VIEWPOINT

Medicare's New Bundled Payments
Design, Strategy, and Evolution

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The Centers for Medicare & Medicaid Services (CMS) is increasingly paying for health care through alternative payment models (APMs) that reward value and quality. Currently, more than 20% of Medicare fee-for-service payments flow through APMs, putting the Administration's goals of 30% by 2016 and 50% by 2018 within reach.[1] These APMs include accountable care organizations (ACOs), bundled payments, and advanced primary care medical homes. In this Viewpoint, we discuss the role of bundled payments.

Bundled, or episode-based, payments link otherwise unconnected payments for individual clinical services provided by clinicians, facilities, and other health care entities during an episode of care. When these services are paid for separately, there may be an incentive to increase the volume of each service irrespective of its cost or effect on outcomes. However, when payments for these services are linked in a bundled payment, this incentive is reduced and an opportunity is created to reward clinicians and organizations for care that is efficient, coordinated, and of high quality.

Even though CMS has been bundling payments to some clinicians and organizations for decades (eg, inpatient prospective payment system and global payment to surgeons), CMS is now implementing bundled payments that encompass longer episodes of care, more clinical services, and multiple clinicians and health care organizations.[2] The CMS Innovation Center—which designs and tests new payment and care delivery models—has launched 3 bundled payment models: Bundled Payments for Care Improvement (BPCI), the Comprehensive Care for Joint Replacement (CJR) Model, and the Oncology Care Model (OCM). Although these models differ in terms of the components of the bundled payment (**Table**), their shared core principle is that a single organization is accountable for most of the care a patient receives during the episode.

BPCI tests 4 variations of bundled payment to develop proof of concept that broadly defined bundles are an effective payment strategy to improve quality and reduce costs of care. As of October 2015, there were 1551 health care organizations participating in BPCI, including hospitals, skilled nursing and inpatient rehabilitation facilities, home health agencies, and physician group practices. Each organization (some partner with a third-party organization that assumes financial accountability) participating in what is referred to as BPCI "models 2, 3, or 4" had an opportunity to choose episodes of care triggered by a hospitalization for 1 or more of 48 different medical and surgical conditions (the most common choice includes hip and knee replacement). Participants also had a choice for the duration of the episode (hospitalization and related readmissions only vs hospitalization and postacute period for up to 90 days vs postacute period for up to 90 days only). In the models involving the postacute period, the awardee (ie, the organization that assumes financial accountability) is eligible for additional payment if aggregate Medicare spending for related care during the episode is below a target price, or may have to repay CMS a portion of Medicare expenditures if spending is above a target price. Preliminary evidence from the earliest participants in the model encompassing the hospitalization and postacute period suggests that more costly institutional postacute care was substituted with less costly home health care and that hospital length of stay and 30-day readmission rates decreased.[3]

The other new CMS bundled payment models, CJR and OCM, build on lessons learned from the early experience of BPCI with several novel aspects. In CJR, scheduled to start April 1, 2016, episodes of care begin with a Medicare fee-for-service beneficiary's hospitalization for hip or knee replacement (or other major lower extremity procedure in the same MS-DRGs [Medicare Severity Diagnosis Related Groups]) and end 90 days after discharge. Most inpatient prospective payment system hospitals in 67 metropolitan areas are required to participate and will be accountable for the cost and quality of related care during the episode. In OCM, which is anticipated to start mid-2016, episodes begin when a patient receives chemotherapy for cancer, last 6 months, and include almost all care provided during that time. Participant physician practices can receive monthly care management payments throughout the episode and are eligible for an additional payment based on cost and quality performance. OCM is the first of the new bundled payment models designed for physician practices and the first to have other payers join CMS by offering a similar payment model, thereby aligning incentives for practices and facilitating improvements in care.[4]

Several principles guide the design and implementation of the new CMS bundled payment models. The first is that related care during an episode is broadly defined to encourage clinicians and health care organizations to be accountable for the full spectrum of services a patient receives. Collaboration across clinicians and care settings is therefore essential to success. To facilitate that collaboration, the Department of Health and Human Services (HHS) has waived certain Medicare payment rules and certain fraud and abuse laws for the CJR and BPCI models.[5]

The second principle is that successful tests of bundled payment models could be expanded without displacing other APMs. Bundled payments for discrete episodes of care triggered by a hospitalization or treatment of a serious illness could be layered on top of other APMs—such as ACOs or advanced primary care medical homes—in which clinicians and health care organizations have accountability for the care of a population over a longer period. Designing the interaction between different

Table. New Bundled Payment Models Launched by the Centers for Medicare & Medicaid Services

	Bundled Payments for Care Improvement Models 2, 3, and 4 (BPCI)	Comprehensive Care for Joint Replacement (CJR)	Oncology Care Model (OCM)
Participant health care organizations	Physician group practices, hospitals, postacute care facilities, home health agencies (voluntary)	Most inpatient prospective payment system hospitals in 67 Metropolitan Statistical Areas (mandatory)	Solo practitioner and physician group practices (voluntary)
Episode definition	Choice among 48 conditions, defined by a specific hospitalization beginning or preceding the episode	Lower extremity joint replacement, defined by a specific inpatient hospitalization	Chemotherapy administration for treatment of cancer
Duration of episode	Choice between hospitalization and related readmissions, postacute period (30, 60, or 90 d), or hospitalization + postacute period (30, 60, or 90 d)	Hospitalization plus 90 d after discharge	6 mo after start of chemotherapy
Payments included in episode	All Part A and Part B payments for clinically related items and services (models 2 and 3)	All Part A and Part B payments for clinically related items and services	All Part A and Part B payments and some Part D payments
Financial performance risk	20% of target price, upside and downside (after CMS discount)	In Year 1, 0% downside and 5% upside; year 2, 5% upside and downside; year 3, 10% upside and downside; years 4-5, 20% upside and downside (after CMS discount)	Upside only for first 2 y, then option to elect downside thereafter
Payment mechanism	Prospective for hospitalization and related readmissions, retrospective for postacute period only and hospitalization plus postacute period	Retrospective	Retrospective
Quality measures	Awardees may make incentive payments only to entities and individuals that meet quality performance targets determined by the awardee; evaluation examines cost and quality and functional improvement	Aggregate performance on complications and patient experience measures and reporting of data to help develop a patient-reported function outcome measure affect payment; evaluation of cost and quality and functional improvement	Payment and monitoring measures align with the CMS Quality Domains and include cancer-specific measures; evaluation of cost and quality

APMs is complex and may require a few iterations, but it can be done in a way that is synergistic, benefiting clinicians, CMS, and patients.

Likewise, multiple bundled payment models can coexist. For example, if a patient undergoes hip replacement by a surgeon in a physician group practice participating in BPCI, but at a hospital participating in CJR, accountability for the episode lies with the physician group practice. Participation in some models, like BPCI, could remain voluntary, whereas other models may apply to all practitioners and organizations in a geographic area, like CJR. Ultimately, if both models were successful and expanded, all lower extremity joint replacements could be in a bundled payment arrangement.

The third principle is that CMS will continue to refine the technical aspects of bundled payment models. For example, CMS will continue to support the development of meaningful quality measures that reward clinicians for outcomes that matter to patients. Furthermore, given the incentives to reduce costs in bundled payments, there is the potential for unintended consequences, such as shifting care outside the episode, stinting in care, or increasing the number of episodes. CMS monitors for these effects, but the quality measurement strategy must also evolve to incorporate shared decision making, patient-reported outcomes, and clinical appropriateness.

Another technical aspect that will likely evolve is pricing, including risk adjustment. Bundled payments effectively reprice groups of services by linking payments for individual services and creating a single episode price. These prices can be adjusted for factors that are predictive of episode spending to pay clinicians and organizations appropriately and to ensure access to care for all beneficiaries. In the CJR model, CMS will set separate target prices based on the MS-DRG of the initial hospitalization and will further risk-stratify prices for hip replacements resulting from a hip fracture. In addition, CJR changes over time from setting prices based on a blend of hospitals' historical spending and regional spending to fully regional pricing to incentivize continued improvements in efficiency.

Bundled payments could be paid prospectively as a single payment, rather than through the retrospective method used in most current bundled payment models. CMS is testing prospective payment in the BPCI model that includes only an inpatient hospitalization and related readmissions. However, there are several obstacles to prospective payment, including the heterogeneous composition of clinicians and organizations involved in an episode of care (each with a different payment system based in statute and a different level of readiness and infrastructure to pay other clinicians) and Medicare beneficiaries' freedom of choice to see any of those clinicians.

Like all APMs being tested by CMS, these new bundled payment models are undergoing rigorous, independent evaluation.[6] If one or more of the models meets the statutory criteria for expansion (neutral quality and lower cost; higher quality and neutral cost; or, preferably, higher quality and lower cost), the secretary of HHS could expand the model through rulemaking. Guided by the principles discussed in this Viewpoint, broad bundled payments for episodes of care could function alongside other APMs and help achieve the aims of better care, smarter spending, and healthier people.

ARTICLE INFORMATION

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