HHS Public Access

Author manuscript

JAMA. Author manuscript; available in PMC 2018 August 16.

Published in final edited form as:

JAMA. 2018 January 23; 319(4): 335–336. doi:10.1001/jama.2017.19205.

The Rise and Fall of Mandatory Cardiac Bundled Payments

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Bundled payments

A type of alternative payment model in which payments for all services provided in a care episode are linked, represents a promising approach to improving the coordination and efficiency of care. In December 2016, the Centers for Medicare & Medicaid Services (CMS), building on a 3-year-old voluntary bundled payment program, announced new mandatory bundled payment models for selected hospitals providing acute myocardial infarction care and coronary artery bypass graft surgery. The mandatory cardiac bundles were to start in 2018, but in late 2017, CMS released a rule cancelling the program.[1] In this Viewpoint we review the rationale for mandatory bundled payments and argue that their cancellation was a step in the wrong direction for pursuing a health care system that focuses on value and not volume.

Rationale and Early Evidence for Bundled Payments

Medicare spending has increased to approximately $650 billion annually and now accounts for 20% of national health expenditures and 15% of the federal budget.[2] This rise in spending has been driven, in part, by a fee-for-service reimbursement system that promotes the delivery of fragmented and inefficient care by physicians, hospitals, and postacute care facilities. Bundled payments have been proposed as a potential way to contain rising health care costs and align the interests of health care organizations and clinicians by providing a fixed payment or target price for each "episode" of care, generally defined as a

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Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Wadhera reported having served as a consultant for Sanofi and Regeneron. Dr Joynt Maddox reported performing contract work for the US Department of Health and Human Services. No other disclosures were reported.

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hospitalization plus all services in the 30-, 60-, or 90-day period that follows. In theory, doing so incentivizes collaboration, care coordination, and efficiency in the delivery of care among clinicians within and across multiple settings.

Early experimentation with bundled payment for cardiac care suggested its potential. In the 1990s, 4 hospitals in a Medicare pilot program that were paid a global price for inpatient coronary artery bypass graft care showed reductions in length of stay and costs of care.[3] A 2007 study demonstrated that a 90-day bundled payment and pay-for-performance package following elective coronary artery bypass graft surgery within a single health care system improved performance, reduced length of stay, and reduced hospital charges.[4] Similarly, the Medicare Acute Care Episode Demonstration, which began in 2009, showed cost savings associated with an inpatient bundled payment for cardiovascular procedures.[5] Although participants in these programs were highly selected and the generalizability of their findings was limited, these early experiences with bundled payments offered promise.

In 2013, the Center for Medicare and Medicaid Innovation launched the voluntary Bundled Payments for Care Improvement (BPCI) initiative. Under the BPCI initiative, hospitals, physician groups, and postacute care facilities that wished to participate could choose from 4 bundled payment tracks that varied by included phases of care (hospitalization and associated readmissions vs hospitalization and post discharge care vs postacute care only), 48 clinical conditions (eg, acute myocardial infarction, gastrointestinal bleeding, hip surgery), and 3 episode lengths (30, 60, or 90 days). Participants whose Medicare payments were less than a benchmark based on their own historical spending could keep a portion of the difference but bore financial risk if the benchmark was exceeded. According to CMS, as of October 2017, 306 acute care hospitals, 550 skilled nursing facilities, 218 physician group practices, 60 home health agencies, and 9 inpatient rehabilitation facilities have joined the program.[6]

Early evidence from the BPCI initiative was equivocal. A 2016 report showed significant declines in per-episode spending for participants who selected 30-day cardiovascular episodes ($1625 in savings for cardiovascular conditions and $4149 for cardiovascular procedures), but those declines were limited to patients who used postacute care, and savings were no longer evident by 90 days.[7] There were similarly modest, albeit more consistent, savings among participants selecting joint replacement bundled payments.[7] However, given the voluntary nature of the BPCI initiative and the early timing of this evaluation, sample sizes were small (41 participants for cardiovascular conditions and 30 for cardiovascular procedures), and follow-up was limited.

The Move to Mandatory Bundled Payments

A major limitation of voluntary bundled payments is that because of their voluntary nature, they likely select for hospitals, physicians, and postacute facilities that are more able to implement and are more likely to benefit from bundled payments. Furthermore, participants in the BPCI initiative are able to disenroll from the program at any time without penalty, and recent evidence suggests that nearly half of participants have done so.[8] In response to these limitations, CMS launched mandatory bundled payments in 67 geographic areas for hip and

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knee replacement in 2016, and mandatory bundled payments for acutemyocardial infarction and coronary artery bypass graft care were set to launch in 98 geographic areas in early 2018.[9]

Mandatory bundled payments came with anticipated challenges for participants, many of which CMS attempted to preemptively address. For example, to ensure participants had adequate time to effectively implement the partnerships and innovation required to succeed, CMS provided the option to delay financial risk until 2019. In addition, CMS developed stop-loss thresholds for all hospitals, which placed a cap on financial risk and were tailored to be more generous for rural, community, and low-volume centers. CMS also assured participants that they could qualify for the 5% automatic payment bonus under the advanced alternative payment model track of the Quality Payment Program (contingent on the use of certified electronic health record technology). Collectively, these steps strengthened the mandatory model, protected institutions and patients, and encouraged buy-in from hospitals, physicians, and postacute facilities.

The Cancellation of Mandatory Bundled Payments

However, mandatory cardiac bundled payments were over before they began. CMS cancelled the program in late 2017, although the cancellation rule also indicated CMS' intent to extend and expand voluntary bundled payments.[1] The rationale provided for the cancellation of the mandatory program included the need for more time to allow physicians, hospitals, and other groups to provide input on model design and greater flexibility to test other voluntary episode based models. However, the decision to cancel may also have been driven by arrival of a new administration, the now former secretary of Health and Human Services' stance on mandatory bundled payments, and a political climate that spurred a lack of enthusiasm for value-based payment programs initiated under the Patient Protection and Affordable Care Act.

The cancellation of mandatory bundled payments was a step in the wrong direction for several reasons. Spending on high-cost health care continues to increase—high and rising health care costs cannot be ignored indefinitely. Absent a mandate, hospitals, clinicians, and postacute care facilities have little motivation to collaborate around innovative care redesign to improve coordination and efficiency. A voluntary program, at least a program in which fewer than 10% of hospitals participate and half of those end participation early, will neither invite meaningful changes in care delivery nor provide usable information about what works and what does not. Without testing a bundled payment model across a diverse, representative group of acute care hospitals, it will never be possible to gain actionable insights to inform iterative improvements in the design and implementation of novel payment models.

Furthermore, although mandatory bundled payments for joint replacement were initially met with resistance, early reports suggest that the program has been associated with greater collaboration and engagement among hospitals, physicians, and postacute facilities; innovative care redesign; and significant cost savings. As a result, bundles are now electively being expanded to other conditions and procedures at many of the institutions selected for this program. [10] Mandatory bundled payments provided the impetus for institutions to

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examine their own internal care processes and refocus on reducing complications, reducing readmissions, and avoiding unnecessary institutional postacute care. The mandatory cardiac bundled payment program could have built on this momentum, and its cancellation represents a lost opportunity to improve the delivery and efficiency of care.

Rising Medicare expenditures, and health care spending in general, are unsustainable and cannot be ignored. Unfortunately, despite a continued and pressing need to bend the cost curve, the use of 1 potential tool—mandatory cardiac bundled payments—has been abandoned.

Acknowledgments

Funding/Support: Dr Wadhera is supported by the National Institutes of Health (training grant T32HL007604–32); Brigham and Women's Hospital, Division of Cardiovascular Medicine; and by the Jerome H. Grossman, MD, Fellowship in Healthcare Delivery Policy at the Harvard Kennedy School's Healthcare Policy Program. Dr Yeh receives research support from the National Heart, Lung, and Blood Institute (K23HL118138 and R01HL136708) and the Richard A. and Susan F. Smith Center for Outcomes Research in Cardiology. Dr Joynt Maddox receives research support from the National Heart, Lung, and Blood Institute (K23HL109177–03).

Role of the Funder/Sponsor: The funding agencies played no role in the preparation, review, or approval of the manuscript or decision to submit it for publication.

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