THE NEW HEALTH CARE

Can Bundled Care Save Medicare Money?

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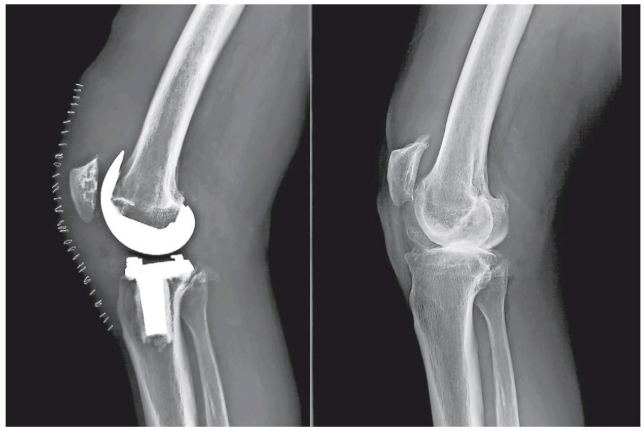
Among the standard complaints about the American health care system is that care is expensive and wasteful. These two problems are related, and to address them, Medicare has new ways to pay for care.

Until recently, Medicare paid for each health care service and reimbursed each health care organization separately. It didn't matter if tests were duplicated or if a more efficient way of delivering care was available — as long as doctors and organizations were paid for what they did, they just kept providing care the way they always had.

But ordinary people do not think this way. We focus on solving our health problem, not which — or how many — discrete health care services might address it. New Medicare programs are devised to more closely align how care is paid for with what we want that care to achieve.

One of these programs is known as bundled payments. Instead of paying separately for every health care service associated with a medical event, you pay (or Medicare pays, in this case) one price for the entire episode. If health care providers can address the problem for less, they keep the difference, or some of it. If they spend more, they lose money. Bundled payment programs vary, but some also include penalties for poor quality or bonuses for good quality.

Medicare has several bundled payment programs for hip and knee replacements — the most common type of Medicare procedures — and associated care that takes place within 90 days.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X-rays of a patient who had a knee replacement. Medicare has several bundled payment programs for hip and knee replacements and recovery.

This includes the operation itself, as well as follow-up rehabilitation (also known as post-acute care). In theory, if doctors and hospitals get one payment encompassing all this, they will better coordinate their efforts to limit waste and keep costs down.

Do bundled payments work? They certainly appear promising, at least for some treatments. But it's important to conduct rigorous evaluations.

Previous studies for Medicare by the Lewin Group and other researchers suggest that Medicare's Bundled Payments for Care Improvement program has reduced the amount Medicare pays for each hip and knee replacement.

But that doesn't mean the program saved money over all.

One possible issue would be if, despite saving money per procedure, health care providers wastefully increased the number of procedures — replacing hips and knees that they might not otherwise. A related concern is if hospitals try to increase profits by nudging services toward patients who may not need a procedure as much as patients with more severe and more expensive conditions. An average joint replacement costs $26,000, split almost equally between the initial procedure and post-acute care. But more expensive cases can be $75,000 to $125,000 — a costly proposition for hospitals.

A recent study published in JAMA examined whether the volume of Medicare-financed hip and knee replacements changed in the markets served by hospitals that volunteered for a bundled payments program, relative to markets with no hospitals joining the program. It found no evidence that the bundled payment program increased hip and knee replacement volume, and it found almost no evidence that hospitals skewed their services toward patients whose procedures cost less.

"These results suggest bundled payments are a win-win," said Ezekiel Emanuel, a co-author of the study. "They save payers like Medicare money and encourage hospitals and physicians to be more efficient in the delivery of care."

But Robert Berenson, a fellow at the Urban Institute, urges some caution. "Studying one kind of procedure doesn't tell you much about the rest of health care," he said. "A lot of health care is not like knee and hip replacements."

Michael Chernew, a Harvard health economist, agreed. "Bundles can certainly be a helpful tool in fostering greater efficiency in our health care system," he said. "But the findings for hip and knee replacements may not generalize to other types of care."

Christine Yee, a health economist with the Partnered Evidence-Based Policy Resource Center at the Boston Veterans Affairs Healthcare System, has studied Medicare's previous efforts and summarized studies about them. (I and several others were also involved in compiling that summary.) "Medicare has tried bundled payments in one form or another for more than three decades," Ms. Yee said. "They tend to save money, and when post-acute care is included in the bundle, use of those kinds of services often goes down."

One limitation shared by all of these studies is that they are voluntary: No hospital is required to participate. Nor are

Paying for all services needed for a medical event in a lump sum.

they randomized into the new payment system (treatment) or business as usual (control). Therefore we can't be certain that apparent savings are real. Maybe hospitals that joined the bundled payment programs are more efficient (or can more easily become so) than the ones that didn't.

Another new study in JAMA examines a mandatory, randomized trial of bundled payments. On April 1, 2016, Medicare randomly assigned 75 markets to be subject to bundled payments for knee and hip replacements and 121 markets to business as usual. This policy experiment, known as the Comprehensive Care for Joint Replacement program, will continue for five years. The JAMA study analyzed just the first year of data.

"In this first look at the data, we examined post-acute care because it is an area where there is concern about overuse," said Amy Finkelstein, an M.I.T. health economist and an author of the study. "In addition, prior work suggested that it's a type of care that hospitals can often avoid."

The study found that bundled payments reduced the use of post-acute care by about 3 percent, which is less than what prior studies found. "Those prior studies weren't randomized trials, so some of the savings they estimate may really be due to which hospitals chose to participate in bundled payment programs," Ms. Finkelstein said. Despite reduced post-acute care use, the study did not find savings to Medicare once the costs of paying out bonuses were factored in. The study also found no evidence of harm to health care quality, no increase in the volume of hip and knee replacements, and no change in the types of patients treated.

"Savings could emerge in later years because it may take time for hospitals to fully change their behavior," Ms. Finkelstein said. In addition, the program's financial incentives will increase over time; bonuses for saving money and penalties for failing to do so will rise.

On the other hand, Dr. Berenson said, health care providers could figure out how to work the system: "In three to five years, we may see volume go up in a way that offsets savings through reduced payments for a procedure. We'll wait and see."

Medicare put its best foot forward by using a randomized design. Not only were the markets selected in a randomized fashion, but providers in those markets were also required to participate. Though common in medical studies, randomization is rare in health care policy, as is mandatory participation. Nearly 80 percent of medical studies are randomized trials, but less than 20 percent of studies testing health system change are. Organizations that would be subject to the experiments often strongly resist randomizing health system changes and forcing providers to participate.

Unfortunately, the randomization of the Comprehensive Care for Joint Replacement program will be partly compromised in coming years. The Centers for Medicare and Medicaid Services announced last year that hospitals in only half of markets under the program would have to stay in it. Participation is voluntary in the other half, and only one-quarter of hospitals opted in.

Going to a partly voluntary program will make it harder to learn about longer-term effects, Ms. Finkelstein said, and to get at the answers we're seeking.