

## Insight on the Issues

# Putting People First by Strengthening Medicare for the Future: Promising Payment and Delivery System Innovations in Medicare

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## Introduction

Medicare is the nation's federal health insurance program for people age 65 and older and many younger people with long-term disabilities. In 2020, about 63 million people rely on Medicare for their health coverage.<sup>1</sup> Medicare helps pay for hospital, doctor, and other medical services, as well as for prescription drugs.

By many measures, Medicare's financial status improved during the past decade.<sup>2</sup> In large part, this is the result of policy changes in the Affordable Care Act (ACA) of 2010, which contributed to slower spending growth. In 2018, Medicare spending was 20 percent lower than had been projected in 2009, a reduction of \$185 billion.<sup>3</sup> Still, while Medicare is not "going broke," the program—like the rest of the health care system—faces long-term financial pressures from rising health care costs, as well as from an aging population.<sup>4</sup>

The COVID-19 pandemic will have substantial impacts on the Medicare population and the program. Although its full effects are not yet known, the public health crisis has driven home the essential nature of having access to life-saving health services and the value of Medicare in providing access to care for millions of

older Americans and younger individuals with disabilities.

To help address long-term financial pressures, Medicare has been developing and testing a variety of new ways to pay for and provide health care that are aimed at both slowing cost growth and improving quality. These innovations involve testing ways of giving hospitals, doctors, and other health care providers financial incentives and new flexibility to change how they deliver care.

In this *Insight on the Issues*, we highlight seven innovations in how health care services are paid for and delivered in traditional Medicare. Among people with Medicare, nearly two-thirds are covered by traditional Medicare (also called original Medicare). In 2019, 37 percent of people with Medicare opted to enroll in private health plans, known as Medicare Advantage plans, for their Medicare coverage, instead of traditional Medicare.<sup>5</sup> The focus of this report is on innovations in traditional Medicare; it does not look at innovations in the Medicare Advantage program.

Early results indicate that these innovations have the potential to help control Medicare spending while at the same time improving or maintaining the quality of care experienced by patients. These

innovations also reveal the wide range of ways in which the Medicare program has been changing.

In identifying promising innovations for this report, in addition to examining the evidence on their effects on cost and quality measures, we considered other implications for the Medicare population—including effects on individuals’ access to care, and patients’ and family caregivers’ experiences. We chose innovations that represent a variety of approaches and span a wide range of Medicare services, excluding prescription drugs.

We categorized these promising innovations into three groups (for a summary, see box 1):

- **Group 1: Innovations with evidence of success.** Innovations in this category have demonstrated significant success in improving quality of care, yielding savings for Medicare, or both. We expect that innovations in this group could yield broad benefits to both consumers and the Medicare program if expanded.
- **Group 2: Innovations with early evidence of success.** This group consists of innovations with limited, early evidence of success, and about which we are optimistic. These innovations have shown early benefits for consumers and, in some cases, savings for Medicare. Given the limited amount of evidence so far, further experience and evaluation will be valuable in assessing the effects of these innovations in greater depth. Nevertheless, we expect that expanding the innovations in this category could produce greater benefits for consumers and Medicare.
- **Group 3: Innovation for which we are cautiously optimistic.** The one innovation in this category has some evidence of success in producing savings while not affecting quality, but we do not yet fully understand its effects on consumers and quality. It will require more thorough evaluation to examine concerns about its implications for consumers and may also need further development to achieve its potential.

## BOX 1

### At A Glance: Promising Innovations in Traditional Medicare

#### GROUP 1

#### INNOVATIONS WITH EVIDENCE OF SUCCESS

- Independence at Home: Comprehensive in-home primary care for people with high needs
- Community-Based Care Transitions Program: Partnerships between community-based organizations and hospitals to improve post-hospital transitions
- Competitive bidding for durable medical equipment
- Payment models for Accountable Care Organizations (ACOs)

#### GROUP 2

#### INNOVATIONS WITH EARLY EVIDENCE OF SUCCESS

- New payment codes for transitional care management, chronic care management, and other services that support coordinated care
- Comprehensive primary care services that support coordinated care

#### GROUP 3

#### INNOVATION FOR WHICH WE ARE CAUTIOUSLY OPTIMISTIC

- “Bundled” payment for specified episodes of care

## Promising Innovations: What's the Context?

The Centers for Medicare & Medicaid Services (CMS) has long used its authority to try out new payment models through Medicare demonstrations and other pilot programs. These real-world experiments test new policy approaches without permanently changing the program. Medicare typically implements demonstrations on a limited basis—in a specific geographic area, for specified groups of Medicare providers or patients, and for a limited duration.

Over the past decade, Medicare has been testing ways of giving providers both financial incentives and new flexibility to change how they deliver care, with the goal of improving coordination and quality, reducing unnecessary or duplicative services, and focusing on outcomes important to patients and their families. Most of the promising innovations highlighted in this report build on the traditional Medicare program by tying a portion of payments to health care providers to quality of care and savings.<sup>6</sup>

## Group 1: Innovations with Evidence of Success

This category includes four innovative ways of paying for and delivering care in Medicare that have demonstrated significant success in improving quality of care, yielded savings for Medicare, or both. The evidence to date suggests that if they became widely adopted, innovations in this category could yield broad benefits to consumers and to the Medicare program.

### 1. Independence at Home: Comprehensive In-Home Primary Care for People with High Needs

#### *What Is It?*

Since 2012, the Independence at Home demonstration has been testing whether providing comprehensive primary care services at home for individuals with very high health care needs leads to better health outcomes, improved patient and caregiver satisfaction, and lower Medicare

costs than usual primary care services, which are typically not delivered at home.<sup>7</sup>

Under the program, participating medical practices provide comprehensive in-home primary care services to Medicare patients with multiple chronic conditions, who need a substantial level of assistance with basic activities (e.g., bathing, transferring from a bed to a chair) and who voluntarily join an Independence at Home medical practice.<sup>8</sup> Under the demonstration, multidisciplinary care teams led by primary care physicians or nurse practitioners provide in-home visits tailored to individuals' needs and preferences.<sup>9</sup> Participating medical practices are expected to coordinate patients' care, offer access to their providers at all times (e.g., by phone), and deliver patient-centered care. In theory, such home-based care allows clinicians to spend more time with their patients and to provide continuous and comprehensive care that reduces the risk for costly preventable hospital stays, readmissions, or emergency department visits.

Currently, there are 13 medical practices and 1 consortium participating in Independence at Home across the country (see figure 1).<sup>10</sup> Starting in 2019, total enrollment across all medical practices in Independence at Home is capped at 15,000 individuals.<sup>11</sup>

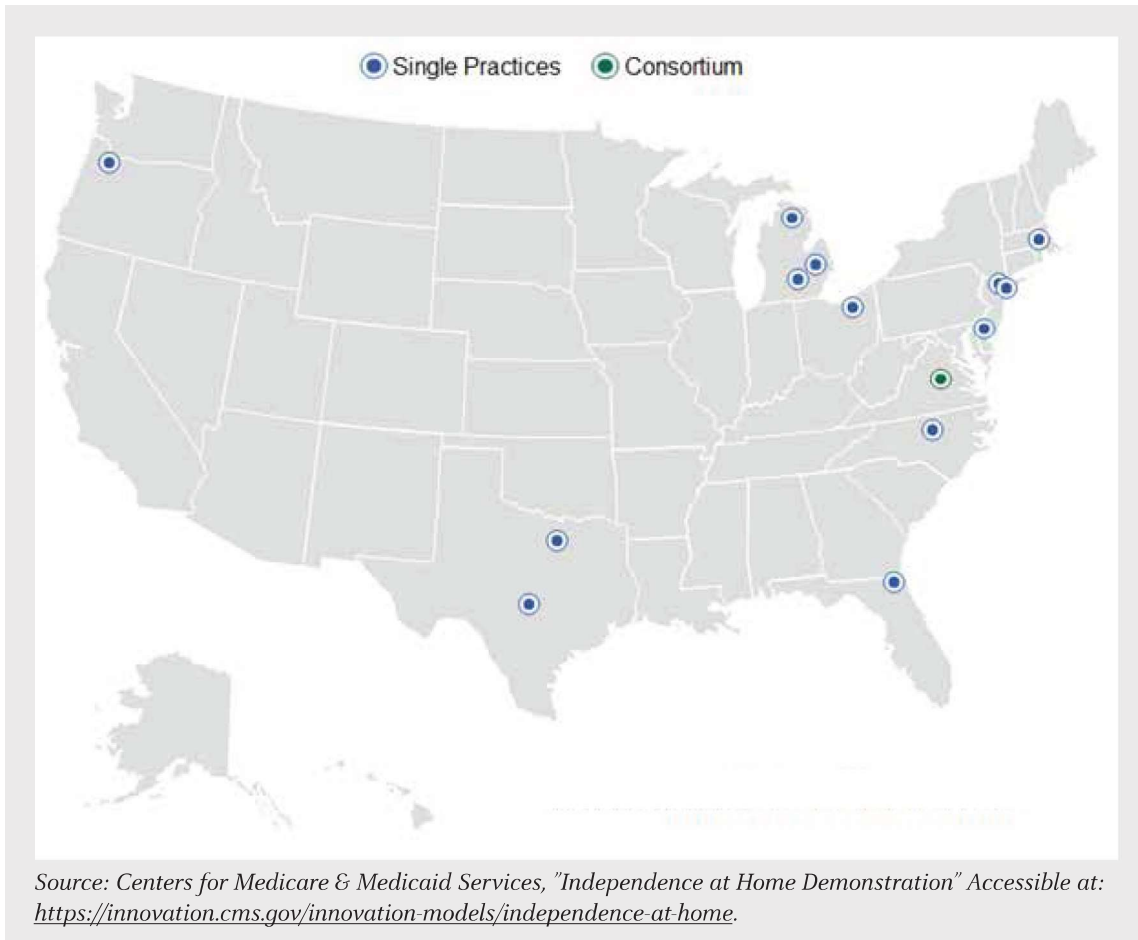
Medical practices that participate in the demonstration can receive a share of the savings, if any, that they generate by providing care at a lower cost than would be expected without the demonstration (that is, lower than a benchmark).<sup>12</sup> To receive this incentive payment, participating providers must also meet required standards for a set of quality measures.<sup>13</sup>

#### *What Are the Results So Far?*

Medicare's Independence at Home demonstration has been a successful program, with some evidence of savings, improved quality of care, and high levels of satisfaction among participating patients and their family caregivers.

Annual CMS evaluations found that over the first five years of the demonstration (2012–2017), the total cost of services (before accounting for incentive payments) for individuals in Independence at Home

FIGURE 1  
Practices Participating in Independence at Home, 2020



was about \$116 million lower than the benchmark, or an average cost reduction of \$2,142 per person.<sup>14</sup> Overall, service costs were 5 percent to 9 percent lower than the benchmark between the program's third and fifth years (corresponding figures for years one and two are not available).<sup>15</sup>

Other evaluations using an alternative approach that compared participating providers' Medicare expenditures to what their spending would have been without the demonstration found similar cost reductions. One such study shows cumulative savings in service costs of \$25 million over the first three years of the pilot (an average \$111 or 2.5 percent reduction per person, per month).<sup>16</sup> Another evaluation found that Independence at Home may have reduced service costs by \$50 million over its first four years (an average \$161

or 4 percent reduction per person, per month).<sup>17</sup> Medicare expenditures for people enrolled in Independence at Home generally decreased more over time, ranging from -\$120 (2 percent reduction) in 2012 to -\$282 (6 percent reduction) in 2016.

Even after accounting for incentive payments to providers, Independence at Home has generated notable savings. During its first five years, the program generated total net Medicare savings (taking into account service costs and incentive payments) relative to the benchmark of \$77 million (averaging \$1,421 per person).<sup>18</sup>

Reductions in service costs for people enrolled in Independence at Home partly reflect lower use of some types of hospital care. For example, participants had fewer preventable hospital



admissions (estimates range from -7 percent to -8 percent), fewer unplanned readmissions (estimates range from -9 percent to -11 percent), fewer emergency department visits (-4 percent), and fewer emergency department visits leading to hospitalizations (estimates range from -6 percent to -7 percent). Medicare also spent notably less on durable medical equipment (-15 percent) for people enrolled in Independence at Home.<sup>19</sup>

During the first five years of the program, participating providers generally performed well on the demonstration's quality of care standards. A relatively large subset of providers even met the performance thresholds for all six quality measures.<sup>20</sup> The vast majority of patients and their family caregivers were highly satisfied with the program—with 93 percent of them reporting being satisfied or very satisfied with the overall quality of care they received from their Independence at Home practice.<sup>21</sup> Generally, participants and family caregivers found the program accessible, reported that clinicians took their opinions and goals into account, and said that they did not have trouble obtaining in-home care when needed.

### ***How Consumers and Medicare Could Benefit***

The Independence at Home demonstration could benefit many individuals with high needs and their family caregivers through improved care. A recent study estimated that if Medicare expanded Independence at Home nationwide, up to 2.4 million people with a similar health profile as people currently in the pilot program could receive comprehensive in-home primary care visits.<sup>22</sup> Such an expansion would generate estimated Medicare savings (after accounting for the shared savings incentive payments) of approximately \$2 billion to \$11 billion over 10 years. The available evidence suggests Medicare could potentially achieve those savings while improving the quality of care.

A central feature of this innovative health care delivery model is its focus on frail older adults who account for a disproportionately large share of Medicare spending. For this population, leaving home for primary care is difficult and care is fragmented. Independence at Home provides access to comprehensive primary care and to team-based

care, which together can help maintain or improve a person's health and keep them from needing hospital or emergency care. Importantly, Medicare's Independence at Home model focuses on providing person- and family-centered care by recognizing and supporting family caregivers who are critical in providing and coordinating care for their loved ones.

## **2. Community-based Care Transitions Program: Partnerships between Community-Based Organizations and Hospitals to Improve Post-Hospital Transitions**

### ***What Is It?***

The Community-based Care Transitions Program, which ran from 2012 to 2017, focused on reducing hospital readmissions for a high-risk Medicare population, a group that usually incurs high Medicare costs.<sup>23</sup> Under this program, Medicare paid participating community-based organizations that voluntarily partnered with high-readmission-rate hospitals to deliver transitional care services to discharged Medicare patients who were considered to be at high risk for hospital readmission (see box 2).<sup>24</sup> Specifically, each community-based organization received a single, all-inclusive dollar amount to cover transitional care services for a six-month period after hospital discharge for each eligible Medicare participant they served. The ACA mandated the Community-based Care Transitions Program.

Recognizing that many of the drivers of hospital readmission are beyond the walls of the hospital (e.g., medication errors or not receiving sufficient assistance with activities of daily living), this initiative relied heavily on community-based organizations with experience connecting patients and family caregivers to community support services (e.g., Meals on Wheels, transportation). Most of the 101 community-based organizations that participated in the initiative were Area Agencies on Aging and their affiliated Aging and Disability Resource Centers.<sup>25</sup>

### ***What Are the Results So Far?***

Overall, individuals who participated in the Community-based Care Transitions Program had lower 30-day readmission rates and lower Medicare

## BOX 2

**What Are Transitional Care Services?**

In the Community-based Care Transitions Program, each participating community-based organization could select which transitional care services to provide, but participants were required to do at least one of the following:

- Contact the patient no later than 24 hours prior to hospital discharge.
- Provide post-discharge education that was culturally and linguistically appropriate so patients could recognize signs of deterioration in their condition and other health problems if they arose.
- Ensure timely follow-up with ambulatory care and post-acute care providers (e.g., skilled nursing facilities and home health agencies).
- Provide patient-friendly support and information that would help individuals manage their condition.
- Provide comprehensive medication review and education, including appropriate counseling and support to help patients manage their medications.

*Source: Based on CMS, "Community-based Care Transitions Program," webpage, last updated July 27, 2020 <https://bit.ly/2Dvi0yz>.*

spending relative to comparable nonparticipants.<sup>26</sup> Readmissions were 1.8 percentage points lower (14.6 percent versus 16.4 percent). The results suggest the program was associated with about 12,000 fewer readmissions for the approximately 660,000 participating individuals than would have otherwise occurred during the entire program. Medicare spending averaged an estimated \$634 (or about 8 percent) less per person, during the 30 days after discharge, before taking into account the cost of that program (that is, the fees paid to the community-based organizations).

An analysis of the 44 longest-serving sites (that is, combination of hospitals and community-based organizations) found that they successfully improved quality and reduced costs by identifying patients' needs, effectively linking participants with community-based services, and effectively coordinating with post-acute care providers. Specifically, these sites responded to challenges with the provision of support services by identifying new service providers, sources of funding, and ways to connect individuals with appropriate services in a timely manner. These 44 sites (with about

530,000 discharges) had 30-day Medicare spending that averaged \$570 (7 percent) less for people in the program, and a readmission rate that was almost 13 percent less, than would otherwise have been expected based on a comparison group. After taking into account the fees paid to the community-based organizations for the program, net savings averaged \$211 (2.8 percent) per participating individual.<sup>27</sup>

Evaluators did not estimate net Medicare savings—that is, savings after accounting for the cost of the program—for the overall program.

***How Consumers and Medicare Could Benefit***

Despite successes in reducing readmissions and spending, this program was terminated in 2017, at the end of its five-year testing period, without being expanded in the Medicare program. CMS did not provide a specific explanation for this decision. However, because of the structure of the Community-based Care Transitions Program, the evaluators could not attribute net Medicare savings to the program itself. As a result, it appears that this program did not meet a key criterion set for its continuation or expansion; that is, to reduce Medicare spending without reducing quality.<sup>28</sup>

Given the opportunity, this program could be improved in a number of ways, which could enhance its potential impact on people with Medicare, their family caregivers, and the Medicare program. For example, CMS could allow other types of organizations, in addition to community-based organizations, to participate in the program.<sup>29</sup> Providers, such as home health agencies, could deliver transitional care services to reduce hospital readmissions. Another potential improvement would be to add multidisciplinary Community Health Teams (e.g., including nurse coordinators, social workers, counselors, dietitians, health educators, and others), such as those used in Vermont's Multi-Payer Advanced Primary Care Demonstration.<sup>30</sup> The Vermont demonstration used these teams to smooth transitions and reduce readmissions for high-risk patients discharged from hospitals. Vermont placed some of these teams in low-income housing complexes to help identify high-risk, high-need patients and provide them with care coordination and transitional care services as appropriate.

With changes such as those described above, the Community-based Care Transitions Program might very well have a substantial impact on Medicare spending and quality of care.

### **3. Competitive Bidding for Durable Medical Equipment**

#### *What Is It?*

Historically, Traditional Medicare pays durable medical equipment (DME) suppliers using a fee schedule based on updated average industry charges first established in the 1980s. In 2011, CMS implemented competitive bidding in certain geographic areas for many DME items, such as wheelchairs and hospital beds, and, over time, expanded it to 130 designated areas in the United States. Generally, in these areas, only suppliers who are awarded a contract can furnish Medicare-covered DME items at competitively determined prices to people residing in those areas.

Unlike Traditional Medicare's payment method, Medicare's Competitive Bidding Program for DME pays suppliers based on competitive bids. In theory, when forced to compete with each other, one way

DME suppliers can gain a competitive edge is by reducing their costs while maintaining or even improving quality—which can translate into savings and better outcomes for consumers.

Under this payment model, suppliers submit sealed bids to contract with the Medicare program for delivery of a specified set of items. Under the program, a competition is conducted among DME suppliers who operate in a particular geographic area. Suppliers are required to submit a bid for a wide range of items. Some complex DME items, such as ventilators, are not subject to competitive bidding. Bids are evaluated based on the supplier's eligibility, its financial stability, and the bid price. Contracts are awarded to qualified suppliers who offer the best price and meet applicable quality and financial standards.<sup>31</sup>

As required by Congress, starting in 2016, CMS began using information from the competitive bidding program to adjust traditional Medicare's fee-for-service payment rates for certain DME nationwide in areas that had previously not been subject to competitive bidding (known as nonbid areas).<sup>32</sup>

However, in 2019, CMS suspended the program for two years while the agency reviews the bidding process. During this temporary suspension, any qualified supplier will be permitted to furnish DME to Medicare patients and CMS has increased payment amounts for DME items.<sup>33</sup>

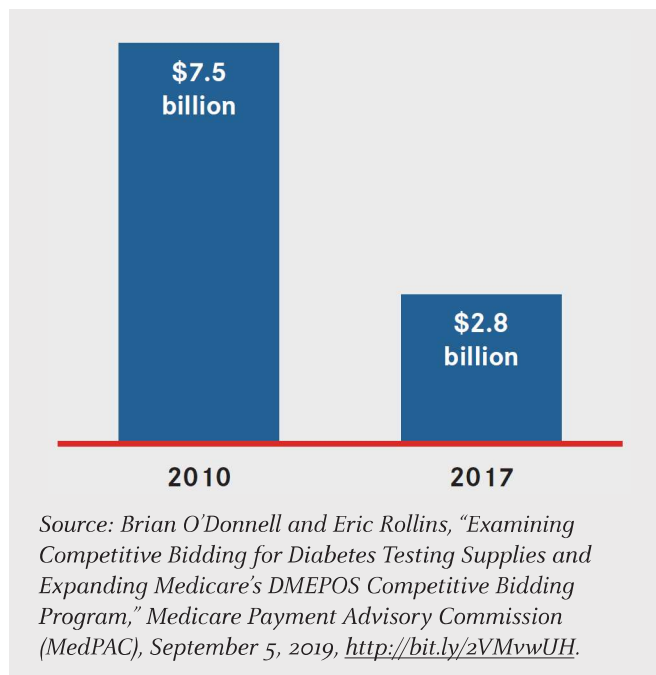
CMS appears to have taken this step in response to industry concerns about the bidding process and the application of competitively set prices to nonbid areas. Hopefully, once CMS completes its review, the competitive bidding program will be re-implemented, which would renew the substantial savings that had been accruing to the Medicare program and individuals.

#### *What Are the Results So Far?*

Competitive bidding has proven successful for DME, according to the Medicare Payment Advisory Commission (MedPAC).<sup>34</sup> Although precise savings figures are not available, CMS estimated that the program would save Medicare almost \$26 billion between 2013 and 2022.<sup>35</sup> In 2017, total Medicare spending on competitively bid DME supplies was

\$4.7 billion less than in 2010 (\$2.8 billion compared with \$7.5 billion; see figure 2) and median payment rates for the 25 highest-spending DME supplies declined by nearly 50 percent.<sup>36</sup> For example, from 2010 to 2017, Medicare's payment rate for diabetic test strips fell from \$33 to \$8.

**FIGURE 2**  
**Medicare Spending on Durable Medical Equipment Before and After Competitive Bidding**



Quality of service, meanwhile, appears to have been maintained. CMS has not detected any changes in health status (i.e., death rates, hospital and nursing home admission rates, monthly hospital and nursing home days, physician visit rates, or emergency department visits) associated with the DME competitive bidding program.<sup>37</sup> Concerns have been raised that some people have experienced difficulty getting prompt access to DME because of competitive bidding. However, the US Government Accountability Office and CMS Ombudsman have characterized consumer complaints as relatively rare.<sup>38</sup>

**How Consumers and Medicare Could Benefit**  
MedPAC has suggested resuming the competitive bidding program for DME and expanding it to

include additional DME items.<sup>39</sup> The success of Medicare's DME competitive bidding program suggests that extending competitive bidding to other Medicare services, such as clinical laboratory services, might yield even more savings for the Medicare program and consumers.

However, competitive bidding also has some disadvantages, such as greater administrative cost for the program and a potential for price collusion among competitors. In addition, competitive bidding in Medicare is a controversial topic that is frequently discussed and much maligned by all sectors of the health care industry, ostensibly due to lower payment rates and reduced profits.

Industry has blocked past efforts to conduct competitive bidding demonstrations for some Medicare services. For instance, during the 1990s, CMS tried unsuccessfully to implement a competitive bidding demonstration for clinical laboratory services that are paid under a fee schedule. Then in 2006, Congress authorized CMS to conduct such a demonstration, and the President's Budget for Fiscal Year 2008 estimated that a clinical lab competitive bidding demonstration could save Medicare more than \$2 billion over five years. (Because Medicare pays the full cost of covered lab services, people with Medicare would not see direct savings on such costs; however, they would benefit from slower growth in Medicare premiums.) Unfortunately, an industry lawsuit blocked implementation of the demonstration in 2008.

#### 4. Payment Models for Accountable Care Organizations

##### *What Is It?*

Since 2012, Medicare has been testing new ways to pay groups of health care providers that voluntarily join together to form an accountable care organization (ACO).<sup>40</sup> The providers who participate in a Medicare ACO are collectively responsible for the total cost and quality of Medicare services for the patients CMS attributes to the ACO.<sup>41</sup>

In most models, Medicare ACOs receive a portion of any savings they generate by keeping Medicare spending below a specified benchmark<sup>42</sup>—without any penalties for spending over the benchmark



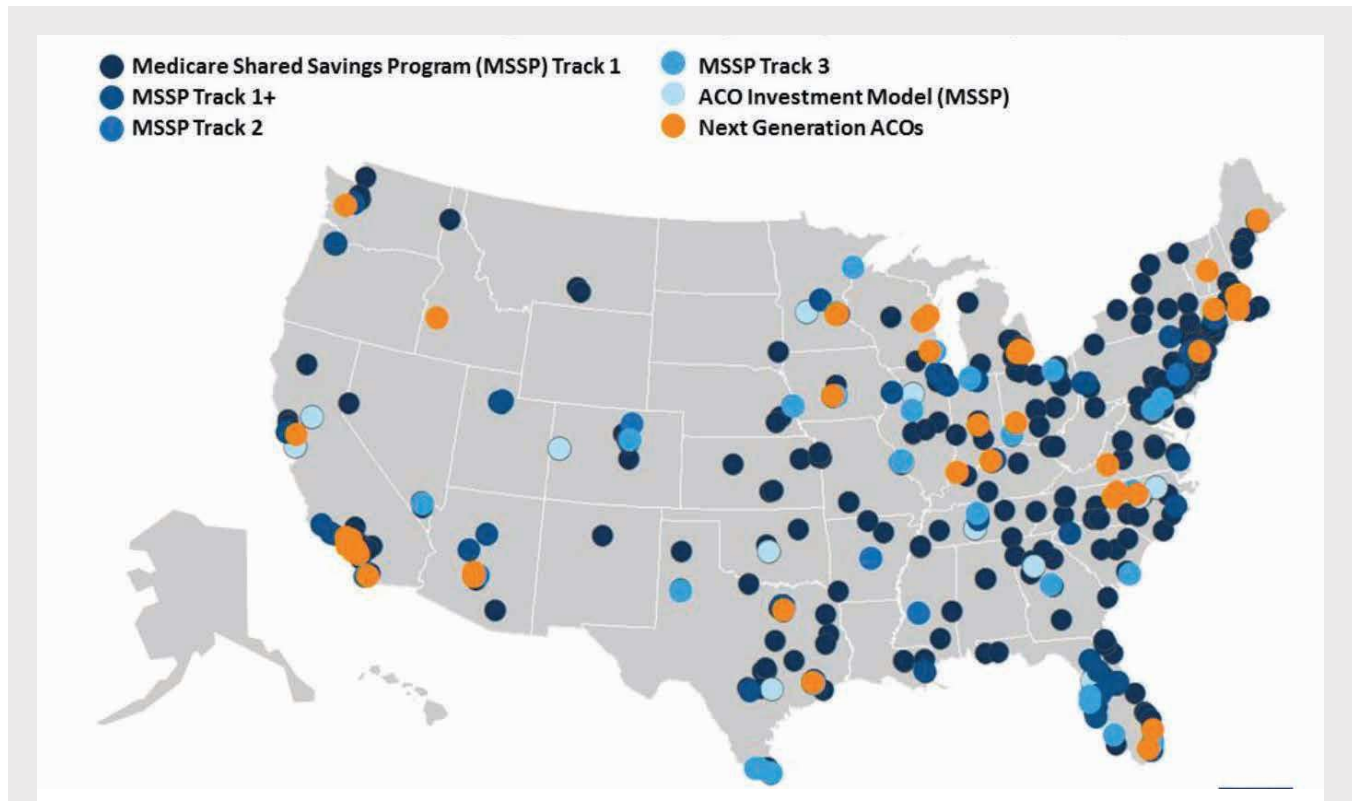
(this type of ACO is therefore known as “one-sided risk” ACOs). In other models, ACOs can share in any savings but must also return money to CMS if their spending exceeds the benchmark (“two-sided risk” ACOs). All ACOs are held to a set of quality metrics that affect their potential bonus payment.<sup>43</sup>

The premise of ACOs is that when providers are collectively responsible for meeting cost and quality targets, they are more likely to collaborate to reduce unnecessary tests, duplicative services, and medical errors. ACOs’ financial incentives are expected to encourage providers to invest resources in figuring out ways to improve cost-effectiveness and better coordinate care for patients, including by focusing

on prevention and on improving care coordination for people with multiple chronic conditions. One goal is for clinicians to provide more timely and comprehensive care that will help reduce medical complications and avoidable services, such as preventable inpatient hospital admissions.

CMS has developed several different ACO payment models and is testing them across the country (see figure 3).<sup>44</sup> The first Medicare ACOs were introduced in 2012, when CMS established two programs: the Medicare Shared Savings Program (MSSP), a permanent program that includes the majority of Medicare ACOs, and the Pioneer ACO, a model launched by the Center for Medicare &

**FIGURE 3**  
**Medicare Accountable Care Organization (ACO) Models, 2018**



*Note: ACOs in the MSSP Track 1 are one-sided risk ACOs. The following ACO models are two-sided risk models: MSSP Track 1+, MSSP Track 2, MSSP Track 3, and Next Generation ACOs. The ACO investment model includes both one-sided and two-sided risk models.*

*Source: Kaiser Family Foundation, “8 FAQs: Medicare Accountable Care Organizations (ACOs)”, January 2018 <https://bit.ly/3fSqaQ1>.*

Medicaid Innovation that ended in 2016.<sup>45</sup> Since then, Medicare has added a range of other ACO models, including the Next Generation ACO model in 2016 (scheduled to end in 2020). As of 2018, there were 649 Medicare ACOs across the country, serving 12 million attributed Medicare patients (or about a third of all people in traditional Medicare).

### ***What Are the Results So Far?***

Overall, results to date show that Medicare ACOs generated modest savings while maintaining or improving care quality.<sup>46</sup>

According to MedPAC, in 2016 (the latest year for which comprehensive data are available), overall Medicare spending for ACOs was \$761 million lower (or about 1 percent less) than the benchmark before accounting for any shared savings and penalties.<sup>47</sup> After factoring in shared savings and penalties, ACOs had total net savings of \$48 million in 2016, compared to their spending targets.<sup>48</sup>

In the MedPAC analysis, the types of ACO models that were required to repay Medicare for any losses (that is, two-sided risk models) achieved overall net savings in 2016 (\$119 million total, ranging from 0.4 percent to 2.7 percent of the benchmark depending on the ACO model). In contrast, bonus-only ACO models did not generate overall net savings compared to the benchmark. On the contrary, this type of ACO incurred net Medicare costs of \$72 million (or about 1 percent of benchmark spending).

While the MedPAC study found that bonus-only ACOs had not, overall, yielded net savings for Medicare, another study that used a different analytic method suggested these types of ACOs have achieved some small savings. Specifically, when comparing spending for Medicare patients in ACOs to that for Medicare patients served by non-ACO providers (rather than comparing to the benchmark) the study found that bonus-only ACOs achieved net savings of 0.7 percent in 2014.<sup>49</sup>

Within these overall findings, the results differ among individual ACOs. Generally, an ACO's performance improves significantly with more years of program participation as providers gain experience with the payment model.<sup>50</sup> For

example, a recent evaluation shows that ACOs in the MSSP (most of which are one-sided risk ACOs) collectively performed significantly better over time, achieving overall net savings relative to the benchmark for the first time in 2017.<sup>51</sup> Sixty-six percent of MSSP ACOs had lower costs than the benchmark in 2018, up from 54 percent in 2012–13. Similarly, average per person net savings for MSSP ACOs went from -\$21 in the program's first year to \$73 in 2018.

Overall, ACOs performed well on care quality.<sup>52</sup> They scored as well or better than non-ACO providers on comparable quality measures, including hospital readmission rates, preventive services, and diabetes care. In addition, quality scores generally improved with longer participation in Medicare's ACO programs. In 2016, the overall average quality score was 93 percent (out of a possible maximum of 100 percent) for Pioneer ACOs and 95 percent for ACOs in the MSSP program.<sup>53</sup> Less than 1 percent of MSSP ACOs did not meet the specified quality performance standards required to qualify for shared saving bonuses.<sup>54</sup> Finally, patients in Medicare ACOs generally reported having consistently positive experiences with ACO providers.

### ***How Consumers and Medicare Could Benefit***

Results to date suggest that Medicare ACOs have the potential to improve care quality for many people with Medicare. This payment model also shows promise for patients to receive safer and more appropriate care that fosters their and their family caregivers' involvement in making care decisions. A key feature of this innovation is that it encourages health care providers to work together as a team to deliver higher-value care.

Although the evidence on overall savings for the Medicare program is mixed, some ACO models have generated notable savings and others have shown improved savings results in more recent years, as individual ACOs gained experience. Further, ACOs could also generate additional indirect savings that evaluations to date do not usually account for. These may include spillover savings from Medicare patients who are not formally attributed to the

ACO but may nonetheless benefit from the ACOs' improved care efficiencies.

To date, the evidence on ACOs suggests that policymakers should prioritize two-sided risk models as a means of promoting greater care efficiency, quality, and value in Medicare—since those models have, on the whole, yielded larger net savings than the one-sided risk models that let Medicare ACOs share in any savings without taking on potential loss. In doing so, an important challenge will be to ensure that health care providers are not discouraged from participating in Medicare ACO models that require shared losses—for example, by offering ACO providers enough time and flexibility to develop the infrastructure they need (e.g., clinical staff and other professionals with the appropriate skill sets, health information technology).

As Medicare continues to test payment models for ACOs, it will be critical for policymakers to closely monitor the impact on individuals, and to ensure that ACO incentives are not having negative outcomes for consumers. For instance, ACOs may have an incentive to seek to have a healthier and less costly group of patients attributed to them, since doing so may increase the ACOs' likelihood of shared savings.<sup>55</sup> Policies should ensure that the entire Medicare population can benefit from the care improvements associated with ACOs.

Another concern has to do with ensuring individuals' access to needed care. Researchers have pointed out that, in practice, ACOs' savings have not primarily resulted from better care coordination and improved outpatient management for chronic conditions (or from associated lower inpatient spending).<sup>56</sup> Instead, the major drivers of program-wide savings so far have been reductions in the use of post-acute care services such as skilled nursing facilities, hospital outpatient care, and home health care. Early evidence points to ACOs reducing this type of care where it is overused or unnecessary, without deterioration in the quality of care.<sup>57</sup> Policy makers should ensure that ACO quality standards are robust enough to safeguard against ACO providers discouraging individuals' access to needed health care services.

## Group 2: Innovations with Early Evidence of Success

The second group consists of innovations with limited, early evidence of success, and about which we are optimistic. These innovations have shown early benefits for consumers and, in some cases, produced savings for Medicare. Given the limited amount of evidence so far, further experience and evaluation will be valuable in assessing the effects of these innovations. However, we are hopeful that expanding innovation in this category could produce greater benefits for consumers and Medicare.

### 5. New Payment Codes for Transitional Care Management, Chronic Care Management, and Other Services that Support Coordinated Care

#### *What Is It?*

To improve patient care, Medicare now allows doctors, nurse practitioners, and other clinicians to bill the program for a variety of activities supporting more coordinated and consistent care. Specifically, Medicare has added several new payment codes to the fee schedule that physicians, nurse practitioners, and other clinicians use to receive payment from Medicare. These new codes are intended to encourage clinicians to provide various types of care management that benefit patients but are currently underprovided. All eligible clinicians nationwide may provide and bill Medicare for these services.<sup>58</sup>

The first area of focus in the new billable services is transitional care to improve the safety and continuity of care for individuals who move from a hospital or skilled nursing facility to home or other community setting, such as an assisted-living residence.<sup>59</sup> To receive payment for Transitional Care Management, an eligible clinician takes responsibility for the patient's care for a 30-day period beginning when the person is discharged from a facility. Transitional Care Management requires that the clinician contact the patient within two business days of discharge and meet with the patient in person within one or two weeks after

discharge, along with other in-person and “non-face-to-face” (that is, outside an office visit) services. Transitional Care Management has been a billable service since 2013.

A second area of focus is care management activities that take place outside of office visits, such as developing a comprehensive plan of care and communicating with other providers involved in a patient’s care. Starting in 2015, Chronic Care Management has been a billable service that allows primary care and other eligible providers to receive a monthly payment for non-face-to-face care management activities for eligible patients.<sup>60</sup> To be eligible, patients must meet certain criteria indicating a substantial need for care management, such as having multiple serious chronic conditions, and agree to participate.<sup>61</sup>

To receive payment for Chronic Care Management, a medical practice must give patients (and family caregivers, as appropriate) a way to reach a doctor or other professional in the practice at any time for urgent needs. They must also support continuity of care by ensuring a patient can meet with the same clinician for routine appointments.

Other billable care management services, added between 2016 and 2018, include advanced care planning, integration of behavioral health, cognitive assessment and care planning services, and remote patient monitoring. Starting in 2019, new billing codes are available for additional electronic-based services designed to enhance care management. These services are virtual patient-clinician check-ins, asynchronous video image review and storage, inter-professional consultations (that is, provider-to-provider electronic consultations), and chronic care remote physiologic monitoring.<sup>62</sup>

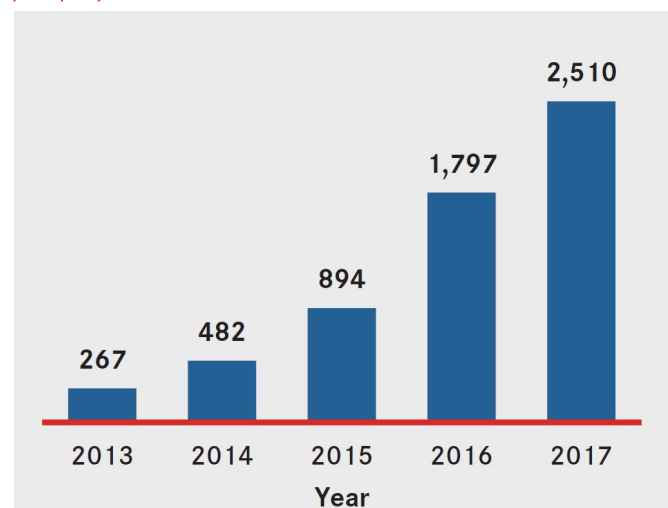
### What Are the Results So Far?

The number of people receiving care management services under these new payment codes has grown steadily. A 2019 report by the Government Accountability Office examined a set of Medicare care management services consisting of Transitional Care Management, Chronic Care Management, Advanced Care Planning, and Behavioral Health Integration.<sup>63</sup> The number of people who received at least one of these four types of services increased

from about 267,000 in 2013 to about 2.5 million in 2017—about 4 percent of the Medicare population (see figure 4). The number of people who could potentially receive these services is much larger, however. For example, a study of Medicare’s Transitional Care Management service found that, in 2015, only about 1 in 14 people eligible for this service received it.<sup>64</sup>

As far as we are aware, published evaluation findings are available for only two of the new billable services: Transitional Care Management and Chronic Care Management. A study of the first three years in which Transitional Care Management has been available (2013–15) found that it was associated with lower mortality and lower Medicare costs during the month that followed the month in which Transitional Care was received.<sup>65</sup> For patients receiving Transitional Care Management, average

**FIGURE 4**  
**Number of People Receiving Medicare Care Management Services, 2013–17** (in thousands of people)



*Note: Figure shows the number of unique individuals who received at least one of the following services: Transitional Care Management, Chronic Care Management, Advance Care Planning, and Behavioral Health Integration.*

*Source: US Government Accountability Office, Medicare Physician Services: Spending On and Use of Billing Codes for Comprehensive Care Planning Services, Report to Congressional Committees (Washington, DC: GAO, July 2019).*



Medicare costs were about \$325, or about 10 percent, less during the subsequent month, than for a comparison group of patients who did not receive these services.

For Chronic Care Management, an evaluation of its first two years (2015–16) found positive effects for individuals (such as less need for hospital services), as well as savings for Medicare.<sup>66</sup> People receiving Chronic Care Management had lower Medicare spending for inpatient hospital, skilled nursing facility, and some outpatient services. While they also had higher use of Medicare home health care and some other outpatient procedures, the costs of these services were more than offset by the savings from others. Clinicians interviewed for the evaluation said they were better able to support staff members who could connect patients with supportive services, such as personal care at home.

Medicare spending grew more slowly over time for people who had received Chronic Care Management than for a comparison group of people with similar health and other characteristics over 12-month and 18-month follow-up periods. Chronic Care Management reduced monthly per-person Medicare spending by an average of \$28 (or about 1.8 percent) over 12 months, before taking into account the fees Medicare paid for Chronic Care Management. The monthly per-person reduction was even greater over 18 months—\$74 (or about 4.6 percent).<sup>67</sup> In contrast, for a six-month follow-up period, the evaluation found no statistically significant effect on spending, suggesting that it may typically take several months before savings result.

These savings more than outweighed the fees paid to clinicians for Chronic Care Management.<sup>68</sup> In percentage terms, Medicare's spending for people receiving Chronic Care Management—after accounting for the Chronic Care Management fees—was about 0.7 percent lower over 12 months than it otherwise would have been.<sup>69</sup> Medicare's total savings over 18 months were not estimated by the evaluators, but the percentage savings would be larger than for 12 months, based on the larger average monthly savings amount described above.

An important finding is that while individuals received Chronic Care Management for an average of six months, savings from their lower use of hospital and other services occurred over longer periods. These results suggest consumers gained longer-lasting benefits from a period of care management services, which helped them avoid the need for hospital services.

### *How Consumers and Medicare Could Benefit*

A major goal of the new billing codes for coordinated care services is to encourage doctors and other health care professionals to redesign and transform their practices so they are better able to support patients and family caregivers. The idea is that resources generated from billing for these services will enable practices to invest in enhancements, such as making e-mail communications available and hiring staff members to help coordinate supportive services such as personal care at home, physical therapy, and transportation services. They will also encourage clinicians to allocate more of their time to activities patients value, such as communicating with other clinicians involved in a person's care.

If adoption of Transitional Care Management, Chronic Care Management, and other new billable services continues to expand, numerous people with Medicare could benefit. Further, the reach is likely to go beyond the individuals directly eligible for the specific services—such as Chronic Care Management—because other patients may also benefit if medical practices change their care processes and staffing to better address patients' care management needs.

The evaluation results for Transitional Care Management and Chronic Care Management show both quality improvements for consumers and savings for Medicare. As the use of these and other new billable care coordination services grow, additional studies will be needed to assess their effects on consumers and on Medicare spending. Future studies should also examine the reasons some clinicians do not offer care management services and the factors that can encourage more clinicians to offer them.<sup>70</sup> In addition, evaluators should consider factors that may affect consumers'

awareness of, and willingness to participate in, optional care management services, such as whether waiving patients' cost sharing for Chronic Care Management would encourage more individuals to participate.

## 6. Comprehensive Primary Care

### *What Is It?*

In the Comprehensive Primary Care Plus (CPC+) initiative, which began in 2017, as in the earlier Comprehensive Primary Care (CPC) initiative, CMS is testing a model designed to improve the quality and cost-effectiveness of primary care. A key feature of these initiatives is that Medicare is partnering with other payers (such as private insurance plans and state Medicaid programs) to give primary care practices financial support and incentives to transform their practices to better meet patients' needs.<sup>71</sup> For example, practices could use the enhanced financial support to offer round-the-clock phone access to a medical professional in the practice, or to hire staff to help patients arrange services such as transportation or physical therapy.

To support such transformations, Medicare and the other participating payers agree to pay primary care practices a monthly amount per patient for care management. These amounts are in addition to what they pay for the specific services patients receive during visits. Medicare and most other payers also offer additional payments to reward performance based on certain quality and cost measures.<sup>72</sup> Practices are expected to stay in the program for five years.

CPC+ began in January 2017 in 14 regions across the United States, expanding to 18 regions in 2018.<sup>73</sup> In 2018, about 2,900 practices and 56 payers (plus Medicare) participated.<sup>74</sup> These practices served about 15 million patients, including more than 2 million people with Medicare.<sup>75</sup> In comparison, the earlier CPC initiative, which ran from 2012 through 2016, was much smaller. It was available in seven regions and included about 500 practices, which served about 3 million patients, including 300,000 with Medicare.<sup>76</sup>

Building on lessons learned from the earlier initiative, CPC+ has higher standards that practices

must meet to participate, which are intended to speed the time it takes for practices to achieve the performance goals for improving quality and cost-effectiveness. The newer initiative also has larger payments for care management, so practices receive more financial support.<sup>77</sup>

CPC+ requires participating practices to meet several objectives considered important for comprehensive primary care. Examples include providing access to timely care; managing care, including documenting a patient's goals in a care plan; and supporting patients and caregivers in managing the patient's health conditions (see box 3).

### *What Are the Results So Far?*

To date, only two years of evaluation evidence is available for CPC+.<sup>78</sup> The evaluators found that participating primary care practices made meaningful changes in how they delivered care during the first two years of the initiative and planned further changes in the upcoming years. They found a few small differences in service use and quality measures between the Medicare patients in participating practices and a comparison group, suggesting CPC+ led to some small improvements in care. Specifically, individuals in the initiative had slightly fewer emergency department visits, slightly larger gains in certain recommended preventive services, and slightly higher use of hospice services than those in the comparison group. The study found no statistically significant effects in the first two years on hospital use or hospital readmissions.

The evaluation found Medicare spending for services was about the same for participating practices and nonparticipating practices. When Medicare's enhanced payments were included, total spending was about 2 to 3 percent higher for the participating practices than for the comparison group during the first two years of the initiative. The evaluators explained that they had not expected to see Medicare savings after only two years of the five-year model, given the complexity of primary care transformation, and that it is too soon to draw conclusions about the longer-term effects of the CPC+ initiative.

## BOX 3

### Transformation Objectives in Comprehensive Primary Care Plus (CPC+) Initiative

- **Access and continuity.** To meet the access objective, practices need to ensure patients can receive timely care. For example, a practice could ensure that patients have telephone access to a clinician in the practice at all times. To achieve continuity, practices must provide an ongoing relationship over time between the patient and a team of professionals.
- **Care management.** Practices need to provide short-term and long-term management of a patient's health care, including documenting the patient's goals and preferences in a care plan.
- **Comprehensiveness and coordination.** For this objective, practices must meet the majority of a patient's medical care needs (comprehensiveness). They must also assist patients and family caregivers with care coordination, such as identifying and communicating with specialists, assisting with care transitions among settings, and following up after hospital stays or emergency care.
- **Patient and caregiver engagement.** To meet this objective, practices need to support individuals and family caregivers in managing health conditions. They also need to involve patients and family caregivers in practice improvement.
- **Population health.** For this objective, practices need to organize care delivery to meet the needs of the total population of patients seen by the practice. For example, practices may use data on quality and outcomes to improve their services.

Source: Based on Deborah Peikes et al., Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report (Princeton, NJ: Mathematica Policy Research, April 2019).

An evaluation of the earlier CPC initiative suggested it had a small positive effect on quality and no overall effect on Medicare spending. The evaluation found emergency department visits were lower for patients in the initiative than in the comparison group; however, for all other quality and patient experience measures, there were no statistically significant differences. The CPC initiative generated lower spending for services, but, after including management fees, did not affect total Medicare expenditures.<sup>79</sup>

#### *How Consumers and Medicare Could Benefit*

By encouraging primary care practices to invest in transformation activities that enhance care coordination, management of chronic conditions, and timely access to primary care, the CPC+ initiative has the potential to improve the quality of care and experiences of patients and their families, as well as to improve cost-effectiveness (for example, by reducing the need for emergency department visits). A strength of this model is the partnership between Medicare and other payers to promote and support comprehensive primary care. The potential reach of primary care transformation is large and would extend beyond the Medicare population.

Further experience with the model and evaluation, however, will be needed to gauge its effects. The earlier CPC initiative produced small improvements in quality of care with no overall effect on Medicare spending. By building on the lessons learned from the earlier initiative, the current CPC+ initiative has the potential to yield greater gains for consumers and payers. In its first two years, CPC+ generated some small improvements in quality of care. As the evaluators pointed out, transformation takes time, so it is not surprising to see only small gains so far. More time and further evaluation are needed to measure this multipayer model's full potential.

### Group 3: Innovation for Which We Are Cautiously Optimistic

The one innovation in this category has some evidence of success in producing savings while not affecting quality; however, at the same time, we do not yet fully understand its effects on consumers and quality. It will require more thorough evaluations to examine concerns about its implications for consumers and may also need further development to achieve its potential.

#### 7. “Bundled” Payment for Specified Episodes of Care

##### *What Is It?*

“Bundled” payment refers to a single, comprehensive payment or benchmark amount that covers multiple health care services and items a patient receives during an episode of care. The underlying idea is that bundled payment gives providers a financial incentive to control the resources used in each episode, because they can earn rewards if their costs are less than a certain amount (either the episode payment or a benchmark amount, depending on the model design) and are at risk for potential losses if their costs exceed a certain amount. Medicare adopted a form of bundled payment for inpatient hospital episodes in the mid-1980s, when it began to pay hospitals a specified amount based on the patient’s diagnosis and major treatment decisions, rather than on the specific services the patient received during the stay.<sup>80</sup>

Building on this approach, recent Medicare initiatives are testing various bundled payment models. Most of the models are based on episodes that include a hospital stay along with a specified period of time after discharge, and encompass certain other providers’ services in addition to the hospital’s services. To earn financial rewards, participating organizations must meet certain quality requirements, in addition to meeting cost criteria. The Medicare program can potentially save money when the total payment for an episode is lower than what Medicare would have paid without bundling.

Medicare’s Bundled Payments for Care Improvement initiative, which ran from 2013 to 2018, consisted

of four bundled payment models that varied in the range of services included in the bundle. Participation by providers was voluntary. The most widely adopted and studied model, known as Model 2, bundled inpatient hospital services and post-acute services (such as skilled nursing facility and home health care) for up to 90 days after hospital discharge.<sup>81</sup> Participating organizations chose the types of episodes for which they received bundled payment from a total of 48 medical and surgical episodes, such as heart attack, stroke, cardiac surgery, and hip or knee replacement surgery.

CMS is continuing to test voluntary participation in bundled payment with the Bundled Payments for Care Improvement Advanced initiative, which began in October 2018. In this program, participating organizations can choose from 31 inpatient medical and surgical episodes, which are similar to those in the previous version, plus 4 outpatient episodes.<sup>82</sup>

A third bundled payment initiative is testing mandatory participation by hospitals as well as voluntary participation. In the Comprehensive Care for Joint Replacement (CJR) model, begun in 2016, Medicare is testing episode payment specifically for elective hip and knee replacement surgeries.<sup>83</sup> The episode begins with a patient’s admission to the hospital and continues for 90 days after discharge. The bundled payment covers hospital, physician, and other professional services, plus any post-acute care during the episode.

Medicare is testing the CJR model in 67 selected metropolitan areas across the nation. Originally, nearly all hospitals in these 67 metropolitan areas were required to participate. After the first two years, mandatory participation was scaled down to 34 metropolitan areas, with hospitals in the other 33 metropolitan areas given the choice of whether to continue to participate voluntarily.<sup>84</sup> When a hospital participates, the bundled payment applies to all Medicare patients who undergo the covered knee and hip procedures in that hospital. The initiative’s design enables evaluators to compare the impacts of mandatory and voluntary participation designs. The CJR initiative is scheduled to run through 2020.



### What Are the Results So Far?

The Bundled Payments for Care Improvement initiative and the CJR model have been studied in several evaluations, with broadly similar findings. For the newer Bundled Payments for Care Improvement Advanced initiative, there are no published findings so far of its effects on consumers or Medicare spending.<sup>85</sup> The information available to date indicates that more Medicare patients have received services covered by the Bundled Payments for Care Improvement initiative than the CJR. During its first four years, the Bundled Payments for Care Improvement initiative covered more than 1 million episodes (see table 1). In comparison, CJR covered nearly 150,000 episodes in its first two years. Evaluations of Model 2 in the Bundled Payments for Care Improvement initiative found that it achieved some savings for the Medicare program for many, but not all, types of episodes. In particular, studies found Medicare savings occurred for lower extremity (that is, hip and knee) joint replacement

surgeries but not for the medical conditions or other types of surgery they examined.<sup>86</sup> Savings were generated primarily by reducing spending on post-hospital care—mainly through less use of skilled nursing facility services.<sup>87</sup>

Despite lower spending on services for many types of episodes, overall, Medicare incurred net losses on the Bundled Payments for Care Initiative during its first three years, after taking into account reconciliation payments to participating providers.<sup>88</sup>

With respect to quality, evaluations of Model 2 have not found evidence of adverse effects for patients, as measured by emergency department visits, unplanned hospital readmissions, mortality, or complications related to hip or knee surgery (among patients with those surgeries).<sup>89</sup> Evaluations also found no gains in quality, based on these measures, though one study found some modest gains in patient-reported outcomes, including satisfaction.<sup>90</sup>

A recent study that focused on hip and knee joint replacement surgery—the most common types

**TABLE 1**  
**Number of Patient Episodes in Two Medicare Bundled Payment Initiatives**

Initiative	Number of Episodes
<b>Bundled Payments for Care Improvement,</b> total models 2-4 (years 1-4, October 2013-September 2017)	1,092,800
<b>Model 2</b>	990,500
<b>Model 3</b>	88,700
<b>Model 4</b>	13,600
<b>Comprehensive Care for Joint Replacement (CJR),</b> total (years 1-2, 2016-17)	147,900

*Notes:* Number of episodes are rounded to the nearest 100. For Models 3 and 4, episodes are for October 2013–December 2016. Model 2 episodes cover the hospital stay plus post-acute and related services for up to 90 days after hospital discharge. Model 3 episodes cover post-acute services only for up to 90 days after hospital discharge; Model 4 episodes cover all services furnished by hospital, physician, and other providers during a hospital stay. In Model 1 (not shown), the episode consists of the hospital stay and covers hospital services only.

*Sources:* Center for Medicare & Medicaid Innovation, CMS, “Findings at a Glance: Bundled Payment for Care Improvement (BPCI) Initiative, Models 2-4, Evaluation Years 1 through 4 (through September 30, 2017),” accessed September 10, 2020, <https://innovation.cms.gov/data-and-reports/2020/bpci-models2-4-fg-yr6>; Center for Medicare & Medicaid Innovation, CMS, “Findings at a Glance: Bundled Payments for Care Improvement (BPCI) Initiative, Models 2-4, Evaluation Years 1 through 3 (through December 31, 2016),” accessed August 3, 2020, <https://innovation.cms.gov/bpci2-4-fg-evalyrs1-3.pdf>; Center for Medicare & Medicaid Innovation, CMS, “Findings at a Glance: Comprehensive Care for Joint Replacement (CJR) Model, Evaluation of Performance Years 1 and 2 (2016–2017),” accessed August 3, 2020, <https://innovation.cms.gov/files/reports/cjr-fg-secondannrpt.pdf>.

of episodes in the Bundled Payments for Care Improvement initiative—found that over a three-year period, participation in the initiative was associated with a 1.6 percent decrease in Medicare spending, or about \$662 per person, for the episode, compared with episodes that were not covered by the initiative.<sup>91</sup> The study found no differences in four measures of quality: mortality, unplanned hospital admission, emergency department visits, and complications related to the surgery.

Early results from the CJR program are similar to those from the Bundled Payments initiative. One evaluation of the first two years of CJR found a small reduction in spending per episode for both hip and knee replacement surgeries, with no increase in complications.<sup>92</sup> Spending for services was about 3 percent lower, on average, mostly because of reduced spending for post-acute services. Because bonuses paid to hospitals offset most of these savings, overall savings to the Medicare program were less than 1 percent.

A second evaluation of CJR found spending decreased 3.7 percent during the first two years.<sup>93</sup> After taking bonus payments into account, savings to Medicare were estimated to be about 0.5 percent; however, because there was a wide range for this estimate, the authors concluded that savings were likely but not certain. The study overall found quality of care was unaffected. CJR patients and a comparison group of patients experienced similar improvements in functioning and pain over the period from before surgery to the end of the episode, and similar levels of satisfaction with their overall recovery and care. However, after returning home, people in CJR reported needing slightly more help from a caregiver than people in the comparison group.

Researchers have considered whether the incentives of bundled payment might lead to an increase in the number of episodes or encourage hospitals or physicians to avoid treating patients who are expected to incur high costs. So far, the evidence indicates that bundled payment has not led to a significant increase in volume.<sup>94</sup>

However, evaluations suggest that in both the Bundled Payments for Care Improvement and CJR initiatives, providers may have shifted their patient

mix somewhat, so patients receiving covered hip and knee surgeries were healthier on average.<sup>95</sup> This could occur if less-healthy patients are steered away from elective surgery or steered to other, nonparticipating, hospitals. For example, surgeons who practice in both participating and nonparticipating hospitals might steer their less-healthy patients to nonparticipating hospitals.<sup>96</sup> If such a shift has occurred, then at least some of the observed decrease in average costs may have been because of a healthier mix of patients. A recent study of joint replacement surgery in the Bundled Payments for Care Improvement initiative estimated that about one-fourth of the savings was due to a change in patient mix.<sup>97</sup>

#### ***How Consumers and Medicare Could Benefit***

Evaluation results to date suggest bundled payment for some types of episodes could potentially lower spending without adversely affecting quality of care. However, nearly all studies have examined only a small set of outcome measures, so there is not yet a full picture of the impacts on individuals and their families. In addition, more evaluation is needed to understand for which types of episodes and patients bundling would be appropriate and yield benefits for consumers and Medicare—and when it might not be appropriate. Although quality improvements are possible in theory (for example, bundling could encourage better coordination of care transitions, leading to fewer complications), nearly all studies have found no evidence of quality gains.

The research reveals that the main way organizations have saved money on bundled episodes is by reducing use of skilled nursing facility care after a hospital stay. This has been achieved both through shorter stays in skilled nursing facilities for patients who receive those services, and by more individuals being discharged directly home after a hospital stay, often with Medicare-covered home health care.

More discharges to home could mean better experiences of care for some individuals and families—when appropriate for the individual and their family situation and when they are able to obtain needed, good-quality therapies and medical care. Research has found that historically, the incentives of hospitals have led to more people

being discharged to skilled nursing facility care than was necessary, raising costs for the program and diminishing the experience of care for individuals who would have preferred to go home.<sup>98</sup>

On the other hand, the change in patterns of care and the financial incentives of bundled payment might lead to various problematic outcomes, which research has not yet thoroughly examined. A key concern is that individuals may not receive the right type, intensity, or amount of post-hospital care needed for maximum possible recovery. For example, the amount of post-hospital physical therapy a person receives may contribute greatly to his or her recovery and ability to resume regular activities, but it may have little effect on the quality measures that potentially affect financial rewards, such as avoiding unplanned hospital readmissions.<sup>99</sup> Findings from a recent study underscore these concerns.<sup>100</sup> The authors estimate that if Medicare adopted bundled payment for hip and knee surgeries nationwide, it could lead to significant decreases in therapy services and, thus, to declines in patients' functional gains after surgery, as well as to reductions in quality of life.

In addition, individuals with high or complex needs may especially be at risk of barriers to receiving high-quality care tailored to their individual situation.<sup>101</sup> It is difficult to set an appropriate benchmark for a bundled payment for situations where individuals' needs are complex and uncertain. Further, significant consumer protections are needed to ensure that organizations do not restrict access to appropriate care to individuals as a way to increase their profits.

A third concern is that the shift of care from skilled nursing facility care to home-based care means individuals will have increased reliance on family caregivers and, often, incur higher—and potentially much higher—expenses for assistance at home. While Medicare's home health benefit is designed to provide needed therapy, skilled nursing care, and aide visits, in practice these services are often quite limited.<sup>102</sup> Further, they do not include the home care assistance many people need for safe transfers, such as from bed to chair, or to use the bathroom. For assistance with these routine activities,

individuals will need to rely on family caregivers or, in many cases, pay out of pocket for home care. Expectations on family caregivers can be steep and may include complex medical or nursing tasks (such as giving injections and changing wound dressings) that in a skilled nursing facility or hospital would be carried out by a nurse.<sup>103</sup>

Bundled payment models need further evaluation and development to address these important concerns. It is crucial to measure and monitor a wide range of outcomes, especially those most important to individuals, such as restoring and maintaining functioning and quality of life. For the shift to more home-based post-hospital care to achieve its potential benefits for individuals, the way home health care is provided may need to adapt and improve.<sup>104</sup> Individuals need home health care and other essential services at home that are timely, high quality, tailored to their individual needs and family caregivers, and sufficient to maximize and maintain their recovery and functioning.

## Conclusion

The COVID-19 pandemic has underscored the critical value of a strong Medicare program that people with Medicare can count on to meet their health care needs in a time of crisis. The coverage offered by Medicare has enabled thousands of people to obtain life-saving medical care.

In recent years, traditional Medicare has tested a range of promising innovations in how health care services are paid for and delivered. The seven innovations highlighted in this report have all been evaluated, but they vary in the extent of their evaluations to date (see table 2 for a summary of the seven promising innovations). Some innovations show evidence of reducing program spending while maintaining or improving quality of care. In other cases, they have shown potential for success in improving quality and producing savings, but so far, have only early, limited evidence of achieving those goals. Finally, we are cautiously optimistic about one innovation in a third category; it has some evidence of success in producing savings while not affecting quality, but we do not yet fully understand its effects on quality of care, patients, and family caregivers.<sup>105</sup>

TABLE 2  
Summary of Seven Promising Innovations in Medicare

Innovation	Extent of Evidence	Results So Far		Comments
		Quality	Medicare Spending	
<b>GROUP 1: Innovations With Evidence of Success</b>				
<i>These innovations have demonstrated significant success in improving quality of care, yielding savings for Medicare, or both. If expanded, we expect they would yield broad benefits to consumers and the Medicare program.</i>				
<b>Independence at Home</b> Participating medical practices provide comprehensive primary care at home for Medicare patients with very high health care needs.	Evaluation of first five years and a few studies	Improved	Lower	Expansion would benefit high-needs individuals and their family caregivers through improved person- and family-centered care.
<b>Community-Based Care Transitions Program</b> With the goal of reducing readmissions, hospitals partnered with community-based organizations that offer support services for high-risk Medicare beneficiaries leaving the hospital.	One evaluation	Improved	Lower	Program completed. Results indicate that targeting high-risk patients with transitional care services can reduce hospital readmissions and improve outcomes.
<b>Competitive Bidding for Durable Medical Equipment (DME)</b> Medicare paid DME suppliers based on competitive bids rather than average industry charges.	Several reports	Unchanged	Lower	Program currently suspended. Re-implementing it could yield substantial savings for Medicare beneficiaries who use DME.
<b>Accountable Care Organizations (ACOs)</b> Groups of providers who are collectively responsible for meeting cost and quality targets share in any Medicare savings they generate. The model uses two basic designs: the ACO realizes some of the savings but is shielded from any losses (one-sided risk) or the ACO shares in any losses as well (two-sided risk).	Several evaluations and studies	Unchanged or improved depending on model design	Lower for two-sided risk models; usually higher for one-sided risk models	Medicare ACOs have the potential to deliver better-coordinated and more cost-effective care to millions of Medicare beneficiaries.
<b>GROUP 2: Innovations With Early Evidence of Success</b>				
<i>These innovations have shown benefits for consumers and, in some cases, savings for Medicare. Given the limited amount of evidence so far, further experience and evaluation will be valuable, but we are optimistic that with expansion these innovations could benefit both consumers and the Medicare program.</i>				
<b>New Payment Codes for Transitional Care Management, Chronic Care Management, and Other Services that Support Coordinated Care</b> Doctors and other clinicians can bill Medicare for a variety of services, supporting more coordinated and consistent care.	Evaluations of two services: transitional care management and chronic care management	Improved	Lower	New payment codes encourage clinicians to provide various types of care management that benefit patients and family caregivers. Additional studies are needed to assess the effects of the full range of new services.
<b>Comprehensive Primary Care</b> Medicare partners with other payers to financially support primary care practices in transforming care (e.g., 24-hour access to a medical professional, hiring staff to arrange services such as transportation).	Evaluations of first two years of current initiative and of earlier initiative	Improved	Higher or unchanged	Program has the potential to improve primary care quality for people with Medicare and other consumers. Because care transformation takes time, full effects on quality and potential savings will likely take time to develop.



Innovation	Extent of Evidence	Results So Far		Comments
		Quality	Medicare Spending	
<b>GROUP 3: Innovation for Which We Are Cautiously Optimistic</b> <i>This innovation has some evidence of success but we do not yet understand its full effects on consumers and quality. It will require more thorough evaluation to examine concerns about its implications for consumers and may also need further development to achieve its potential.</i>				
<b>“Bundled” Payment</b> Medicare sets a single, comprehensive payment or benchmark amount that covers multiple services a patient may receive during an episode of care.	Several evaluations and studies	Unchanged	Lower for hip and knee surgeries; unchanged for medical conditions and other surgeries	Programs need further evaluation of the effects on patients and family caregivers, and further study to determine the types of episodes for which bundled payment may yield benefits for consumers and the Medicare program.

Ultimately, with varying degrees of evidence, the innovations we highlight here illustrate the wide range of ways in which Medicare has been changing to enhance efficiency in the program while also improving outcomes for people with Medicare and their families. While these innovations have shown positive results, the evidence suggests that the financial gains and improvements in care quality associated with them have been relatively small so far. This may not be surprising, given that these innovations have been in place for a relatively short amount of time. Hospitals, clinicians, and other health care providers and organizations need time to change the way they deliver care and to invest in infrastructure and relationships that enhance quality and yield savings. Further, given the size of the Medicare program and its links to and interactions with other sectors of the US health care system, system-wide transformation

will occur from better integrating, coordinating, and expanding models that started small and were initially tested separately. Over time, applying ongoing lessons learned from Medicare’s innovative approaches can also drive greater efficiency and other improvements in the broader health care system. A top priority will be an ongoing focus on delivering care that meets the needs and goals most important to individuals and their family caregivers.

The promising innovations highlighted here suggest that the Medicare program is moving in the right direction. Looking ahead, policy makers should continue to focus on incremental changes that benefit both consumers and the Medicare program, and are implemented with adequate assessment and evidence of effectiveness.

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- 2 Juliette Cubanski, Tricia Neuman, and Meredith Feed, *The Facts on Medicare Spending and Financing* (Washington, DC: Kaiser Family Foundation, August 2019), <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>.
- 3 Authors' calculations based on data from the Boards of Trustees, *2020 Annual Report*, Table V.B1; and Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Centers for Medicare & Medicaid Services, May 12, 2009), Table III, A1, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2009.pdf>.
- 4 Harriet Komisar, *Medicare Financial Outlook: What Do Trust Fund Solvency Projections Mean?* (Washington, DC: AARP Public Policy Institute, May 2020), <https://www.aarp.org/ppi/info-2020/medicare-financial-outlook.html>.
- 5 Boards of Trustees, *2020 Annual Report*.
- 6 Most of the recent demonstrations in traditional Medicare were either authorized by the ACA or initiated by the Center for Medicare & Medicaid Innovation—also known as the Innovation Center—which was established by the ACA. Through the Innovation Center, CMS has more tools to design, test, and evaluate new value-based payment models than in the past. For models created by the ACA or the Innovation Center, the Secretary of Health and Human Services has unprecedented authority to expand successful pilots—defined as those that lower spending without reducing quality, or improve quality without increasing spending—to the entire Medicare program, without Congress needing to pass new legislation. Rocco J. Perla et al., “Government as Innovation Catalyst: Lessons from the Early Center for Medicare and Medicaid Innovation Models,” *Health Affairs* 37, no. 2 (2018): 213–21.
- 7 The ACA initially authorized the Independence at Home demonstration for three years (2012–15). The Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015 subsequently extended it to 2017. The Bipartisan Budget Act of 2018 further extended the demonstration to 2020.
- 8 To be eligible, individuals in traditional Medicare must have two or more chronic conditions (e.g., congestive heart failure, diabetes, chronic obstructive pulmonary disease, ischemic heart disease, stroke); need help with at least two activities of daily living (e.g., walking, bathing) because of a functional limitation or disability; have had a hospital stay in the previous year; and have received rehabilitation services in the previous year. Medicare covers the same benefits and has the same cost-sharing requirements for beneficiaries in Independence at Home as for people who are not in the demonstration. People who get services from providers participating in the demonstration can also see other providers and get other Medicare covered services.
- 9 The care team can also include physician assistants, pharmacists, social workers, and other health and social services staff.
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- 11 Before 2019, the total number of people with Medicare who could be enrolled in Independence at Home could not exceed 10,000.
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- 13 The Independence at Home quality metrics are (a) follow-up contact within 48 hours of a hospital admissions, hospital discharge, or emergency department visit; (b) medication reconciliation in the home within 48 hours of a hospital discharge or emergency department visit; (c) annual documentation of patient preferences; (d) all-cause hospital readmissions within 30 days; (e) hospital admissions for ambulatory care sensitive conditions; and (f) emergency department visits for ambulatory care sensitive conditions. The share of savings that an Independence at Home practice receives depends on its performance on these quality measures.
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