

Do Bundled Payments Have a Future in Medicare?

In an [op-ed](#) written for the Wall Street Journal on September 19, 2017, Seema Verma, the new administrator for the Centers for Medicare & Medicaid Services (CMS), announced a “new direction” initiative for the Center for Medicare and Medicaid Innovation (CMMI).^[1] The Affordable Care Act (ACA) created the CMMI to design and evaluate new payment models designed to either lower spending without reducing the quality of care, or improve the quality of care without increasing spending.^[2] The CMMI [established payment initiatives](#) that used Medicare to test and implement payment reforms that focused on rewarding value rather than traditional fee-for-service billing. Bundled payments are one of many payment reforms that require providers to accept some responsibility for providing care that meets both quality and cost goals.^[3]

In her op-ed, Administrator Verma says that the new direction initiative includes reassessing the value of payment initiatives and that CMS is “analyzing all Innovation Center models to determine what is working and should continue, and what isn’t and shouldn’t.”^[4] Administrator Verma’s op-ed and CMS’s new direction initiative came less than a month after CMS and the Trump Administration issued a [proposed rule](#) to cancel four, new bundled payment programs and to make a fifth program voluntary. On Friday, December 1, 2017, CMS issued a final rule cancelling the four new programs and making the [Comprehensive Care for Joint Replacement](#) (CJR) program voluntary in almost half of the markets where it was voluntary (33 of the 67 markets). This blog examines what these announcements mean for the future of payment reforms in Medicare, Medicare beneficiaries, and the American public, as a whole.

The Potential and Risks of Using Bundled Payments

The U.S. healthcare system has historically reimbursed health care providers for each service they provide. This traditional fee-for-service model incentivizes providers to order more treatments because payment depends on the *quantity* of care. CMS and many other payers, however, recognize the need to emphasize the *quality* of care and have begun implementing and testing alternative payment models, including shared savings, shared risk, bundled payments, and population-based payments, that reward doctors and hospitals for providing high-quality care at lower costs.[\[5\]](#)

[Bundled payments](#) are a single reimbursement for a course of treatment that typically includes all inpatient and outpatient care, and all physician fees. They give providers financial incentives to reduce waste and provide more efficient care. Streamlining the efficiency of healthcare delivery and removing unnecessary care will reduce costs, but implementing these payment reforms requires careful consideration of the payment incentives to prevent unintended consequences.[\[6\]](#) For example, setting reimbursement rates too low or choosing improper quality metrics could lead providers to avoid expensive, but necessary care. As a government payer responsible to Congress, Medicare provides an ideal platform for testing implementation of these value-based initiatives. Medicare can and should play a central role in assessing these programs and piloting payment reform programs to ensure that they deliver more cost-effective care, as well as access to expensive, but necessary, treatments.

How Medicare Uses Bundled Payments to Reduce Costs

Medicare has multiple bundled payment programs that target specific clinical conditions. In Medicare's CJR model, for example, the hospital, surgeon, anesthesiologist, home health providers, and skilled nursing facilities share one bundled payment from CMS, to inspire collaborative and efficient patient care. If providers provide care for less than the bundled payment amount by identifying and eliminating

unnecessary care, they retain any remaining cost-savings. In addition, bundled payments incentivize hospitals to improve care, because the hospital must cover the cost of any complications, readmissions, or medical errors. As a result, patients benefit from both fewer complications and better coordinated care.

CMS has created many bundled [episode-based payment initiatives](#), including the [Bundled Payment for Care Improvement](#) (BPCI) Models, the [Oncology Care](#) model, and the [Comprehensive Care for Joint Replacement](#) (CJR) model. Four additional models, the [Acute Myocardial Infarction](#) (AMI) model, [the Coronary Artery Bypass Graft](#) (CABG) model, the [Surgical Hip and Femur Fracture Treatment](#) (SHFFT) model, and a [Cardiac Rehabilitation model](#) (CR) were scheduled to begin on Jan. 1, 2018, but were cancelled by the CMA in a [final rule](#) on December 1, 2017.[\[7\]](#)

Do Bundled Payments Improve Quality and Lower Costs?

The CJR model requires hospitals, physicians, and post-acute care providers to accept one bundled payment for the care received during hip and knee replacements, from initial hospitalization through recovery.[\[8\]](#) Participation was mandatory for providers in 67 geographical markets across the country, but hospitals in other geographic regions could join the program voluntarily. The CJR program initially faced reluctance where it was mandatory, but now many [providers support it](#) and believe it has helped uncover inefficiencies in how they serve joint replacement patients, particularly in the unnecessary use of skilled-nursing facilities and home health care after surgery.[\[9\]](#) Similarly, a [report](#) commissioned by CMS and released in October 2017 found that the voluntary [BPCI program](#), which bundles inpatient and outpatient care for more than 40 acute care conditions, saved approximately 4% on costs and that the length of stay in skilled nursing facilities declined. The authors of the report, however, acknowledged that “there is a consistent pattern of participants entering

into clinical episodes in which they had higher than average baseline payments, which may indicate that they had the most inefficient patterns of care that would be easier to change.”[\[10\]](#) The authors cautioned against generalizing the results of the voluntary BPCI program to all bundled payments and suggested that CMMI needs further studies to determine how and when bundled payments save money without compromising patient care.[\[11\]](#)

If Bundled Payments Have So Much Potential, Why Were the Programs Cancelled?

The Trump administration cited the concern that mandatory programs make providers more resistant to implementing future programs. This concern resonates with Administrator Verma’s op-ed that states that providers should have more flexibility in designing new methods of delivering care. The changes to the bundled payment programs seem to be another step in the Trump administration’s march toward deregulating health care, including allowing states more flexibility in Medicaid waivers[\[12\]](#) and in defining essential health benefits for insurance plans.[\[13\]](#) While this flexibility can be a positive change, it can also loosen protections for patients. In the case of bundled payments, removing the mandatory requirement in most markets for the CJR model allows hospitals to choose to participate only when they believe it will be financially beneficial, i.e. when they can get higher reimbursements from Medicare.

Why Bundled Payment Programs Should Not Have Been Cancelled

While many hospitals were initially reluctant to implement the CJR programs because they feared lower reimbursements, many are now supportive of the program, and physicians even report being surprised to find inefficiencies in how they deliver care. In an interview, Jon Fohrer, network vice president for orthopedics and neuroscience at Community Health Network in Indianapolis, reported that “[i]t was so eye-opening to go

through and find all the inefficiencies and to see how we have moved the bar from both a clinical and financial perspective in a way I would never have imagined.”[\[14\]](#) CMS estimates that Medicare will lose \$106 million in savings over the next three years just from the decrease in the number of markets in which the CJR model is mandatory.[\[15\]](#) The amount of money that could be saved from the four proposed programs remains unknown. Now that the programs are officially cancelled, not only will Medicare fail to realize savings from the program, but private insurers will also lose the opportunity to draw on Medicare’s experience in designing their own bundled payment programs as they seek to shift to value-based reimbursement.

The Acceleration of Payment Reform Models: Medicare Will Miss Out

The use of alternative payment models is accelerating. The Department of Health and Human Services (HHS) [set a target of shifting 30%](#) of Medicare fee-for-service payments to alternative payment models by 2016, and 50% by 2018. A [study](#), released in October 2017 by the Health Care Payment Learning and Action Network, found that 29% of health care payments (including Medicare, Medicaid, and private insurers) used alternative payment models in 2016, a substantial increase from 2015.[\[16\]](#) The rate of increase in alternative payment models among private and public payers reflects the eagerness of private payers to follow Medicare’s lead and implement these payment reforms.[\[17\]](#) In its commentary in the final rule, CMS says that “[d]elivery system reform and movement toward value-based payment remain CMS priorities|we believe offering more opportunities for providers to engage in such activities on a voluntary basis will allow us to continue to pursue our goals.”[\[18\]](#) CMS Administrator Seema Verma said “We anticipate announcing new voluntary payment bundles soon.”[\[19\]](#)

The Obama Administration used a combination of voluntary and mandatory changes to transform how medical care is paid for and delivered. Under the Trump Administration, CMS appears

reluctant to push doctors into payment arrangements that could lower their reimbursements.^[20] Michael Leavitt, Health and Human Services Secretary under President George W. Bush, told Bloomberg Law that successful value-based payment systems should be made mandatory. “If we fail to apply the pressure required to motivate change, the opportunity to avert the growing economic crisis that health-care costs present will be missed.”^[21] CMS should use voluntary programs to prototype payment reform initiatives and use what they learn from those programs to implement mandatory changes in how providers are reimbursed by Medicare. CMS is moving in the wrong direction by cancelling voluntary programs and scaling back mandatory programs intended to test how to bundle payments to save costs while maintaining or improving patient care without replacing them with other models.

^[1] Heather Landi. **“In Op-Ed, CMS Signals “New Direction” for Innovation Center, Issues Request for Information.”** September 20, 2017. Available at: <https://www.healthcare-informatics.com/news-item/value-based-care/op-ed-cms-signals-new-direction-innovation-center-issues-rfi>

^[2] **About the CMS Innovation Center.** CMS. Updated June 23, 2017. <https://innovation.cms.gov/About>.

^[3] Melinda K. Abrams, Rachel Nuzum, Mark A. Zezza, Jamie Ryan, Jordan Kiszla, and Stuart Guterman. **“The Affordable Care Act’s Payment and Delivery System Reforms: A Progress Report at Five Years.”** *The Commonwealth Fund*. Published May 7, 2015. Available at: <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years>.

^[4] *Ibid.*

[5] Jordan M. VanLare, and Patrick H. Conway **“Value-Based Purchasing – National Programs to Move from Volume to Value.”** *NEJM* 367, no. 4 (2012): 292-295

[6] Michael Ciarametaro and Robert Dubois **“Designing Successful Bundled Payment Initiatives”** *Health Affairs Blog*, April 20, 2016. <http://www.healthaffairs.org/doi/10.1377/hblog20160420.054542/full/>.

[7] In the Final Rule, CMS refers to the AMI, CABG, and SHFFT models as Episode Payment Models (EPM). Some media reports say that CMS has cancelled two bundled payment programs the EPM and CR models. In this post, we refer to four models because we disaggregated the three voluntary programs (AMI, CABG, and SHFFT).

[8] **Comprehensive Care for Joint Replacement Model.** CMS. <https://innovation.cms.gov/initiatives/cjr>.

[9] Harris Meyer, **“Hospitals warm up to CMS bundled payments as agency cools off on them”** *Modern Healthcare*. October 26, 2017. Available at: <http://www.modernhealthcare.com/article/20171026/NEWS/171029904/hospitals-warm-up-to-cms-bundled-payments-as-agency-cools-off-on-them>.

[10] The Lewin Group, **“CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report”** October 2017. Available at: <https://downloads.cms.gov/files/cmimi/bpci-models2-4yr3evalrpt.pdf>.

[11] Virgil Dickson. **“Value of CMS’ voluntary bundled-payment program remains unclear.”** *Modern Healthcare*. October 31, 2017. Available at: http://www.modernhealthcare.com/article/20171031/NEWS/171039975?utm_source=modernhealthcare&utm_medium=email&utm_content=20171031-NEWS-171039975&utm_campaign=am

[12] Adam Cancryn. **"How the Trump administration is reshaping health care – without Congress."** *Politico*. September 13, 2017. Available at: <https://www.politico.com/story/2017/09/13/trump-obama-health-care-legacy-242683>.

[13] Kathryn Watson. **"Trump administration proposes rule to give states flexibility on "essential" health benefits."** *CBS News*. October 28, 2017. Available at: <https://www.cbsnews.com/news/trump-administration-proposes-rule-to-let-states-decide-essential-health-benefits/>.

[14] Meyer (2017).

[15] Virgil Dickson. **"CMS Makes it official: Two mandatory bundled-pay models canceled."** *Modern Healthcare*. November 30, 2017. Available at: http://www.modernhealthcare.com/article/20171130/NEWS/171139986?utm_source=modernhealthcare&utm_medium=email&utm_content=20171130-NEWS-171139986&utm_campaign=am

[16] Health Care Payment Learning & Action Network. **"Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs."** October 30, 2017. Available at: <https://hcp-lan.org/groups/apm-fpt-work-products/apm-report/>.

[17] Vera Gruessner. **"Private Payers Follow CMS Lead, Adopt Value-Based Care Payment."** *Health Payer Intelligence*. October 17, 2016. Available at: <https://healthpayerintelligence.com/news/private-payers-follow-cms-lead-adopt-value-based-care-payment>

[18] <https://www.federalregister.gov/d/2017-25979/page-57075>, 82 FR 57075.

[19] Ilene MacDonald. **"CMS puts an end to mandatory cardiac, hip fracture bundled payment models."** *Fierce Healthcare*. November 30, 2017. Available at:

https://www.fiercehealthcare.com/finance/cms-puts-end-to-mandatory-cardiac-hip-fracture-bundled-payment-models?mkt_tok=eyJpIjoiTVRBelpHUmp0R015WXpkaiIsInQiOiIxZdzVCalZ5dmx2Mit2NWZVNDV0R3V5b2FjTHh2ZDIrQVY3THVK0TJ6YnFQWkxPZEltazB0dFM3N2J0K1p0XC91eGZBNVpDNjIyYkhrWFFxOTViXC90T1JBTFYzekRINmR2R2FRRWhQc3RVXC9UM05DeUFMdWZrTjE1ZFA4NURIEXR6RSJ9&mrkid=55782816&utm_medium=nl&utm_source=internal.

[20] Drew Armstrong. **“Trump Health Nominee Embraces Obamacare Programs the Last Guy Ended.”** *Bloomberg News*. November 30, 2017. Available at: <https://www.bloomberg.com/news/articles/2017-11-30/trump-health-pick-embraces-obamacare-programs-predecessor-ended>.

[21] Mike Stankiewicz. **“Hospital Industry Rallies Behind Future Bundled Payments.”** *Bloomberg BNA*. November 27, 2017. Available at: https://www.bloomberglaw.com/product/blaw/exp_blp/ewogICAgImN0eHQiOiAiRE9DIiwKICAgICJpZCI6ICJYNFNEU0gwODAwMDAwMD9yZXNvdXJjZV9pZD000GE40Dc3NDZiMzIxNWNiZGI3MjhmMTU3ZDA4YmQzMStSc0AgICAic2lnIjogIlwveXBrdFV2RThETFhrR25aWlhIb3pla3dzYk09IiwKICAgICJ0aWllIjogIjE1MTE1ODE1MTEiLAogICAgInVlaWQiOiAiWmNXdHJlb3BucTZVbVh0OUVoVjR0dz09diswTHN4MFC0WDJHK2R5MmlpRHBtZz09IiwKICAgICJ2IjogIjEiCn0K?emc=BLAW:153710137:0