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## Redesigning provider payment: Opportunities and challenges from the Hawaii experience

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### ABSTRACT

**Objectives:** To describe the process of developing a new physician payment system based on value and transitioning away from a fee-for-service payment system

**Study design:** Descriptive. This paper describes a recent initiative involving redesign of primary care provider payment in the State of Hawaii. While there has been extensive discussion about switching payment from volume to value in recent years, much of this change has happened at the organizational level and this initiative focused on changing the incentives for individual providers.

**Methods:** Descriptive paper. In this paper we discuss the approach taken to shift incentives from fee-for-service towards value using behavioral economics as a conceptual framework for program design. We summarize the new payment system, challenges in its design, and our approach to piloting of different behavioral economic strategies to improve performance.

**Results:** None.

**Conclusions:** This paper will provide useful guidance to health plans or health delivery systems considering shifting primary care payment away from fee-for-service towards value highlighting some of the design challenges and necessary compromises in implementing such a system at scale.

### 1. Introduction

Replacement of volume-based incentives embedded in fee-for-service (FFS) payment with value-based payments has the potential to significantly increase the amount of health derived from health spending. Policy initiatives have focused on new approaches like episodes of care and accountable care organizations in which organizations assume financial risk for cost and quality outcomes. However, much less attention has been paid to the micro-incentives for individual providers. Many organizations have compensated physicians by largely leaving fee-for-service compensation intact and adding some relatively

small incentives for quality (e.g., P4P programs). Not surprisingly, standard P4P programs have had little effect on physician behavior.<sup>1,2</sup> Efforts to more fundamentally redesign provider payment have generally not considered recent advances in behavioral economics, which has documented many ways that behavior is not always fully rational.<sup>3,4</sup> Redesigning provider payment using principles such as simplicity, salience, defaults, loss aversion, goal gradients, and frequency of feedback could significantly boost the effectiveness of provider payment reform initiatives.<sup>5,6</sup>

In 2016, Hawaii Medical Service Association (HMSA), the Blue Cross Blue Shield plan of Hawaii, launched a new initiative to transform

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payment of primary care providers from fee-for-service (FFS) to a population value-based model. Our team was engaged to help design the new payment model with special emphasis on incorporating principles from both economics and behavioral science. The focus of this initiative has been on changing payment for primary care providers (PCP); while their compensation represents only 8% of total spending in Hawaii, they influence the other 92% and providing PCPs with both tools and incentives can help them wield that influence more effectively. HMSA defined a set of goals for the new system including: 1) to design an approach to health care delivery in Hawaii that includes more sustainable cost growth and 2) to remodel the underlying incentives for providers to focus on delivering patient-centered, high quality care, oversight of their patients' health, and controlling the rate of increase in cost of care.

In this manuscript we describe the basic approach and the compromises required for implementation that will be helpful for program designers in other states to understand as they move away from FFS payment towards a system based on value. While there are myriad different elements of such a new model that could be tested, our pilot testing focused on two features: augmenting the basic model with social comparisons of performance among providers and member incentives for better glycemic control, each of which has strong evidence supporting effectiveness.<sup>7–9</sup>

## 2. Challenges in designing the new model

The five components of the payment model are: 1) a shift away from FFS payments; 2) a risk-adjusted PMPM, 3) engagement incentives, 4) quality incentives, and 5) incentives tied to lowering the rate of increase in health care costs. We summarize key challenges in implementing this model and how we addressed them and our rationales below.

### 2.1. Patient attribution methodology used by HMSA

A fundamental challenge in moving away from FFS and paying providers based on patient panels is development of a fair and accurate mechanism to attribute patients to providers. Although there is no gold standard approach to attribution, attribution algorithms should be reliable, transparent to providers and patients, and include a provision for adjudication of assigned patients. Because our goal was to incentivize PCPs to actively manage the full scope of their patients' health care in partnership with their patients, we prioritized patient attestation in assigning patients to providers. Approximately 43% of HMSA members prospectively elected a PCP. For those without a chosen PCP, we used an algorithm tying patients to the provider they had selected in the HMO product, the PCP most often seen in the last sixteen months, or the PCP seen most recently. Following these rules brought the total attributed patients to 88%. An additional 10% were attributed via the clinic in which they were seen most recently and an additional 2% by provider request. PCP attribution was limited to internal medicine, general practice, family medicine, or pediatric physicians; advanced practice registered nurses; and physician assistants. A central challenge here was that some specialist physicians also provided primary care services, particularly in predominantly rural areas of Hawaii. However, after substantial deliberation about the complexities of discerning primary care versus specialty services based on billing codes, we elected to make specialists ineligible to be listed as PCPs in the new model.

### 2.2. Risk adjustment

Risk adjustment of PMPM and total cost of care is critical to preventing cherry-picking of healthy patients and dumping of the most ill. Our goal was to adjust for patient comorbidities and demographic factors while not adjusting for factors potentially correlated with poor-quality or inefficient care. We used a commercial product called

episode risk group (ERG) risk adjustment, with which HMSA has years of experience. Each member is assigned to one or more of 120 possible medical conditions (called episode risk groups) based on diagnostic and procedural information available in medical and pharmacy claims. Like many similar risk adjustment systems, this uses claims data that are available and complete for all patients. The ERG system adjusts based on diagnosis codes and complexity; to avoid the tautology of using a utilization-based measure to adjust for utilization; it must not be based on utilization per se.

There are several limitations to using ERG for identifying risk. For instance, it does not adjust for age or gender, nor are the episode groups particularly suited to categorize risk among pediatric patients. Another downside to this approach to risk adjustment in the context of payment transformation is that it requires providers or their staffs to continue to code all encounters, which risks keeping them in a FFS mentality. The evidence that the ERG outperforms potential alternatives is limited, but some validation studies suggest that it has reasonable discriminatory ability<sup>10</sup> and that additional risk adjustment beyond ERG may not be necessary.

We deliberated about the value of risk-adjusting PMPM and TCOC with sociodemographic factors. While social determinants and costs of care are strongly linked, this can cut both ways. On the one hand, disadvantaged individuals may have greater needs; on the other, they may utilize health services less often. We did not incorporate such adjustment because of a lack of available data on individual sociodemographic characteristics and because it is unclear how to adjust given the two directions in which socioeconomic status may affect health service utilization. Instead, we worked with HMSA to incorporate collection of patient-level social determinants of health information into the initiative – with incentives to providers for such collection – to facilitate such risk-adjustment in the future. We also were unable to adjust for clinical characteristics that may be documented in patients' medical records but not claims; however, prior studies have shown that claims-based models predict health outcome risk as well as chart models for patient groups.<sup>11–16</sup>

We chose not to adjust for sociodemographic risk in setting quality measure targets. Doing so would mean that higher risk groups, such as Medicaid patients or rural patients, would have lower performance targets, exacerbating socioeconomic disparities in quality of care. Some providers serving high proportions of low-income patients are achieving high quality scores,<sup>17</sup> demonstrating that high quality for all patients is achievable.

### 2.3. Setting a PMPM

A central goal is to reward efficient providers and provide incentives for high-cost providers to become more efficient while providing adequate support to providers for care coordination and management services for their panel of patients. Ideally there would be a single capitated rate, risk-adjusted based on patient clinical and demographic characteristics and possibly socioeconomic status. When we assessed current FFS billings within primary care in the Commercial line of business at HMSA, however, we found wide variation across practices; the median was \$17.50 per month with a range of \$8 to \$100 per month. This left us with the challenge of managing the transition to a single rate while being fair to providers and allowing them time to transform their practices. We decided to lock in existing FFS revenue in year 1 of the new payment model by converting the 3-year average of HMSA FFS reimbursements for all members per provider and using that to calculate separate PMPMs for each provider; these calculations were performed separately for each line of business (QUEST Integration (Medicaid), HMSA Akamai Advantage (Medicare), and Commercial). The cost of acquiring and storing immunizations were removed and will continue to be paid on a FFS basis to prevent primary care practices from ceasing to provide them. To eventually achieve a single rate, we proposed a 4-year transition in which providers receive 100% of their

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