Will Trump Dump New Mandatory Bundled Payments?

Robert Lowes | December 23, 2016

President-elect Donald Trump's choice to head the US Department of Health and Human Services (HHS) doesn't like Medicare experiments in which physicians, hospitals, and patients have no choice but to participate.

That means four mandatory bundled payment models just approved by the Centers for Medicare & Medicaid Services (CMS) are on a collision course with the incoming Trump administration.

The bundled payment models represent another attempt by CMS to pivot from fee-for-service to value-based reimbursement. With bundled payments, a payer such as Medicare sets a target price for an episode of care such as surgery (and postdischarge care as well) that covers hospital and physician charges.

If the hospital and its collaborating physicians can beat the target price, they share in the savings, provided they meet certain quality standards. Avoiding surgical complications and revolving-door readmissions are two prime ways of coming under budget. Go over budget, however, and providers owe the third-party payer some money.

That's the basic framework for the four new bundled payment models that CMS set in regulatory stone, at least for now, on December 20. Three apply to episodes of care for acute myocardial infarction, coronary artery bypass graft surgery, and cardiac rehabilitation after a heart attack or heart surgery. The government sees an opportunity for both efficiency and improved care here. The cost of bypass surgery and recovery varied in 2014 by 50% across hospitals, as did the share of hospitalized patients with heart attack who were readmitted within 30 days. And only 15% of patients with heart attack underwent cardiac rehabilitation, which can lower the risk for a second heart attack or death.

The fourth bundled payment model involves surgical treatment of hip and femur fractures, excluding lower-extremity joint replacement. This last model builds on an existing bundled-payment program in Medicare for hip and knee replacements that was the first to be mandatory, as opposed to voluntary: Comprehensive Care for Joint Replacement (CJR), which took effect April 1.

The scheduled launch date for the new bundled payment models is July 1, 2017. Similar to CJR, they will debut in select geographic regions, with all acute care hospitals there required to participate. CMS will roll out the programs for heart attack and coronary artery bypass graft, for example, in an estimated 1120 hospitals in 98 locales. The models are technically voluntary for physicians, although they may feel forced to participate, depending on their economic relationship to the hospitals, critics note.

All these reimbursement models are the handiwork of the CMS Center for Medicare and Medicaid Innovation, charged with testing new ways to deliver and pay for healthcare. House Republicans have targeted the center for repeal, contending it oversteps its authority with massive, as opposed to limited, experiments that disregard input from physicians and hospitals.

"A Train Already Going Down the Track"

CMS proposed its new bundled payments in August. Surgical societies gave high marks to one particular aspect of the plan: The new models, as well as CJR, would qualify for preferred treatment under the Medicare Access and CHIP Reauthorization Act (MACRA). That bipartisan law set up a two-track reimbursement system for Medicare. The default track for physicians is the Merit-Based Payment System, which comes with bonuses and penalties, and lots of unpopular performance reporting, as in existing incentive Medicare programs.

The other MACRA track, Advanced Alternative Payment Models (APMs), offers participants a lump sum bonus of 5% a year beginning in 2019 as long as they assume serious financial risk under their particular model. One example of an Advanced APM is a so-called Next-Generation Accountable Care Organization (ACO).

Lacking the reporting hassles and potential penalties of the Merit-Based Payment System, Advanced APMs look good to physicians willing to operate in a managed care environment. Organized medicine has asked CMS to expand the number of

Medicare programs that qualify for this payment track, and that is what the agency has done in the final regulations for the new bundled payment models. CMS has designated them, along with CJR, as Advanced APMs.

However, a number of medical societies, such as the American Association of Orthopaedic Surgeons, have objected to making bundled payments mandatory for hospitals. Some hospitals and their surgeons might not be ready to participate, the argument goes. And surgeons who don't want to sign a bundled payment contract with a hospital might risk losing their privileges.

The American Medical Association also chimed in, writing CMS that "it does not believe there is any need for a mandate to encourage participation in a properly designed bundled-payment system."

Perhaps the most significant protest from the ranks of medicine came from Donald Trump's pick for HHS secretary, Rep. Tom Price, MD, (R-GA), an orthopaedic surgeon. In a September letter to CMS, Dr Price as lead signatory and 178 other House members said that by proposing mandatory bundled payments, the Center for Medicare and Medicaid Innovation "has upset the balance of power between the legislative and executive branches." The new models don't represent limited, low-risk tests, as envisioned by the ACA, but sweeping changes that warrant Congressional say-so, the lawmakers argued. "Medicare providers and their patients are being forced into high-risk government-dictated reforms with unknown impacts."

If confirmed as HHS secretary by the Senate, Dr Price will be in a position to erase or rewrite the final regs for mandatory bundled payments, said Jack Lewin, MD, president and chief executive officer of the Cardiovascular Research Foundation. "And he'll have the support of a majority of Congress."

That said, Dr Lewin told *Medscape Medical News* that Dr Price may very well preserve the bundled payment models, but make them voluntary.

"There will be physician organizations that are going to think, 'Maybe this is the way to go,' " said Dr Lewin, the former chief executive officer of the American College of Cardiology and the California Medical Association. "This isn't a brand-new, big surprise. We have bundled payments for cataract procedures. We have them for labor and delivery.

"I do think a voluntary process of bundled payment is a train already going down the track."

Baby Steps Toward Downside Risk

The CMS regulations issued on December 20 made final some Medicare reimbursement policies that aren't as controversial as mandatory bundled payments. The agency granted Advanced APM status and all its perks under MACRA to a new kind of ACO in its Medicare Shared Savings Program.

Right now, there are three tracks for ACOs in the Medicare Shared Savings Program. Most are in track 1, which gives participating physicians and other providers a chance to make extra money — a cut of shared savings — without any risk of losing money. ACOs in tracks 2 and 3, however, come with downside risk, and therefore qualify as Advanced APMs.

The new ACO just created by CMS is called ACO Track 1+. It will expose participants to a smaller degree of downside risk than found in tracks 2 and 3. Physicians whose ACO doesn't save Medicare any money would be penalized no more than 8% of their fee-for-service revenue.

CMS estimates that the ACO Track 1+, the new bundled-payment models, and the existing CJR program will bring some 70,000 additional clinicians into the Advanced APM fold by 2018, on top of the 120,000 or so in the agency's original estimate.

More information on these new Medicare reimbursement arrangements is available on the CMS website.

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