Bundled Payments, BPCI, and CJR: What You Need to Know

The basics of bundled payments

What is a bundled payment?
Bundled payment refers to a single price paid for all services related to a patient's episode of care. An episode refers to any healthcare services provided that are related to a specific event over a defined period of time, such as 90 days from the time a patient is admitted to a hospital for knee replacement.

Using this example, if a health system has entered into a bundled payment arrangement with a payer for knee replacement surgery, then the hospital and outpatient providers who care for the patient are paid a fixed price for the surgery and all related services over the 90-day period.

How does bundled payment work?
In practice, most bundled payment contracts involve a target price that providers in the arrangement must meet during the episode. A target price is a fixed amount providers have agreed to meet for a payer.

By their very nature, target prices imply reward and risk. Participating providers bill the payer for the patient's care on a fee-for-service basis. At the end of the episode, if the total for all claims is under the target price, providers earn a reconciliation payment for the difference. If total claims exceed the target price, the providers may have to repay the difference to the payer.

Why are bundled payment arrangements occurring?
The Affordable Care Act (ACA) set in motion a payment climate based on value, not volume. Bundled payments encourage providers to coordinate care. This approach is intended to align provider and payer incentives, reduce variation in care, improve quality, and control costs.

Are bundled payments appropriate for all patient care?
Experience suggests that some clinical conditions are better suited for bundled payments than others. Conditions with established clinical guidelines and a predictable course of disease, such as acute coronary diseases and hip and knee replacements, are often candidates for bundling.

Is this a new concept?
Medicare has been experimenting with bundled payments for a quarter century. It's only since the passage of the ACA, however, that these programs have proliferated, because the Centers for Medicare and Medicaid Services (CMS) has made bundled payments a staple of its goal to funnel 50% of reimbursement through alternative payment models by 2018.
2 CMS bundled payment programs: The Bundled Payments for Care Improvement (BPCI) initiative and the Comprehensive Care for Joint Replacement (CJR) model

In 2013, CMS launched BPCI, a voluntary program involving more than 1500 hospitals, physician group practices, and other providers. In 2016, CMS implemented CJR, a mandatory bundled payment program for patients who undergo lower-extremity joint replacement.

**BPCI**

Providers who participated in BPCI could choose from 4 reimbursement models. The most popular model involving inpatient care, Model 2, provides a bundled payment for the index hospitalization and all related care for 30, 60, or 90 days from the time of admission. As of July 1, 2016, a total of 350 hospitals and 213 physician group practices were participating in Model 2.

**CJR**

The reimbursement model for CJR is similar to BPCI Model 2, in that the bundled payment includes the index hospitalization and related post-acute care, though in CJR the episode lasts through 90 days after discharge. When CJR was implemented on April 1, 2016, approximately 800 IPPS-paid, acute care hospitals in 67 metropolitan statistical areas were automatically enrolled.

### Similarities and differences

Though BPCI Model 2 and CJR are similar, there are some key differences between them.

<table>
<thead>
<tr>
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<th>BPCI Model 2</th>
<th>CJR</th>
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</thead>
<tbody>
<tr>
<td><strong>Eligible DRGs</strong></td>
<td>48 to choose from; approximately 75% of participants chose LEJR</td>
<td>LEJR (MS-DRGs 469 and 470) only</td>
</tr>
<tr>
<td><strong>Services in the bundle</strong></td>
<td>Defined by participants</td>
<td>Defined by CMS</td>
</tr>
<tr>
<td><strong>Providers in the bundle</strong></td>
<td>Defined by participants from a list of eligible provider types</td>
<td>Hospital is liable for all costs; may share savings or losses through gainsharing</td>
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<tr>
<td><strong>Payment mechanism</strong></td>
<td>Claims reconciled against target price negotiated by participants with CMS</td>
<td>Claims reconciled against target price set by CMS</td>
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<tr>
<td><strong>Quality-of-care requirements</strong></td>
<td>Reimbursement not contingent on meeting quality metrics</td>
<td>CMS sets specific quality-of-care thresholds for reconciliation payments</td>
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DRG=diagnostic-related group, IPPS=Inpatient Prospective Payment System, LEJR=lower-extremity joint replacement.

### References