Since up to one-third of medical spending is excessive and unnecessary, reforming how Medicare pays for health care is essential to reducing health-care costs and improving the quality of care. Rather than paying a fee for each specific service separately, payments should be bundled together for multiple providers. This would create strong incentives for providers to coordinate care and eliminate unnecessary costs.

For fully integrated providers that form accountable care organizations—teams of providers that coordinate care—payments will be bundled to cover all of a patient’s care. But for most providers—which are not integrated—payments must be bundled for an episode of care, with providers dividing the payment among themselves.

For instance, a bundled payment for a hip replacement would cover pre-surgical preparation, anesthesiology, the surgical procedure, operating room fees, the hip implant, radiological examinations, laboratory tests, and rehabilitation. Bundled payments must be adjusted for the quality of care and health status to prevent providers from skimping on care or avoiding high-risk patients.

The Affordable Care Act requires a five-year pilot program for bundling payments for episodes of care around hospitalization for 10 conditions, with voluntary participation by providers. The secretary of health and human services is authorized to expand the program in 2016 if doing so would reduce costs and improve quality. This transition to bundled payments should be broadened and accelerated.

Recommendations

Expand the Acute Care Episode, or ACE, bundling program for cardiac and orthopedic procedures nationwide—and include related post-acute care such as rehabilitative and home health services—by January 2013. Building on over a decade of testing, in
2009 Medicare introduced the ACE program, which operates in only 11 hospitals. The bundled payment covers all Part A and B costs around hospitalization for 29 cardiovascular (such as coronary bypass and cardiac pacemaker) and eight orthopedic (such as hip and knee replacement) procedures. While the program has not undergone a definitive evaluation, preliminary results indicate that it improves quality and saves 1 percent to 6 percent of costs.

**Require bundled payments for other specialists and primary care physicians by January 2016.** For specialists, bundled payments would be modeled after the ACE program. For primary care physicians, a portion of payments would be a fee for each service and the rest would be a capitation payment—a fixed payment for each beneficiary. Beneficiaries would be able to designate a primary care physician, who would receive the capitation payment. The capitation payment would be adjusted based on patients’ health status and the quality of care, but would not increase with the quantity of care. By reducing their reliance on fee-for-service, primary care physicians would not be penalized for spending more time visiting with patients and coordinating their care.

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**Notes**

1 The Institute of Medicine, Roundtable on Evidence-Based Medicine, “The Healthcare Imperative: Lowering Costs and Improving Outcomes: Brief Summary of a Workshop” (2010).