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Moving Risk to Physicians

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America has a healthcare cost problem, and that means we have a fee-for-service problem. Fee-for-service incentivizes physicians to order more tests and treatments—many of which are unnecessary. According to the Institute of Medicine, unnecessary tests and interventions add approximately $210 billion of waste to the US healthcare system.[1] In addition, inefficiently administered interventions and unnecessarily high healthcare prices for items such as implants and imaging studies add an additional $130 billion and $105 billion, respectively, to the already bloated healthcare bill. Reducing waste by removing incentives to order excessive and unnecessarily costly tests and treatments is critical to reducing healthcare spending.

Accountable care organizations (ACOs) are one solution that have been touted since the enactment of the Affordable Care Act. Currently, there are 19 ACOs participating in CMS' Pioneer ACO Model Program; however, there are not a whole lot of programs, and the amount saved is not very impressive. In the past 2 years, these ACOs reportedly saved only $384 million, further confirming that[2] we desperately need additional cost control solutions.

Another alternative to fee-for-service is bundled payments. This July, CMS announced it would require hospitals in 75 metropolitan statistical areas (MSAs) to participate in a test of bundled payments for hip and knee replacements.[3] Each hospital in those regions will receive a fixed payment for the hip and need replacement, and they will be accountable for the quality and costs of the entire 90-day episode of care. This will incentivize hospitals to negotiate and reduce the price they pay for implants, and it will also act to incentivize them to be efficient in terms of avoiding costly canceled operations, surgical site infections, and in-hospital rehabilitations, thereby saving Medicare money and improving the patient experience. Hip and knee bundles are currently included in Medicare's voluntary initiative around bundled payments, but making the bundles mandatory in 75 MSAs, rather than a voluntary demonstration project, shows that the Obama administration is serious about moving the US healthcare system away from fee-for-service and more toward bundled payment.

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This is a welcomed development. We need to make it clear to providers that the future is not fee-for-service. If they have not already, providers can begin developing bundles for hip and knee replacements, as well as for other procedures like back and bowel surgery and vascular procedures, and even for nonsurgical care services such as cancer chemotherapy, radiation therapy, and asthma exacerbations. With the knowledge that the bundled payment model is here to stay, providers can begin to commit to working to develop the infrastructure they need to handle this developing model.

However, if Medicare and private insurers are going to get costs under control, more work needs to be done. The main reason to shift away from fee-for-service is to change incentives, and the key to changing incentives is the sharing of risk. In most cases, physicians are the decision mak-

ers: they choose which knee replacement part to use for their patient; if physicians themselves do not share the risk of the knee replacement bundle, they have little incentive to switch from the expensive part they have always used to an equally effective, cheaper part. Hospitals cannot be the only ones that hold the risk for episodes of care. In order for bundled payments to really work, hospitals and providers must move some risk to the physicians involved.

Furthermore, physicians are the individuals who ultimately decide whether to admit a patient with an asthma or congestive heart failure exacerbation or, rather, to invest in having more intensive care at home instead of in an institution to try to forestall exacerbations. When physicians are sharing the risk for both quality and cost, they will consider the best and most cost-effective way to care for a patient. Additionally, with incentives to provide high-quality care, such as 90-day guarantees and re-admission penalties, physicians will not focus solely on the bottom line.

If physicians share risk, they are also more likely to go along with reforms designed to lower cost or increase quality, as instituted by the hospital. They may show more enthusiasm for reforms such as using the less expensive knee-replacement parts or out-patient rehabilitations services and hospital at home programs than they would have if they did not experience risk for cost and quality.

Despite the importance of risk sharing, there are few true—and scalable—success stories about how to best share financial risk with physicians. No hospital or provider has figured out the perfect formula yet—that is the big challenge facing the healthcare system. With CMS announcing mandatory hip and knee bundles, and with more bundling and other alternative payment methodologies to come, the next step for transitioning away from fee-for-service is for hospitals and providers to find ways to share risks with physicians. Only with risk sharing will it be possible to truly bend the cost curve.

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