HealthAffairs

HEALTH AFFAIRS BLOG

The "Failure" Of Bundled Payment: The Importance Of Consumer Incentives

James Caillouette, James C. Robinson

AUGUST 21, 2014 DOI: 10.1377/hblog20140821.040928

Bundled payment for orthopedic and spine surgery and other major acute interventions has many attractive features, in principle. But implementation has been difficult in practice. The recent *Health Affairs* paper by Susan Ridgley and colleagues, and the *Health Affairs* Blog commentary by Tom Williams and Jill Yegian, list quite a few practical implementation problems, and the points raised in both these pieces are well taken.

As leaders in the Integrated Health Association (IHA) bundled payment initiative, we shared the same hopes, devoted the same energies, and share the same frustrations with the modest results. We feel it is important to emphasize what we consider to be the initiative's most important design failure: the lack of engagement and alignment on the part of the consumer. No one will ever reform the U.S. health care system without bringing the consumer along and, indeed, placing consumer choice and accountability at the very center of the reform initiative.

On an optimistic note, this design failure is being addressed by the larger health care marketplace in the wake of numerous failed attempts to reform health care by focusing exclusively on provider payment and incentives.

The Resource Barrier To Implementing Bundled Payments

The Hoag Orthopedic Institute (HOI) (where Caillouette is Surgeon-in-Chief) is the largest volume orthopedic surgery facility in California and one of the largest in the nation, performing thousands of hip and knee replacements each year. We are focused on quality and value-driven care delivery. Organizationally, HOI is a joint venture between surgeons and a not-for-profit community hospital. Governance and equity are shared, which helps to align incentives. This has been examined in an earlier *Health Affairs* paper.

Over the past decade we have sought to become a regional and national Center of Excellence (COE) for orthopedic surgery. In 2009 we embraced travel medicine, offering bundled payment rates to self-insured employers such as Kroger. Under travel medicine programs, employers and insurers contract with regional Centers of Excellence (COE) for particular services, such as cardiac

angioplasty or joint replacement, and create-cost sharing incentives for patients to use these facilities.

We were first and the most enthusiastic participant in IHA bundled payment initiative, sending the hospital's entire C-suite to the founding meeting with the health insurers. We signed more contracts and treated more patients than any other participant. But we never received the volume of new patients necessary to cover our incremental expenses, much less finance a much-desired expansion. We are holding the course, still accepting bundled payment from the three IHA payers, and are hoping to negotiate a new bundled payment contract and COE relationship with an additional major national and California insurer.

Many policy observers and health plans feel the potential for efficiency gains under bundled payment are so large that providers can be expected to shoulder the needed investment in care redesign and, simultaneously, accept an immediate reduction in level payments. Our experience, however, is that the investments needed to get physicians and facilities ready for bundled payment are large and ongoing.

These include the following:

1. tangible investments such as information technology, staffing, and administrative capabilities to process and disburse revenue;
2. redesign of the underlying care processes with better patient assessment, operating room throughput, patient discharge planning, elimination of duplicative radiology and lab tests, effective price negotiations with suppliers of implantable devices, and quality monitoring and reporting; and
3. intangible investment of time in enlisting the participation and ultimately the enthusiasm of the many participants, without which the hoped-for performance improvements will never take place.

Consumers: The Missing Ingredient In The IHA Initiative

It goes without saying the purchasers are not willing to pay more to get more in health care. Bundled payment is for them, and rightly so, a means to potentially pay less. But what then can stimulate the essential yet costly changes listed above? Providers that take the lead in value driven bundled payment, and make the needed investments, want to obtain the usual market reward for better performance: more customers.

The essential ingredient for bundled payment is a change in consumer cost-sharing requirements so that patients selecting high-quality, more-efficient providers, who can and will participate in bundled payment, pay less out of pocket than consumers choosing less effective providers who do not make the needed investments. This imperative is consistent with the broader principles of value-based insurance design.

The alignment of incentives between consumers and providers is essential, yet was missing from the IHA initiative. In our experience, up close and personal with the IHA initiative, this was the

biggest single impediment for a successful outcome.

The marketplace is moving in the right direction. Fortunately, the larger health care marketplace seems to be moving towards new structures of consumer cost sharing and engagement. The reference pricing benefit design developed by the California Public Employee Retirement System (CalPERS), the largest purchaser of health insurance in the state, has had a major effect on consumer choice and provider prices, as documented in our earlier study published in *Health Affairs*. HOI and its partner hospitals currently are committed participants in the CalPERS reference pricing initiative. Reference pricing builds on high-deductible health plan designs, which also reward consumers who choose lower-price facilities with lower cost sharing.

Changes in cost sharing are being supplemented in the marketplace by initiatives to improve consumer access to information on price and quality. A recent article in *Health Affairs* documented significant changes in consumer choices and insurer payments for diagnostic imaging, an important component of orthopedic surgery, flowing from active outreach to consumers. We are currently conducting an evaluation for CalPERS of its extension of reference pricing to arthroscopy and other ambulatory surgery procedures.

To summarize, we were enthusiastic participants in the IHA initiative and continue to support bundled payment. We believe that this is the best method for aligning all stakeholders in elective acute interventional care, and that bundled payment has potential for sustainable savings. Our policy focus right now, however, is in encouraging the alignment between consumers and providers through reference pricing, travel medicine, quality reporting, and price transparency. The larger health care market also is moving in this direction. We hope that the adoption of bundled payment will follow as these other components of value-based health care become established.

Let us not forget one important point. Cost-sharing and price-transparency initiatives that encourage patients to choose providers who have invested in quality monitoring, information technology, reduction in unnecessary radiology, supply chain efficiency, and the other components of care design are good for those patients, as well as for the payers and providers. Initiatives that reward efficiency and quality benefit us all.

LOG IN WITH

OR SIGN UP WITH DISQUS ?

Name

Joane Goodroe • 5 years ago

Bundled payments work when there is clear alignment of incentives for payor, provider and patients. The payor must save money, providers must gain volume and have the opportunity to share savings from reengineering efforts, and the patient must have some designated benefit to participate. In the late 90's many bundled payments were implemented for open heart surgery and interventional cardiology. For example, Delta Airlines created a Centers for Excellence program. Delta saved money while participating hospitals and physicians saw incremental volumes. Physicians also participated in gainsharing for cost reduction. Patients and their families had key benefits like no out of pocket costs as well as some other incentives. Aligning the economic incentives makes bundled payments successful.

Complex services, such as bone marrow transplant and other transplants services, are paid mostly through bundled payments for commercial patients. These arrangement are designed with the key features listed above.

Arnold Milstein • 5 years ago

.

Two key unknowns for purchasers such as self-insured employers are
- the % by which COE bundled prices would need to be lower than average payer-allowed total cost of care delivered by local non-COE providers in order to induce purchasers to apply strong consumer incentives and invest in better consumer decision support , and
-how much of savings to purchasers would need to be shared with consumers that selected COEs

Jeff Goldsmith • 5 years ago

Lack of patient incentives wasn't the only failure.

What about confining the provider panel to hospitals? Large orthopedic groups, in combination with freestanding surgical facilities, could have underbid hospitals by perhaps 40% for a procedure many are doing as "overnight stays". All that's missing is the place to "overnight", and many options exist for "recovery center" monitoring.

Not to mention selecting procedures that are largely Medicare driven but then confining the patient panel to those under 65? There are a ton of Medicare Advantage subscribers in southern California. Why not target them, instead of the privately insured younger folks. Alternatively, under 65'ers get a lot of carpal tunnel procedures and arthroscopies. Why not go where the patients are, instead of scraping up procedure volumes at the margin?

Not to mention why WOULD providers accept fixed payments for an expensive procedure that were not risk adjusted? That's not hospital aversion to risk? It's common sense. Southern California providers have been around risk for three decades. I wouldn't accept cases without protection from adverse selection, particularly if orthopedics was one of my "centers of excellence" and I was recruiting sicker, more complex patients. The lack of risk adjustment would have been a deal killer for most folks experienced with managed care. As Peter Kongstvedt says, "they don't call it risk for nothing."

I think we taxpayers ought to demand that a refund of the $2.9 million. It was squandered by people who really don't know how the market works. As the authors of this post suggest, this incompetently framed and managed study doesn't condemn the idea of "bundled payments"

managed study doesn't condemn the idea of "bundled payments".

Reply • Share ›

Subscribe Add Disqus to your siteAdd DisqusAdd Disqus' Privacy PolicyPrivacy PolicyPrivacy

Related

CONTENT

TOPICS

- Bundled Charges
- Quality Of Care
- Health Care Providers
- Surgery
- Hospital Quality
- Cost Sharing
- Reference Pricing
- Insurance Providers
- Health Insurance Exchanges
- Payment

Cite As

"The "Failure" Of Bundled Payment: The Importance Of Consumer Incentives, " Health Affairs Blog, August 21, 2014.
DOI: 10.1377/hblog20140821.040928

Bethesda, Maryland 20814

T 301 656 7401

F 301 654 2845

customerservice@healthaffairs.org