Awardees, 43% of EIs had approval to provide beneficiary incentives during the third quarter of 2014, although only 6% actually exercised this option. The gainsharing waiver, which allows Awardees to share NPRA or other internal cost savings (ICS) or both with partnering providers, was requested by 80% of Awardees.
- We do not have data on how many actually shared any savings with providers; this data will be available in future evaluations. Although 63% of EIs had approval to use the 3-day hospital waiver, which allows Medicare coverage of a SNF stay for beneficiaries following a hospitalization of less than 3 days, only 26% of EIs used it. While Awardees supported the ability to waive the 3-day stay requirement, they were concerned about using it because of difficulties in accurately identifying beneficiaries in BPCI episodes. No Model 2 participants used the telehealth or home visit waivers during the first year of the initiative.

# Model 2 - Industry Experience

- We discerned few distinctions across participants with regard to changes they were making to respond to BPCI. According to IPs, the majority of Model 2 EIs reported that they were implementing interventions related to patient engagement, risk management, care coordination, redesign of care pathways, and enhancements in care delivery. Several participants highlighted patient education efforts in site visit interviews, which they indicated were essential to their care redesign, and many reported that they focused on reducing PAC costs.
- **Among the BPCI challenges participants identified were managing patient expectations related to PAC use, increasing care standardization, and accurately identifying patients who were in BPCI episodes.**

# Model 2 - Adding Relationships

- BPCI participants indicated that they had entered into a variety of relationships with other organizations to prepare for and participate in BPCI.
- **Most frequently, participants indicated that they had engaged external consultants to provide data analysis or information technology.**
- **According to site visit interviews, participants tried to collaborate with area providers, particularly PAC providers, in efforts to improve care coordination and gain efficiencies across the entire episode of care. There were few specific examples of successful collaborations and participants we spoke with indicated that it was challenging to establish relationships with other providers.**
- The Awardees indicated that they discussed quality management with the PAC providers likely to receive the Awardees' patients, even if the providers were not contractually involved in BPCI.

# Model 3 - Approach

- Model 3 EIs identified several reasons for participating in BPCI, including opportunities to learn about bundled payments and anticipated payment reform, develop innovative approaches to care, and generate financial gains.
- Most Model 3 EIs indicated that decisions concerning episode selection were made by the organizations' administrative leadership. Organizational expertise, episode volume, and opportunities to learn about care redesign were some of the factors that influenced episode selection.

# Model 3 - Issue Noted

- The most common clinical episode was congestive heart failure (CHF), which was selected by 95% of EIs. Some participants, though, noted challenges with the CHF episode. In interviews with participants that dropped the CHF episode, they explained that **it was particularly difficult to identify BPCI episodes, manage care, and prevent readmissions for CHF patients.**



# Model 3 - Relationships

- Model 3 EIs described forming or augmenting existing relationships with other PAC providers and hospitals, **and engaging third-party administrators and data management contractors**. These relationships were intended to help the EIs identify and track patients, improve care coordination, ensure downstream quality, and analyze performance in the initiative.
- While Model 3 EIs identified numerous benefits to forming strong relationships, they also **noted several challenges, such as difficulties forming relationships with hospitals and physicians affiliated with different provider systems**.

# Model 3 - Waiver

- Waiver use was limited among Model 3 EIs. During the third quarter of 2014, 38.3% of EIs had approval to distribute beneficiary incentives, but only half actually did so. The majority (83%) of EIs had approval to participate in gainsharing. Data on the use of gainsharing are not yet available. No participants used the telehealth or home visit waivers, which were granted to all participants.



# Model 4 - Reason

- For Model 4 EIs, the decision to participate in BPCI was largely driven by the hospitals' administrative leadership, with support from physician leaders. Model 4 participants indicated that they joined BPCI because they wanted to learn about bundled payments, as they anticipated it would be a component of future payment reform. In addition, they had identified opportunities to lower costs.
- We interviewed the Model 4 EIs that left BPCI. **They indicated that they had faced significant challenges using the monthly data files that they received from CMS, which, in turn, delayed their payments to physicians involved in their BPCI episodes. They said this was the key reason they left the initiative.**

# Model 4 - Feedback

- Model 4 participants indicated that they have developed relationships with PAC providers to improve communication and care coordination. Several participants noted, though, that **it is challenging for the hospital to partner with every PAC provider to which patients may be discharged**. Participants indicated that they **cannot track some patients after discharge**, and that those patients are at an **increased risk for readmission**. Even when they are able to track patients, participants report that the data they rely on about readmissions is often delayed or incomplete.
- In addition to efforts to improve coordination, many participants described implementing care redesign, care standardization and patient education initiatives. Some participants noted, however, that they have **encountered resistance to efforts to standardize care from physicians who are reluctant to adopt new care protocols**. All Model 4 participants indicated that reducing readmissions was their primary strategy to reduce costs, though they described a variety of approaches to do so.

# Model 4 - Impact of BPCI:

- **Impact:** For Model 4, we calculated the impact of BPCI on payment and quality for orthopedic surgery and cardiovascular surgery clinical episode groups. These two clinical episode groups comprised 3,021 episodes during the first year of the initiative (81% of all Model 4 episodes).
- **There were no statistically significant differences in the change in Medicare standardized allowed payments between BPCI and comparison group episodes for the anchor hospitalization plus the 90 days post-discharge from the baseline to the intervention period for orthopedic or cardiovascular surgery clinical episodes.** Although there was a statistically significant increase in payments during the first 30 days post-hospital discharge in the cardiovascular surgery clinical episode group, the change in mortality, emergency department visits, and unplanned readmissions between baseline and intervention periods was not statistically different between BPCI and comparison orthopedic surgery or cardiovascular surgery clinical episode groups.

# Model 4 - Quality

- There were also no statistically significant changes from baseline to intervention in assessment-based quality measures for BPCI patients with orthopedic surgery episodes compared with the comparison group.
- Among cardiovascular surgery patients who received their first PAC treatment at a HHA, a smaller percentage of BPCI patients demonstrated improvement in bathing, ambulation, and bed transferring relative to the comparison group. These results were statistically significant at 0.05. While the share of comparison patients that demonstrated improvement in these areas increased from baseline to intervention, the proportion of BPCI patients demonstrating improvement declined.

# Questions?





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