The implementation of the Affordable Care Act (ACA) introduced significant changes to the healthcare landscape that have affected patients, providers, and payers. Among other things, the ACA has accelerated the shift from fee-for-service care to value-based care across the country. Although there is debate regarding the ACA’s success and the need for modifications, the majority of people would agree that the ACA has helped jumpstart conversations about innovation, quality, and demonstrating value in healthcare. In 2015, the Centers for Medicare & Medicaid Services (CMS) announced its intent to transform 50% of Medicare payments to alternative payment models (APMs) by the end of 2018. APMs are reimbursement models based on value; they were introduced to help reduce Medicare spending, reduce readmissions, and increase care quality while simultaneously creating more coordination across the acute and postacute care continuum.

The new focus on value-based care and APMs has spurred activity in bundled payments models. The concept of bundled payments is not new. Bundled payment models were first proposed in the early 1980s, with the inception of diagnosis-related groups (DRGs) for acute inpatient events. Recently, bundled payment programs have received attention as an alternative to traditional reimbursement models, and these models have extended their purview to manage an entire episode of care.

A bundled payment is a single payment for the care associated with a specific condition or procedure for a predefined period of time. These bundled payment programs focus on a patient’s entire episode of care. Episode-based bundled payments programs take aim at siloed fee-for-service arrangements by encouraging coordination of services across the entire continuum of care.

Having reliable health analytic data is key to allow physicians, clinical leaders, and hospital executives to make accurate decisions with bundled payments and other value-based healthcare decisions. Organizations can no longer remain in silos; they must work together to coordinate care across the healthcare continuum.

The Center for Medicare and Medicaid Innovation (CMMI) paved the way for episode-based bundled payment programs in Medicare. CMMI was created to test healthcare payment and service delivery models aimed at reducing cost, increasing efficiencies, and improving quality in healthcare. In 2011, CMMI unveiled the Bundled Payments for Care Improvement (BPCI) initiative. BPCI is a voluntary program that tests 4 different payment models across 48 clinical bundles. The Bundled Payments: Value-Based Care Implications for Providers, Payers, and Patients

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By design, bundled payment programs extend beyond inpatient acute care to include postacute care services. Bundled payment programs affect postacute care providers, including skilled nursing facilities, home healthcare, rehabilitation hospitals, and long-term acute care.

Hospitals began to be held accountable for managing episode-based Medicare spending across the continuum of care several years ago, with the implementation of the Medicare spending per beneficiary measure in the CMS value-based purchasing program. Medicare spending per beneficiary measures the spending on an episode of care across all providers from 3 days before hospital admission through 30 days after admission. Although drugs are not a large part of the cost, and Medicare Part D is not included in the current CMS bundled care programs, future bundles may focus on drug cost in some bundles of care, such as oncology.

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bundle models include episode payment for services that range from acute care hospital-only episodes to episodes that include all acute, postacute, and physician’s care services for 30, 60, or 90 days after discharge. In April 2016, CMS reported that more than 1500 entities were participating in the BPCI program, including 385 acute care hospitals, 283 physician groups, and 681 skilled nursing facilities.6

To date, CMS has been a major driver in bundled payments, but it is not alone. Payers and providers are evaluating commercial bundled payment programs as tools to manage cost and maintain market share. Large employer groups have also entered into the bundled payments arena, by collaborating with providers to negotiate bundled payment agreements across the country.7 United Airlines offers employees significant incentives for seeking treatment through providers with whom they have negotiated bundled payment programs, such as Cleveland Clinic for some heart procedures, and Rush University Medical Center for hip and knee replacements.

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In November 2015, CMS announced another step toward the shift to value-based care with the final rule for Comprehensive Care for Joint Replacement (CJR) initiative.8 CJR is a mandatory bundled payment program for total hip and knee replacements across 67 metropolitan statistical areas. The program began in April 2016 and includes approximately 800 hospitals.6 In July 25, 2016, less than 4 months after CJR’s implementation, CMS proposed a new mandatory bundled payment program for cardiac care and an extension of CJR to include hip fractures beginning in July 2017.2

The CJR and cardiac APM programs are shared-savings models with upside and downside risks for the management of 90-day episodes of care. The episodes chosen for these programs represent high-expenditure, high-volume episodes of care (ie, lower extremity joint replacement, surgical hip and femur fractures, acute myocardial infarction, and coronary artery bypass graft) for Medicare beneficiaries. The episodes also exhibit a large degree of variation in care practices and clinical outcomes. The CJR and cardiac programs are designed to reduce Medicare spending and to improve the quality of care; however, unlike CJR, in which the volume is predominantly comprised of elective surgeries, the cardiac program contains conditions that can be managed medically or surgically.2 The breadth of these new bundles will have a tremendous impact on how hospitals, physicians, and providers in the postacute care area will need to manage patients and deliver care.

The CJR and cardiac APM programs have a similar structure to the voluntary BPCI program; however, important differences may significantly affect hospital performance under the mandated programs; the most obvious is the distinction between voluntary and mandated programs. Under BPCI, hospitals apply and volunteer to participate in bundled payment programs. Hospitals define the clinical focus and model duration. Hospitals participating in the CJR and cardiac APM models do not have an opt-out option and have no input in the episode definition or duration. Another key difference is the focus on regional pricing variations in the mandated programs.

The CJR and cardiac APM models are designed to test the efficacy of regionally based pricing. Historically, CMS reported significant payment variation in different geographic areas. The total episode spending for lower joint replacements ranges from $16,500 to $33,000 across geographic areas because of variations in practice patterns.8 With the move to regionally based episode payments, CMS is looking to these new payment models to reduce unnecessary spending variation across different regions.

The CJR and cardiac APM models introduce regional pricing gradually. In the first year of the program, a hospital’s target is calculated based on 66% of the hospital’s historic spending and 33% of the regional average. In the third year of the program, the regional component increases to 66% of the target price. In the final 2 years of the program, the target price will be set at 100% of the regional component; this means that all hospitals throughout Illinois, Wisconsin, Indiana, and Michigan, for example, will be measured against the same episode target price in the last 2 years of the program, because they are in the same census region.

The transition to regional pricing will affect hospitals differently, depending on how efficiently they provided care in the baseline period. All things remaining equal, hospitals with a 90-day episode spending that was lower than the regional average can expect their target price to increase over the duration of the program as the weighting shifts toward the higher region spending. These pro-
providers will see improved financial performance as the program progresses. The reverse is true for hospitals with spending higher than their region in the baseline period: their target price will decrease over time, putting more pressure on them to reduce episode spending to avoid financial loss in the program.

However, participating hospitals cannot and should not assume that performance metrics will remain constant. The new focus on value over volume has prompted hospitals across the country to reign in total episode spending. Hospitals involved with various episode-based payment models have become increasingly aware of opportunities to improve performance. The hospitals participating in BPCI achieved an average reduction of $3286 per case for lower-extremity joint replacement episodes in 21 months, without a significant change in quality outcomes.\cite{10,11} CJR and cardiac APM target prices will likely decrease when they are recalculated with new baseline data, because more hospitals will have reduced spending through implementing the redesign and standardization of patient care, and expanding their focus on care management and coordination for postacute care. Hospitals will need to work continuously to reduce Medicare spending to prevent falling behind the reduction in spending that is driven by regional competitors.

Although some of the intricacies to achieving success under joint replacement bundles are different from those required for success in cardiac bundles, some overarching principles apply to both. Success under both programs requires providers to expand their focus from inpatient acute admissions to the postdischarge arena. Spending related to inpatient admission is predominantly comprised of a fixed Medicare severity DRG payment, limiting hospitals’ ability to influence Medicare spending during inpatient admissions. The opportunity to affect spending in episode-based payment models lies in the postacute care setting.

For elective total joint replacements, approximately 39% of episode spending is in the postdischarge period, and approximately 50% of acute myocardial infarction spending occurs after discharge, primarily as a result of hospital readmissions.\cite{10,11} To manage episode spending, providers must focus on care redesign, standardization, and increased physician and post–acute care provider alignment.

Building a clinical and operational infrastructure that facilitates the identification of patients who are at high risk of readmission, discharge planning to the appropriate setting, increasing postdischarge follow-up, improving patient adherence to treatment and drug regimens, and increasing coordination across care settings are critical to success under episode-based payment models.

Bundled payment arrangements are here to stay; in its July 2016 proposed rule, CMS signaled where it may be going next in implementing new payment reform models.\cite{10} In that rule, CMS sought comment on design features for potential condition-specific episode-based payment models that may focus on an acute event or procedure, or long-term care management.\cite{10} CMS also sought comment on episode-based payment models for chronic medical conditions that frequently result in hospitalization as a result of failed outpatient care management.\cite{10}

Recognizing that success under these models would be largely based on coordinated care management in the outpatient setting, CMS acknowledged that models such as these would likely shift accountability for spending and quality from hospitals to providers. In addition, CMS sought comment on payment models that would target procedures that could be performed in either inpatient or outpatient settings.\cite{10} With this, the intent is to encourage providers to select the site of care based on clinical need, not on fee schedules.

Although we do not know the timing, frequency, or model design, it is clear that CMS will continue to put forth APMs that reward quality of care over utilization of services. Some of these future programs may be mandatory, but others will be voluntary. If they have not already, providers need to begin thinking now about how they would perform under these payment arrangements. The competencies, capabilities, and relationships needed to manage episode-based care are different from those required to manage patients from admission to discharge, and they take time to develop and implement.

Although we do not know the timing, frequency, or model design, it is clear that CMS will continue to put forth APMs that reward quality of care over utilization of services. Some of these future programs may be mandatory, but others will be voluntary.

To survive in a value-based healthcare environment with bundled payments, healthcare organizations need reliable healthcare data and analytics to manage care across the continuum and to monitor financial performance in the bundles. Because medical bundles are linked to chronic conditions, a great deal of attention will focus on postacute care. The implications of bundled payments for payers and for providers will be significant.

For providers, strategies to improve patient engagement throughout these episodes and to increase physician alignment will be key to success. They will also need to restructure their operations and rethink their clinical...
pathways to include postacute care. Commercial payers will notice an impact to benefit design and to direct contracting, and an increased interest in narrow network designs from drug development.

If history is consistent, the CMS bundled payment programs will accelerate more commercial bundled pay-

ment models and programs. Ultimately, these bundles will improve value for patients, by improving care quality and reducing cost, which are key traits for any healthcare organization in a competitive marketplace.

Author Disclosure Statement

Dr Scott and Ms Eminger have no conflicts of interest to report.

References

10. Centers for Medicare & Medicaid Services (CMS), HHS. Medicare Program; advancing care coordination through episode payment models (EPMs); cardiac rehabilitation incentive payment model; and changes to the Comprehensive Care for Joint Replacement model (CJR). Proposed rule. Fed Regist. 2016;81:50794-51040.

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