Medicare’s Bundled Payment Models—Progress and Pitfalls

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The Centers for Medicare & Medicaid Services (CMS) is moving increasingly toward alternative payment models that incentivize high-quality, low-cost care. Bundled payments, for example, now cover medical, procedural, and therapeutic episodes, from a broad range of medical and surgical conditions in Bundled Payments for Care Improvement Advanced (BPCI-A); to hip and knee replacements in the Comprehensive Care for Joint Replacement Model (CJR); to chemotherapy administration in the Oncology Care Model (OCM). Bundled payments encourage cost efficiency by setting a total spending benchmark for all services associated with a clinical “episode.” In the full risk-bearing phase of these and other similar programs, if model participants reduce average costs below their benchmark, CMS rewards them with a financial bonus; if their costs exceed the benchmark, they owe CMS a penalty payment.

Many feel that bundled payment programs provide a promising path toward care redesign and payment reform, and prior studies have shown them to be associated with modest reductions in clinical spending with no compromise in quality.1 However, as CMS pushes for more participation in these models, it will be crucial for policy makers to address several concerns regarding benchmarks, market distortions, and health equity.

Bundled payments provide a promising path toward payment reform. As CMS continues to expand these models, policy makers should set appropriate benchmarks, minimize market distortions, and strive for equity.

**Benchmarks**

There are 2 significant challenges related to the current method for setting spending benchmarks. First, continuing to base benchmarks on historical costs will lead to a feedback loop disadvantaging participants with low spending. Those who reduce spending will have lower historical spending in future years and will receive lower benchmarks. They may find it more difficult to meet progressively lower benchmarks and will thus eventually pay penalties, despite being efficient. This concern could become pressing as CMS implements mandatory models, in which participants who are assigned lower benchmarks can no longer opt out of the bundled payment programs.2 To protect efficient participants, policy makers could define an “efficiency floor” under which participants suspend participation or are otherwise exempt from penalties.

**Market Distortions**

The composition of bundled payment episodes is a blunt instrument for cost reduction. First, the distribution of bonuses incentivizes asymmetric cost reduction within the health care system. BPCI-A and CJR benchmarks encompass most inpatient and outpatient spending within 90-day episodes, yet only hospitals or physician groups participating in these payment models are eligible for bonuses. Because spending reductions in these programs have been driven by reductions in use of skilled nursing and inpatient rehabilitation facilities,3 these models reward participants who reduce payments to other players in the health care system without having to change practices at their own site. Policy makers might consider making incentives available to all spenders to reward the entities, in both inpatient and outpatient settings, actively engaged in lowering costs.
Second, by incentivizing lower usage of most services, bundled payments do not account for the different value that each service may provide. For example, cardiac rehabilitation has clear benefit for patients: it is associated with decreased mortality and readmissions and increased quality of life in patients with heart disease. However, its inclusion in total episode spending calculations in BPCI-A increased costs, making it difficult to realize savings in cardiac bundles. BPCI-A recently excluded cardiac rehabilitation costs when calculating episode spending, lessening the disincentive against referring patients to this high-value service. Policy makers could similarly exclude high-value services (such as hormone therapy for low-risk breast or prostate cancers) from spending calculations in other episodes, especially if those services are also expensive.

**Health Equity**

Model design also has important implications for equity. First, bundled payment programs may penalize participants serving medically or socially high-risk patients. For example, in the Bundled Payments for Care Improvement model (the precursor to BPCI-A), hospitals with a higher proportion of patients with multiple comorbid conditions were less likely to achieve at least 2% in savings. In CJR, hospitals serving a high proportion of patients dually enrolled in Medicare and Medicaid were markedly less likely to receive bonuses compared with hospitals with a lower proportion of dual enrollees, despite achieving similar savings on an absolute scale. These programs could worsen existing inequities if they do not take patient complexity into account when assigning benchmarks and assessing performance.

Second, bundled payments need to include carefully selected quality measures alongside spending targets to ensure that cost reduction is not harmful to historically marginalized communities. Black patients may have lower-than-optimal spending, including on outpatient care, because of limitations in access to care rooted in discrimination and poverty. Cost reduction in the absence of a clear focus on quality could worsen equity.

Third, bundled payments should be leveraged as a tool to improve health equity in their future iterations. These programs could include explicit equity measures among their quality measures or offer an “equity bonus” for clinicians and health care centers who narrow disparities in outcomes among their patients. Policy makers could also create separate program tracks that differ in the size and direction of financial risk that participants assume, based on their medical and social caseloads. These tracks could provide more support to less-resourced and less-experienced health centers and offer additional resources for participants interested in developing novel programs to improve health by addressing social determinants.

**Conclusions**

Bundled payments provide a promising path toward payment reform. As CMS continues to expand these models, policy makers should set appropriate benchmarks, minimize market distortions, and strive for equity.

**REFERENCES**