COMMENTARY

Ensuring the Adoption of the Health Care Warranty: A Well-defined Model to Resolve Issues with Risk and Uncertainty

Francois de Brantes, MS, MBA, Meredith B. Rosenthal, PhD, Jeroen Struijs, PhD, MSc

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To accelerate wider adoption of the health care warranty, stakeholders will need to refine the allocation of risk between payer and provider while simultaneously minimizing the real or perceived uncertainty for providers. This must be done through a contract that binds buyer and seller in ways that will align incentives. The authors define a warranty as an implicit acceptance by providers to bear the cost of any complications related to the management of a procedure or condition. So, when providers accept a fixed budget or price for a patient’s total care for a condition or procedure, they are offering an implicit warranty on that care. Current models that strive for a warranty blur the line between risk (which is measurable) and uncertainty (which is not measurable). The authors offer specific design elements for Warranty-Based Alternative Payment Models.

The prospect of a warranty for those who purchase health care has been around for decades. In the 1990s, a Michigan surgeon’s pilot study demonstrated success with a two-year financial warranty for arthroscopic surgery. In the 2000s, Geisinger’s efforts with its ProvenCare and ProvenExperience guarantees have received considerable attention. But to date, a robust embrace of the idea of a warranty for health care remains unfulfilled, largely because of a failure to adequately address both risk and uncertainty.

In a 2009 paper titled “Should Health Care Come With A Warranty?” the authors (which included FdB and MBR) noted that the key to making warranties viable is defining which failures are the supplier’s fault and which are not. However, in 2009, only a handful or so of alternative payment models (APMs) included downside risk for providers. The hypothesis then was that building a warranty into an episode of care would create a signal to the market that a provider had a financial
stake in delivering high-quality care, and was willing to take a measured risk in the outcomes of the care provided. Until then, most “bundles” were case rates, simply combining the inpatient facility and associated professional services in a single payment. Extending the services and the financial and clinical accountability of the managing providers during a period of time that extended beyond the procedure is what created the warranty — any complications during that period of time would not trigger a new payment. That construct, and others that are similar to it bore out our hypothesis, but today’s obstacles prevent more widespread adoption.

As has been widely publicized, large companies such as Walmart have eagerly embraced the pricing of episodes through Centers of Excellence that include a warranty and entered into contracts with providers across the United States to deliver care to their employees. The demand for this version of warranted care — all-inclusive, prospectively priced episodes with a 90-day warranty — has grown substantially and is now part of many employer requests for proposals when sourcing third-party administrators for their health benefits. Unfortunately, third-party administrators continue to struggle to respond to that demand, which is why a number of start-ups, including Carrum Health, Employer Direct Healthcare, and Signify Health, have entered the market to help employers of any size implement these models and expanded ones.

For purposes of this paper, we define a warranty as an implicit acceptance by providers to bear the cost of any complications related to the management of a procedure or condition for the duration of that episode. As such, when providers accept a fixed budget (or price) for a patient’s total care for a condition or procedure, they are offering an implicit warranty on that care.

In the Medicare context, providers — including physician groups, hospitals, and health systems — have responded to opt-in payment initiatives, including the Bundled Payment for Care Improvement Advanced (BPCI-A), demonstrating some appetite for APMs that include downside risk. In the BPCI-A program, providers are at full financial risk for all costs during a 90-day period post discharge.

Nationally, a recent survey has shown that 25% of physician practices participate in episode-of-care payment arrangements, which are most often focused on a limited set of high-volume procedures. A similar percentage of U.S. community hospitals (25%) have entered bundled payment arrangements; overall participation exceeds 50% in some states, and is nearly 60% among major teaching hospitals, but a majority of these bundled payments (83%) are associated with traditional Medicare programs, while just 36% are through commercial insurance plans.

Physician group practices, hospitals, and health systems are, seemingly, ready to supply warranted care, looking to enter into direct contracting with employers on episodes of care. Yet, despite this activity and the widespread acceptance today of value-based care, episode-of-care payment programs managed by private sector payers account for a small share of the market.

If there’s demand for and supply of warranted episodes of care, and if there is a growing group of vendors that can administer these programs at scale, why then has the adoption stayed anemic? In our view, getting to the next stage of adoption requires not only a refinement of the allocation of risk between payer and provider (via the design of the contracts that bind buyer and seller in ways
Risk and Uncertainty Are Not the Same

Previous work has examined program design decisions inherent in APMs and highlighted practices that optimize provider incentives and operational effectiveness. Of note, these features have an impact on both adoption (they can increase the buy-in by providers in both voluntary and mandatory programs) and outcomes (they impact the incentives for providers to deliver savings and quality improvement). However, they don’t always explicitly address the elements of APMs that blur the line between risk and uncertainty. As amply described in economic literature, risk is measurable while uncertainty isn’t, and confusing them has profound implications on the participation of providers in APMs. To sum up that literature, consider that risk presumes that while an outcome is unknown, the probability distribution of the outcome is known and measurable, while uncertainty is characterized by an unknown outcome and unknown probability distribution. Think of it as the difference between playing a game of skill and a game of chance. Elements of episode-of-care payment programs (and other APMs) that introduce uncertainty or increase the probability of measurable loss will, therefore, act as significant deterrents to adoption. That’s all the truer as a consequence of the Covid-19 pandemic, given the impact on provider revenue and earnings.

To guide program sponsors that want to successfully introduce and implement episode of care payment programs (and other APMs) that include downside financial risk, we summarize in a table practices that address potential pitfalls in the design of these programs and contrast them with the current most prevalent models (Table 1).

Of note, many of these concepts have also been articulated and widely accepted as best practices in the context of pay-for-performance and yet remain absent from most APMs. The upshot: The programs that affect the most providers fall short on these design principles and significantly increase uncertainty, hence reducing their appeal and potential uptake.

Reworking the Design for Alternative Payment Models

There may be several practical reasons that current episode-of-care programs violate the design principles described in the table.

First is the payer’s perceived need for operational simplicity — creating all-in episodes is a lot simpler than having more refined ones (i.e., those that only include relevant services and potentially controllable events) because the former don’t require a sophisticated bundling engine while the latter do. Consequently, simplistic all-in episodes include more services related to insurance risk than strictly necessary, which increases the risk for providers and, in turn, the uncertainty of the program.

Second, the combination of data limitations, antiquated information technology infrastructures, and payer reluctance toward transparency causes the information needed to fathom all the
| Essential Element                              | Recommended Practice                                                                 | Rationale                                                                                                                                  | Example of Current Misalignment                                                                                                                                  | Example of Best Practice                                                                                           |
|-----------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Inclusions/exclusions of services             | Services included in the bundle should be influenceable by the provider and relevant to the triggered episode | Including services that are irrelevant to the episode introduces additional random variation in financial outcomes and increases uncertainty | In Medicare’s Comprehensive Joint Replacement, all services for 90 days post-discharge are included in the episode, with very few exceptions. For example, heart failure care is included in the 90 days post orthopedic surgery. | Services included in commercial insurance episodes are typically limited to those directly relevant to that episode. For example, heart failure care would be included in the heart failure episode while the care related to the orthopedic surgery would be in the orthopedic surgery episode. |
| Price target transparency, predictability, and/or specificity at the start of the performance period | Target prices should be set up-front (with or without prospective payment) and transparently, and immutable during the performance period | Price predictability avoids what would otherwise likely be a tournament-style program, which introduces an uncertain outcome and uncertain probability distribution | BPCI-A pricing is complex, making it difficult for providers to trust the legitimacy of the methods and fairness in pricing; some commercial payers cite provider contract confidentiality as the primary reason for not sharing detailed information on target prices. | Case rates (mostly same-day procedural episodes with a very limited number of services) that are transparently priced. |
| Adjustments for patient characteristics, ex ante and ex post | Target prices should be adjusted for patient severity and actual performance should be adjusted for any changes in patient severity during the performance period to avoid the potential for patient selection | Adjusting for patient characteristics is important to engender trust in target pricing and a perception of fairness. Although coding practices and endogenous changes in comorbidities in the baseline and performance period make this challenging, case-mix adjustments will reduce uncertainty for providers. | Few commercial insurance programs adjust for patient characteristics, oftentimes due to lack of adequate historical sample sizes. Many payers also argue these adjustments aren’t necessary. | In the CMS BPCI-A program, adjustments are made up front and at reconciliation. |
| Relevance and actionability of quality measures | Quality measures should only be included if they have been validated and accepted as influencing patient outcomes and controllable by the accountable provider | Providers in alternative payment models often complain about the burden of reporting. Having only quality measures that help them improve patient outcomes eliminates the introduction of perceived frivolous burdens | The Medicare MSSP program includes a small basket of measures that are not representative of the scope of the care for all beneficiaries included in the program or indicative of patient outcomes. Improving those measures’ scores have little relationship to outcomes. | Medicare’s Comprehensive Joint Replacement Bundled Payment program uses surgical complication rates and patient experience measures. Many state Medicaid programs focus on potentially preventable admissions or readmissions that are directly related to the management of ambulatory care-sensitive conditions. |
| Clarity of contract terms                     | All terms and implications of terms on shared savings or losses should be explained up front | Transparency on burden of loss by party creates trust in the program. Commercial insurers don’t fully delineate the total share of savings they would receive, or the burden of loss imposed on providers. | Commercial insurers’ share in the BPCI-A contract includes a specified up-front discount and back-end savings (because provider savings are capped at 20%). | Medicare’s share in the BPCI-A contract includes a specified up-front discount and back-end savings (because provider savings are capped at 20%). |
potential alternatives and consequences to be (often) unavailable. Lack of trust between payers and providers may fuel unwillingness on both sides to resolve information asymmetries that could improve contract completeness. Consequently, the level of uncertainty around APM outcomes is high and the ability of both parties to optimize is limited.

Practical examples from the field illustrate these shortcomings. In one instance, an independent multi-site specialty group was approached by a large local payer to contract for episodes of care around the management of a condition and its principal procedure. The payer wanted to fix a baseline price using 18-month-old data, untrended, with no forward trend and no adjustments for increases in underlying facility fee schedules. The net effect for the provider was an initial price more than 5% below current estimated prices and full responsibility for any facility price increases that could go into effect during the term of the contract; this also applied retroactively and proactively to any other terms negotiated between the payer and the facilities. Those decisions created such an imbalance in the potential reward given the risk that the specialty group had no other option than to refuse.

Another example of current shortcomings is the Comprehensive Care for Joint Replacement model, which is a mandatory program in several geographies. In February 2020, Medicare released proposed changes for the program that would (1) fix the baseline price using a single year and rebase it every year, and (2) apply a retrospective adjustment to account for regional trends. The combination partially turns the program into a tournament wherein the actual result of the participating providers is partially a function of their peers’ performance, which is not controllable, creating significant uncertainty as to the outcome.

The Path Forward

With employers struggling to control health care costs, providers hungry for stable revenues, and consumers leery of incurring any unmanageable expense, the environment is ripe for purchasers and providers to engage in episode-of-care payments with manageable downside risk and reasonable expectations of upside. This also holds true for public-sector payers that will continue to struggle to manage strained public finances and must reduce any wasteful spending. As such, program sponsors hold in their hands the tool to make these programs palatable to providers — the pen that designs the program.

A critical first step will be for each program administrator to transparently and as simply as possible set fixed prospective prices for each episode, adjusting them appropriately over time to avoid ratchet effects and paying for either upcoding or selection. Overall, these design principles act as protective measures to increase transparency and predictability around episode-of-care (or other APM) contracts. Several large employer programs, including one that one of us [FD] helped design with the State of Connecticut offer a potential blueprint for others. CMS will have opportunities to right some of the shortcomings with the next version of the Oncology Care Model as well as other episode-of-care programs. Our table can act as a checklist for existing and future programs to reduce uncertainty while providing the right incentives. Only then can large scale adoption of APMs by providers be realized. Mixed results and early exit from APMs implemented over the past
Mixed results and early exit from APMs implemented over the past several decades make clear that APM adoption and successful impact is not guaranteed. Learning from successes and failures will be crucial.

Francois de Brantes, MS, MBA
Senior Vice President, Signify Health, Episodes of Care Division

Meredith B. Rosenthal, PhD
C. Boyden Gray Professor of Health Economics and Policy, Department of Health Policy and Management, Harvard TH Chan School of Public Health

Jeroen Struijs, PhD, MSc
Associate Professor, Leiden University Medical Center, Leiden, South Province, Netherlands
Senior Researcher, National Institute for Public Health and the Environment, Bilthoven, Utrecht, Netherlands

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