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New Research Explores Benefits of Participation in Multiple Payment Models

An August 2021 study published in the Journal of the American Medical Association (JAMA) analyzed medical and surgical episodes of care in U.S. hospitals to determine whether outcomes differed in hospitals that participated in Medicare's Bundled Payments for Care Improvement (BPCI) Initiative depending on whether the patient being treated was attributed to a Medicare Shared Savings Program (MSSP) accountable care organization (ACO).[1] This Health Capital Topics article will discuss the study's findings and potential policy implications.

The BPCI is a demonstration program established by the Centers for Medicare & Medicaid Services (CMS) whereby healthcare organizations are compensated with a single payment for both the hospital ancillary and technical component services and the physician professional component services related to a single episode of care (rather than reimbursing each provider on a fee-for-service basis).[2] The goal of BPCI was to "align incentives" among hospitals, physicians, and other providers, as well as achieve "higher quality, more coordinated care at a lower cost to Medicare."[3] There were four (4) models under BPCI, each of which include different types of services to be included in the model's bundled payment. Participation in the model commenced in April 2013 and concluded in 2018.[4]

The MSSP was created by the Patient Protection and Affordable Care Act (ACA) and provides for the creation of ACOs, organized networks of providers who coordinate care in order to lower costs and increase quality to achieve financial incentives established through a contract with CMS. Under the program, which has undergone several iterations over the last decade, shared savings incentive payments are distributed to ACO participants that achieve established quality metrics and expenditure reductions for Medicare beneficiaries. The MSSP commenced in 2012 with the Pioneer ACO Model[5] and was revamped in 2019 to include five participation options (called "tracks") that have generally higher financial risks than the predecessor tracks and models.[6]

As the researchers noted, while BPCI and the MSSP have generally similar goals of improving coordination across the care continuum, the mechanisms for achieving these goals differ, which led the researchers to wonder whether models may "complement each other in ways that could produce additive benefits…[or, c]onversely, because they both encompass the period spanning hospitalization and discharge to post-acute care, [whether] the 2 payment models could lead to duplicative services."[7]

In reviewing data for over 9.8 million Medicare beneficiaries between 2011 and 2016, researchers compared costs and quality across 48 episodes of care (24 medical and 24 surgical) and categorized those episodes depending on whether or not the hospital participated in BPCI, and whether or not the patient was attributed to an MSSP ACO.[8] Additionally, researchers analyzed the data before versus after the start of BPCI in October 2013. The outcomes on which the research focused included 90-day post-discharge institutional spending (i.e., skilled nursing facility [SNF], inpatient rehabilitation facility, long-term acute care, and readmissions spending), as well as readmission rates, 90-day morality rates, discharge to institutional post-acute care and home health, and SNF length of stay.[9] The goal of reviewing this data was to determine whether outcomes in BPCI differed depending on whether patients were attributed to ACOs in the MSSP, i.e., is there benefit to participating in both bundled payment and value-based payment programs simultaneously.

Specific to medical episodes, researchers found that in the non-ACO group, patients in bundled payment programs had differentially lower post-discharge institutional spending than patients not in bundled payment programs.[10] In the ACO group, patients in bundled payment programs had lower 90-day readmissions rates, a higher discharge to home health, and a lower SNF length of stay than patients not in bundled payment programs.[11] Further, patients in both bundled payment programs and ACOs had greater decreases in SNF length of stay and 90-day unplanned readmissions than those patients in BPCI or the MSSP only.[12]

In surgical episodes, the research similarly found that in the non-ACO group, patients in bundled payment programs had differentially lower post-discharge institutional spending than patients not in bundled payment programs.[13] In the ACO group, patients in bundled payment programs also had differentially lower post-discharge institutional spending compared with patients not in bundled payment programs.[14] Patients in bundled payment programs in the ACO and non-ACO groups did not differ with respect to changes in spending.[15]

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In contrast to policymaker concerns that participating in multiple alternative payment models are counterproductive,[16] the study found that "simultaneous inclusion in both ACOs and bundled payment programs was associated with lower institutional postacute care spending and readmissions for medical episodes and lower readmissions but not spending for surgical episodes."[17] The research asserted that the "study results suggest three possible policy implications":

(1) Potential additive benefits when bundled payments and other alternative payment models overlap;

(2) Policymakers may now be motivated to revisit "the existing approach for handing ACO-bundled payment program overlap, as the MSSP currently "effectively penalizes ACOs whose patients receive care from rapidly improving bundled payment participants"; and,

(3) Undertaking further research to "evaluate outcomes when different payment models overlap in patients' care."[18]

This study provides the first evidence related to outcomes when participating in overlapping payment models[19] and indicates that, contrary to policymakers' beliefs, participating in multiple value-based and bundled payment initiatives may have additive benefits for patients, providers, and payors (i.e., Medicare) alike. It is the researchers' hope (and likely the hope of healthcare industry stakeholders) that these findings will translate to CMS initiating additional payment program participation options.

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1 "Association of Patient Outcomes With Bundled Payments Among Hospitalized Patients Attributed to Accountable Care Organizations" By Amol S. Navanth, MD, PhD et al., JAMA Health Forum, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2752104 (Accessed 9/19/21).

2 "Bundled Payments for Care Improvement (BPCI) Initiative: General Information" Centers for Medicare & Medicaid Services, 6/29/2021, https://innovation.cms.gov/innovation-models/bundled-payments (Accessed 9/20/21).

3 *Ibid.*

4 CMS subsequently launched the BPCI Advanced model, "a new iteration o…continuing efforts in implementing voluntary episode payment models." "Bundled Payments for Care Improvement (BPCI) Initiative: General Information" Centers for Medicare & Medicaid Services, 6/29/2021, https://innovation.cms.gov/innovation-models/bundled-payments (Accessed 9/20/21); "BPCI Advanced" Centers for Medicare & Medicaid Services, 9/16/2021, https://innovation.cms.gov/innovation-models/bpci-advanced (Accessed 9/22/21).

5 "Pioneer ACO Model" Centers for Medicare & Medicaid Services, 5/4/2021, https://innovation.cms.gov/innovation-models/pioneer-aco-model (Accessed 9/20/21).

6 "Shared Savings Program Participation Options for Performance Year 2022" Centers for Medicare & Medicaid Services, April 2021, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf (Accessed 9/20/21).

7 Navanth, MD, PhD et al., JAMA Health Forum, (Accessed 9/19/21), p. 2-3.

8 *Ibid*.

9 *Ibid*, p. 3.

10 *Ibid*, p. 5-6.

11 *Ibid*.

12 *Ibid*.

13 *Ibid*, p. 6-9.

14 *Ibid*.

15 *Ibid*, p. 7.

16 For example, CMS previously cited "model overlap issues that impact providers already participating in [alternative payment models]" in canceling the Episode Payment Model for cardiac conditions. "Medicare program; cancellation of advancing care coordination through episode payment and cardiac rehabilitation incentive payment models; changes to comprehensive care for joint replacement payment model: extreme and uncontrollable circumstances policy for the comprehensive care for joint replacement payment model." Federal Register, Vol. 82, No. 230 (December 1, 2017). p. 57069.

17 Navanth, MD, PhD et al., JAMA Health Forum, (Accessed 9/19/21).

18 *Ibid*, p. 9-10.

19 *Ibid*.

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