The uncertain future of bundled payments

By Joe Cantlupe | June 15, 2017

Under the Obama administration, many healthcare organizations looked at bundled payments as the first step toward major payment reform — and assumed that more and more providers would need to gain competency with them.

But under the Trump administration, the future of bundled payments is uncertain. Secretary of Health and Human Services Tom Price, M.D., has spoken out against the programs. His department has delayed a proposed expansion of some mandatory bundling initiatives, as well as the implementation of new cardiac and orthopedic bundled-payment models.

And even some major advocates of alternative payment models have asked HHS for revisions and delays.

This shifting landscape represents a challenge for startups such as Archway Health, a partner with athenahealth's More Disruption Please program. The Massachusetts-based company specializes in managing bundling programs with software tools. And, its clients are beginning to realize significant savings under bundled payment plans, says Dave Terry, the company’s co-founder and CEO.

Under those plans, Medicare pays hospitals a set fee from the time of surgery until 90 days later, rather than paying for care and rehabilitation separately. The goal is to reduce costs and increase incentives for providers to coordinate care.

“We’re starting to see improvements in the process that we hadn’t even thought about,” Terry says.

Still, even Terry has qualms about the way bundled payments have worked so far. A major sticking point for him is the mandatory nature of some CMS programs, such as Comprehensive Care for Joint Replacement (CJR) and cardiac Episode Payment Models (EPMs).

Terry says he found that many physicians lacked engagement in the mandatory programs, in part because they were removed from all aspects of the care strategy.

“We prefer the voluntary programs, and I wouldn’t have said that two years ago,” Terry says. “Providers in the voluntary programs are much more engaged and have buy-in, and they are motivated to change. We’re really focused on providers and purchasers...
who believe that there’s a better way to do this and a real opportunity to push forward.”

The end of mandatory bundling?

Price, an orthopedic surgeon, has made his dissatisfaction with mandatory bundling programs widely known, saying they are tantamount to government overreach and “experimenting with America’s health.”

Price has been particularly negative about the CJR program, despite its financial results. A JAMA Internal Medicine study of nearly 4,000 patients who received joint replacement surgery under Medicare bundling documented a decrease of more than 20 percent in total spending per episode.

Josh Luke, a former hospital CEO and a professor at the University of Southern California, says he suspects the Trump administration will eliminate mandatory bundling programs within the next two years, which he believes would be a correct move.

Voluntary programs represent “the right approach to incentivize hospitals to participate and financially give them no downside risk,” says Luke, who founded the National Bundled Payment Collaborative.

CMS has launched some successful voluntary bundling programs, such as the Bundled Program for Care Improvement (BPCI), a general framework that involves 48 episodes of care. A JAMA study published this year found significant cost savings in thousands of joint replacement patients: An average of 21 percent savings in uncomplicated joint replacement cases and 14 percent in complicated ones.

That program “has been good for our practice,” says Michael Ochal, a partner at IntraHealthGroup in Atlanta and an Archway Health client.

“It allows us to coordinate the patient’s care and decision-making from the beginning of an encounter to discharge, truly follow a patient through the process, and guide the appropriate levels of care,” Ochal says.

A role for mandates?

Not all healthcare leaders prefer a fully voluntary approach. Tamra Minnier, R.N., MSN, FACHE, chief quality officer for the University of Pittsburgh Medical Center, says mandatory bundling can be a “win-win,” depending on the needs of the organization.

“Bundling does work, and the reason that it works [is] it provides a coalescing moment for a care team to come together to do what is best for the patient,” she says. “The aligned incentives to do the right thing for the right patient is the most powerful strategy.”

Minnier says some providers, who are immersed in a fee-for-service environment, might need some extra prodding to recognize the benefits of bundling.

“Sometimes that regulatory push is needed,” she says. “At the federal level, we haven’t aligned all the incentives. Once we do that, people will voluntarily run toward the program and make it is easier to do the right thing.”

UPMC, an integrated healthcare system with 25 hospitals, started using bundled payment programs for hip and knee surgeries in 2013, before CMS launched its mandatory models, Minnier says.

In a review of its bundling programs over the last several years, UPMC and its UPMC Health Plan reported a wide array of improvements, from higher quality of care to more engaged physicians to greater accountability. The quality improvements included at least 75 percent of hip and 85 percent of knee patients showing “functional improvement.”

Before the launch of bundling, “there was a great variation and utilization of post-acute services” in the hospital system, Minnier says. “Overall, we’re seeing nothing but powerful outcomes from the program, and we are getting people home, and we’re pretty excited about that.”

The way forward — sooner or later

Still, the backlash against current bundling programs has been strong. In filings with HHS, many hospitals
and advocacy groups have argued that the programs are too complex, have flawed designs, and are being rolled out too quickly.

Even UPMC favors delays in implementing new bundling plans, as does the American Medical Association, the Medicare Payment Advisory Commission and the Healthcare Financial Management Association.

François de Brantes, executive director of the nonprofit Health Care Incentives Improvement Institute, said his organization supports the concept of bundling. But he's concerned that CMS's bundling plans, as currently structured, contain too many variables for evaluating payments — and may reward hospitals even when their patients develop complications.

To truly encourage a systemwide shift to bundled payments, de Brantes says, CMS should make sure its programs work as intended.

"[The current] programs should be ultimately dismantled because of what they are," de Brantes says. "Not just delay. Abandon. We need alternative payment models to succeed."

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