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Bundled Payment Model Success Unaffected by Type of Participation

Historically, Medicare has offered value-based payment models to healthcare organizations on both a voluntary and a mandatory participation basis. Because voluntary participants could self-select into programs to reduce spending, it was assumed that they achieved greater savings than mandated participants, but until recently, no data had tested this. However, a June 2021 study in the Journal of the American Medical Association (JAMA) found no difference in risk-adjusted episodic spending between voluntary and mandatory payment model participants.[1] This Health Capital Topics article will examine the bundled payment program observed in this study, discuss the methods and results of the study, and explore possible implications for Centers for Medicare and Medicaid Services (CMS) value-based payment programs going forward.

Background of Medicare Bundled Payment Programs

Traditional fee-for-service (FFS) Medicare makes separate payments to providers for each service or procedure they render to a beneficiary in treating or managing health conditions, which may drive up costs and spending, as this reimbursement scheme discourages cost-effective, coordinated care. In 2013, CMS launched a bundled payment program to test ways to improve care coordination and reduce costs for Medicare beneficiaries.[2] Bundled payments, in contrast to FFS reimbursement, consist of a single payment to a provider for a patient's entire episode of care. This payment strategy seeks to push providers to become more responsible for the comprehensive care of a patient by incentivizing the provider to provide services in a cost-efficient, high quality manner in order to realize a financial return.[3] The first Bundled Payments for Care Improvements (BPCI) Initiative developed by CMS was comprised of four models of care that linked a beneficiary's episode of care to the payments providers received for those services, which included hip and knee joint replacements.[4] The four models were differentiated by the setting in which the episode of care was provided.[5] The four models concluded in 2018, and remaining participants could choose to resign the program or move into the newer BPCI Advanced program.[6]

In 2016, CMS commenced the Comprehensive Care for Joint Replacement (CJR) model, which sought to test cost and quality measures for episodes of care related to hip and knee replacements, also referred to as lower extremity joint replacements (LEJR), under bundled payments.[7] Medicare beneficiaries account for a large proportion of LEJR, and recovery, rehabilitation, and complications (such as readmissions) alone account for more than $7 billion in annual Medicare spending.[8] The CJR model incentivizes participating hospitals to deliver comprehensive, cost-effective care from the time a patient is admitted for their surgical procedure until 90 days after discharge to ensure that patients have fully completed their recovery.[9] The CJR model is most similar to Model 4 of BPCI, wherein providers are paid prospectively for all services rendered during a patient's episode of care, including the inpatient stay in an acute care hospital, post-acute care, and all rehabilitation services up to 90 days post-discharge.[10]

The CJR model holds hospital participants financially responsible for effectively coordinating providers along the continuum of care, such as surgeons, post-acute care providers, and clinicians, and consequently reduce costs and improve quality.[11] Benchmarks on spending are set for providers, and if hospitals do not achieve cost and quality metrics, they may face repayments to Medicare.[12] Conversely, if providers are efficiently coordinating care, they may "earn" or keep the difference between their spending and benchmark payments.[13]

In July 2015, CMS originally planned to implement the CJR model in 75 MSAs, and use a control group consisting of the remaining 121 MSAs.[14] However, in November 2015, 8 MSAs were dropped due to an increase in participation in the BPCI model, making them ineligible for the CJR model.[15] Thus, CMS implemented the CJR model in 67 MSAs, and required hospitals within those MSAs to participate.[16] During 2018, the third performance year of the CJR model, CMS reduced mandatory participation to the lowest performing 34 MSAs with the highest average historical episodic payments, and began offering an opportunity to voluntarily opt-in to the model for the higher performing participants in the 33 MSAs with lower average episode payments.[17] Of the over 300 providers that were eligible for voluntary participation in the 33 voluntary MSAs, 86 providers opted-in to participate in CJR for its remaining performance years.[18]

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Study Findings

The June 2021 JAMA study conducted by University of Pennsylvania researchers followed prior work that examined the spending differences between mandatory and voluntary participants in the CJR model, based on 2011-2017 data.[19] The researchers grouped CJR participants based on whether they participated in the BPCI program prior to their CJR model participation (i.e., the mandatory and voluntary participants), and then utilized hospitals in 121 MSAs that continued to receive traditional Medicare FFS payments as a "control," or comparison, group, as nonparticipating hospitals.[20]

The JAMA study found that after risk adjusting, episodic payment decreases after implementation of bundled payments for voluntary hospital participants versus mandatory hospital participants did not differ significantly, and non-participating hospitals performed slightly better than voluntary hospitals. Risk-adjusted episodic spending, after implementation of bundled payments, decreased approximately 12.8% for voluntary participants (from $21,182 to $18,452); 14.8% for mandatory participants (from $18,390 to $15,652); and 13.2% for non-participating hospitals (from $17,132 to $14,871).[21]

More Mandatory Programs to Come?

The JAMA study results, which showed lesser savings among voluntary participants, may provide support for future mandatory payment models. CMS has been foreshadowing more mandatory bundled payment models for some months, with the Center for Medicare and Medicaid Innovation (CMMI) director, Elizabeth Fowler, hinting at pivoting away from voluntary models. She reported to Health Affairs that voluntary models cannot generate system-level savings because providers tend to leave programs if they are not generating additional revenue, and those that do generate additional revenue tend to remain static and do not take on more risk.[22] Fowler wants to forge a path forward for organizations that are doing well under value-based care models, boost stragglers down the same path, and reach out to organizations that have not yet participated.[23]

In 2020, then–CMS Administrator Seema Verma made comments that CMS is planning to implement more mandatory payment models in the future because many are not generating statistically significant savings.[24] She additionally asserted that mandatory participation is vital to success, much to the chagrin of several medical groups and hospital associations. The Medical Group Management Association (MGMA), for example, stated that while they support efforts to improve value-based care, it is their position that it is unfair to require participation in payment models that lack evidentiary support.[25] Further, MGMA added that payment models are not one-size-fits-all, and that CMS should instead focus their attention to creating models that meet diverse needs.[26]

Additionally, hospitals have asked CMS to keep bundled payment models as voluntary initiatives. The Greater New York Hospital Association has argued that mandatory bundled payment initiatives pose a threat for safety net hospitals that primarily rely on Medicare payments.[27] The California Hospital Association and Missouri Hospital Association have echoed these frustrations by asking CMS to cancel any mandatory pay models because they place extreme hardships on providers' financial stability.[28]

Conversely, a population-based JAMA study in 2021 found that savings from the CJR program had dissipated between the second and fourth years of the program.[29] This study looked at 2014-2019 claims data to determine how changes in the program (i.e., the opportunity for hospitals to drop out of the program) affected episode spending.[30] Researchers suggested that the drop in episode spending savings is largely due to hospitals opting out of the CJR model.[31] To mitigate such issues, researchers suggested that future episode-based payment models be made mandatory, while changing some structural components (such as the risk adjustment changes in benchmarking) that may hamper savings and making models more flexible to evolve with clinical innovation.[32]

The CJR model was set to conclude on September 30, 2021, but a CMS final rule extended the payment model through December 31, 2024.[33] Additionally, CMS announced another round of changes to the BPCI Advanced model that could make participation mandatory as early as 2024.[34] CMS is continually working to develop more bundled payment models that pay providers with minimal burden and push system-level change in cost and quality.[35]

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