Physician Payment Options for Effective Reform- Lessons from the Hawaii Experience

Part I: Cost control strategies and physician motivation

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Abstract

The current model of health care payment and delivery system reform promoted by the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA) is called "value-based" payment, and it is presumed to encourage more cost-effective care than fee-for-service payment of doctors, hospitals, and other providers. However, "value-based" payment is turning out to be administratively complex, burdensome, and expensive to implement; it is driving doctors out of independent practice; and it does not appear to be capable of achieving the "quadruple aim" goals of improved care, improved population health, reduced total health care cost, and improved physician morale.

Part I of this paper discusses general health care cost control strategies and what is known about effective strategy to enlist physician motivation in controlling health care cost.

Part II considers the implications of the major physician payment options, and the increasingly apparent problems with "value-based" payment.

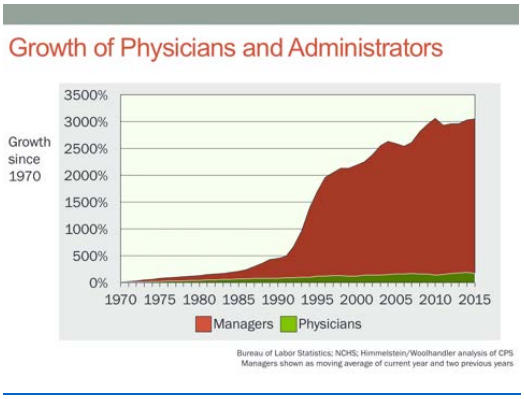
Part III suggests a simpler strategy of returning to fee-for-service, but modified so as to be as incentive-neutral as possible concerning choice of services and treatment, enabling large administrative savings and a much more realistic pathway to achieving the "quadruple aim" goals.

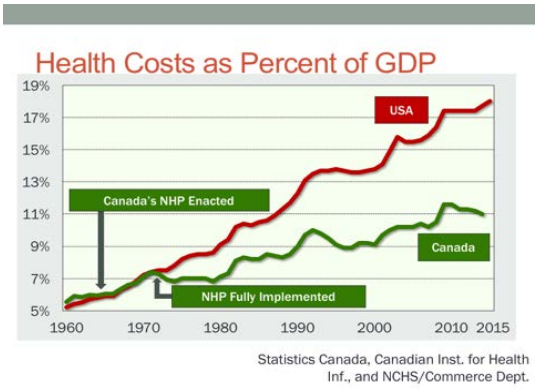
Cost Control Strategies

Managed care, utilization management, "value-based" payment, and increased patient cost-sharing are all strategies that attempt to control health care costs by restricting utilization or establishing incentives for doctors and hospitals to deliver less care, or for patients to seek less care. The underlying assumption is that a major driver of US health care cost is unnecessary care driven by fee-for-service incentives.[1] Although there is certainly some unnecessary care, this rationale has been overblown. [2] Restricting utilization does not restrict disease, and preventable complications and avoidable ER and hospital care driven by inadequate access to necessary outpatient care[3] may be bigger cost drivers than unnecessary care due to fee-for-service incentives.

According to the OECD [4], doctor visits and hospital days per capita in the US are among the lowest of all industrialized countries, yet those other countries provide universal coverage and spend an average of half what we do per capita for health care. Efforts to restrict and manage utilization in the U.S. have resulted in a marked rise in administrative expenses compared to other countries,[5] while total U.S.

health care expenditures have continued to rise faster than other countries, and much faster than inflation.





Other developed countries generally use a different strategy to control health care cost. They try to assure universal access to care, and rely on controlling their supply of doctors and hospitals and controlling prices instead of trying to restrict access to care and manage utilization.[6] There have been some attempts in European countries to implement utilization controls in the form of benefit restrictions, patient cost-sharing, and financial incentives aimed at doctors and hospitals, but none of these have successfully reduced cost. The only effective cost control strategies have relied on price controls and budget setting.[7] The United Kingdom invested heavily in pay-for-performance over the past decade, but this effort has proved expensive, with mixed effects on quality and demoralizing effects on physicians, and they have had to scale the program back markedly.[8] Scotland recently scrapped much of their pay-for-performance program.[9]

Under Hawaii's Prepaid Health Care Act (PHCA), in place since 1974, and with Hawaii Medical Service Association (HMSA) as a dominant insurer, Hawaii basically relied on the same strategy used in other countries. The PHCA includes an employer mandate, comprehensive required benefits, and 80-90 percent coverage with no deductibles. This meant broad risk pooling and minimal restrictions on utilization. HMSA is a BCBS plan with 70% market share, with most of the remaining market in Kaiser, a closed-panel HMO. HMSA's dominance enabled imposition of price controls, and the company prided itself on having the lowest health insurance administrative cost in the country. Prior to the ACA, Hawaii had the highest rate of insurance, the best benefits, low patient cost-sharing, and among the lowest commercial health insurance premiums in the country,[10] despite a high cost of living. Hawaii's per-capita Medicare spending was also the lowest in the country.[11] All of this was accomplished with largely small independent physician practices paid with fee-for-service. Those of us in practice prior to the managed care era recall that physician supply was adequate, morale was generally good (despite complaints about HMSA's control over fees), and a high proportion of Hawaii physicians accepted Medicaid.

Hawaii is now attempting to rapidly shift from this successful model to the unproven model of "value-based" payment, which is being aggressively imposed by Centers for Medicare and Medicaid Services (CMS) and HMSA. The Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA) provide strong financial incentives for doctors, hospitals, and health plans to implement Merit-Based Incentive Payment Systems or Alternative Payment Models utilizing "value-based" payment strategies [12] such as bundled payments, shared savings, and capitation, that shift insurance risk onto the providers of care. The goal is for doctors and hospitals to assume responsibility for population health while holding them accountable for the cost of care.

In the past few years, many health insurance plans are also escalating their efforts to manage care by administrative policy, using utilization controls such as prior authorizations and formulary restrictions administered by third party corporate contractors. The time and effort doctors must spend coping with these restrictions is interfering with their productivity and attention to their patients,[13] leading to dangerously high levels of frustration, anger, and "burnout." [14,15] Widespread implementation of utilization controls and quality measures is forcing physicians to reduce their patient loads and impairs their ability to care for patients with complex problems, undermining the goal of managing population health. The result is accelerating loss of physicians from clinical practice, declining access to care for patients, and growing threats to overall quality of care and patient safety.[16]

The ideal would be that physicians make patient care decisions according to what is best for each patient, with individualized care informed by knowledge of medical science and clinical experience, relying on intrinsic motivation and professional ethics that place patient welfare ahead of financial considerations. It is also appropriate for physicians to include consideration for what is best for the entire population, given that they are accountable to both the individual patient and also stewards of public resources that are not unlimited.

Every form of physician payment involves compromises from this ideal [17], but the compromises are not equal among different payment schemes. It is essential that we ask which payment scheme would allow physician practice to come closest to this ideal. Even if we are constrained by federal law under the ACA, MACRA, etc., we still need to be clear about what does and does not work and why, and strive to come as close as possible to a truly workable system.

Motivating Physicians

Commercial versus Professional Ethics

Jane Jacobs, in her book *Systems of Survival: A Dialogue on the Moral Foundations of Commerce and Politics*,[18] makes the argument that there are two broad ethical paradigms in the world of economics: commercial ethics and "guardian" ethics. The commercial paradigm assumes a seller and buyer of goods or services, whose power and interests are balanced through the marketplace and the laws of supply and demand, with financial incentives as a primary motivator. Guardian ethics are applicable to socially necessary services that require specialized training and expertise not available or achievable by the general public, so that there is an inherent imbalance of power between the provider and recipient of services. Classic examples are the military, medicine, and other specialized professions. In these cases, the interests of the public are protected by a tradition of professionalism and concern for the welfare of the public, or patient, or client, which is held to be a higher ethical value than financial considerations.

There has been a movement in this country for the past 50 years to de-professionalize medicine, with an underlying assumption that commercial ethics are the only valid and trustworthy ethics. This justifies increasing interference in health care decisions by insurance plans and government, and an over-reliance on financial incentives to "fix" problems in health care, and especially its high cost.

Medical students start their training with the Hippocratic oath and with an idealistic desire to help others. However, they are often burdened with exorbitant debt, and they discover that almost half their time [19] is spent "treating the chart"[20] so that the hospital or clinic where they work can get

paid. These problems are compounded by payment reform initiatives that rely on financial incentives, supposedly intended to improve care, such as pay-for-performance, pay-for-outcomes, bundled payments, shared savings, capitation, and denial of payment for adverse events. These strategies add administrative burdens and generally fail to account for the difficulties in accurately defining "quality" or "outcomes" due to the complexity of health care.

Unfortunately, if doctors are stripped of their professional autonomy and treated as if financial considerations are paramount, they may begin to abandon professional ethics for commercial ones. They may start responding to financial considerations above patient needs; they may select patients according to their insurance status; they may try to avoid taking on sicker, more complex patients; and they may look for ways to game the system or to make more money from things other than professional services.

Intrinsic vs Extrinsic Motivation – Lessons from Behavioral Economics

Behavioral economics is the branch of psychology that studies motivation. Intrinsic motivation refers to the inherent rewards in an activity, and in health care this means things like helping patients, relieving suffering, advancing medical knowledge, satisfaction in solving complex diagnostic problems, and the like. Extrinsic motivation is based on external (financial) rewards and punishments.

Daniel Pink's book, *Drive: The surprising Truth About What Motivates Us* [21] offers an excellent, in-depth, and very readable review of the field. Mr. Pink makes a compelling case that "extrinsic" motivation based on financial rewards and punishments is appropriate only for tasks that are routine, uninteresting, and require some kind of external reward in order to motivate people to do them. For complex endeavors such as health care, where the professional work force brings a high degree of "intrinsic" motivation, then extrinsic financial rewards and punishments are counterproductive and undermine intrinsic motivation, performance, and quality. His summary points are:

"CARROTS AND STICKS: The Seven Deadly Flaws

1. They can extinguish intrinsic motivation.
2. They can diminish performance.
3. They can crush creativity.
4. They can crowd out good behavior.
5. They can encourage cheating, shortcuts, and unethical behavior.
6. They can become addictive.
7. They can foster short-term thinking.

Fostering Motivation:

1. Autonomy (practice within scope)
2. Excellence (continuous improvement)
3. Pursuit of a goal larger than oneself. "

Steffie Woolhandler and Daniel Ariely summarized the implications of behavioral economics and the psychology of motivation for health care [22] in a thoroughly documented Health Affairs Blog post.

"A meta-analysis summarizing 128 studies indicates that such findings are representative of a consistent body of research. The conclusions that emerge from the extensive literature on motivational crowd out include:

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- Tangible rewards — particularly monetary ones — undermine motivation for tasks that are intrinsically interesting or rewarding, an effect that is quite large.
- Symbolic rewards (e.g. praise or flowers) do not crowd out intrinsic motivation, and may augment it.
- The negative effects of monetary rewards are strongest for complex cognitive tasks.
- Crowding-out effects tend to reduce reciprocity and augment selfish behaviors.
- Crowding-out may spread (both to other tasks and to co-workers), decreasing intrinsic motivation for work not directly incentivized by the monetary rewards.
- Crowding-out is strongest when external rewards are large; perceived as controlling; contingent on very specific task performance; or associated with surveillance, deadlines or threats."

Health care and physician practice are very complex and involve a high degree of intrinsic motivation – exactly the conditions under which pay-for-performance is most likely to undermine intrinsic motivation and worsen actual performance and quality of care.

Physician "Burnout" and its causes

Physician practice requires arduous training, and doctors generally work long hours, often under difficult circumstances. Medical practice is very demanding, complex, requires a very large knowledge base, and must be personalized to accommodate a wide range of patient situations. Autonomy in practice is necessary to deal with the complexity of health care, to sustain physician motivation, and to make the sacrifices of medical training and practice worthwhile. When physicians are second-guessed at every turn by bureaucrats who know nothing about their patients, when they are manipulated with often trivial financial incentives, and when their time is usurped by excessive administrative demands at the expense of attention to their patients, then widespread "burnout" is the result. A December 2015 Mayo Clinic study[14] found that 55% of U.S. physicians suffer from symptoms of "burnout," a frightening statistic for anyone needing health care. Stripping physicians of their professional autonomy undermines morale and threatens actual quality of care and population health.[16]

Successful reforms must acknowledge the complexity of health care, respect physician autonomy, and engage physicians as leaders in designing reforms. Quality improvement and efforts to improve the cost-effectiveness of health care will be most effective if they are founded on the professional ethics and intrinsic motivation that are already built into medical training.

Is Fee-For-Service Really the Problem?

Blaming fee-for-service (FFS) as a cost driver is widely assumed in the health policy community, and it is the underlying rationale for the push toward "value-based" payment. There is indeed some unnecessary care driven by FFS, most notable in areas with an oversupply of procedural specialists and in for-profit hospitals that bill with FFS and impose productivity incentives for employed physicians, but this has

never been an issue in Hawaii, with a relative shortage of physicians, no for-profit hospitals, and historically low utilization under FFS.

The Dartmouth group studies[23] on regional variation in health care utilization showed wide variation in Medicare spending between different areas in the country, hence the assumption that about 30% of care may be unnecessary, and substantial health care savings could be achieved by policies aimed at reducing this variation.[24] However, the assumption that FFS accounts for regional variation in health spending ignores the obvious fact that high and low utilization areas used FFS equally. The famous 2009 New Yorker article by Atul Gawande, "The Cost Conundrum"[25] explored this issue in some depth, and points to a conclusion that the difference is in the physician culture in different cities or regions, and the degree to which the physicians in each area had abandoned traditional professional ethics (patient welfare comes first, before financial considerations) for commercial ethics (money is the bottom line; medicine is just another business). For most of the country including Hawaii, professional ethics still prevailed. A subsequent study re-analyzing the Dartmouth data[2] concluded that about 82% of the variation was due to population characteristics and other factors, and only 18% was attributable to differences in physician practice patterns. The idea that excess U.S. health care cost is due to FFS incentives has some truth, but has been overblown.

A better policy solution would be to make physician pay as incentive neutral as possible and deliberately promote and support professional ethics instead of commercial ones. This happens to cost much less to administer, it handles health care complexity much better, it works better to promote quality, and it is much, much better for physician morale.

The current fad of "value-based" payment is actually pushing us in the opposite direction. It starts with the assumption that physicians are primarily motivated by money and need to be incentivized financially to deliver less (presumably unnecessary) care. The majority of physicians who were trying to do the right thing for their patient all along are then in the position of being told they are to blame for excessive health care cost and that they must do a lot less for their patients or be punished financially, when there is actually little waste to cut from their practices. Then they are expected to provide much more detailed documentation and data reporting so that CMS or health plans can tell them what is and is not quality care, and what they must pay attention to in their practices. The metrics used are often poorly aligned with patient priorities. "Value-based" payment is very time consuming, costly, and demeaning for doctors, and it is a major reason for our epidemic of physician demoralization and burnout. It is also turning out to cost more in administration and bonuses than it can save from reduced utilization,[26] and it has not slowed the rise in total health care spending.

Part II of this series will consider the implications of various physician payment options, and Part III will suggest a much simpler incentive-neutral payment option that would enable large administrative savings and a realistic pathway to achieving the "quadruple aim" goals of improved quality of care, improved population health, reduced cost, and improved physician morale.

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Physician Payment Options for Effective Reform- Lessons from the Hawaii Experience

Part II: Implications of different payment models

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Abstract

There are advantages and disadvantages to all forms of physician payment, including fee-for-service, salaried payment, and capitation. "Value-based" payment reforms now being promoted under the ACA and MACRA laws are intended to counter the incentive under fee-for-service to provide unnecessary care, but they introduce new perverse incentives to skimp on necessary care and avoid caring for sicker, more complex, and socially disadvantaged patients. The counter-incentives of pay-for-performance and risk adjustment are administratively complex, burdensome, and expensive to implement; they are damaging to physician morale and driving doctors out of independent practice; and they do not appear to be capable of achieving the "quadruple aim" goals of improved care, improved population health, reduced total health care cost, and improved physician morale.

Part I reviewed general health care cost control strategies, what is known about effective strategy to enlist physician motivation in controlling health care cost. Part III will introduce a simpler strategy of returning to fee-for-service, but modified so as to be as incentive-neutral as possible concerning choice of services and treatment, enabling large administrative savings and a much more realistic pathway to achieving the "quadruple aim" goals.

Physician Payment Options:

Fee-for-service

Fee-for-services (FFS) in the U.S. is governed by our Resource-Based Relative Value Scale (RBRVS), Current Procedural Terminology (CPT), and Evaluation/Management (E/M) procedure coding. The RBRVS was supposed to base fees on the amount and complexity of "work" associated with a procedure, but it has evolved to over-value some procedures at the expense of others, and to undervalue cognitive services. The E/M system likewise attempts to base cognitive services on the amount and complexity of work, but has ended up being a "pay-for-documentation" system that rewards over-documentation and leads to gaming of documentation for payment.

FFS can be simple and relatively inexpensive to administer, although the complexities of RBRVS, E/M coding, and "pay-for-documentation" make it unnecessarily complex. FFS is compatible with intrinsic motivation and traditional professional ethics and accountability to the patient's best interest, but when some services are paid more highly than others, it can also encourage inappropriate care.

FFS pays more for more work, rewarding productivity, which can be an advantage when there is a physician shortage relative to population health needs, provided there is reasonable access to care for all who need it.

The disadvantage of FFS is that it can encourage unnecessary care because doctors and hospitals can increase reimbursement by increasing volume of services. This incentive is constrained for physicians in independent practice because of traditional professional ethics that place the welfare of the patient above financial considerations, and because there are only so many hours in a physicians' day. It is more of a problem with some hospitals that can hire more physicians and pressure them to increase volume of profitable services to increase revenue. Along with higher overhead and market clout in negotiating rates, this is one reason why hospital ownership of physician practices generally increases cost compared to independent practices,[1,2] and integrated delivery networks [3] have been associated with increased, not decreased, health care costs.

Salaried payment of physicians

Paying physicians on salary is incentive neutral with regard to procedural vs cognitive services, and salaried arrangements can be simple and cheap to administer. Salaried arrangements are most clearly appropriate for physicians doing shift work who can't control their patient load, such as emergency room physicians, hospitalists, and intensivists, or those working in clinics and community health centers funded with global budgets.

Physicians paid on straight salary who can influence their work load tend to see fewer patients [4] than those under FFS because their pay does not depend on volume of care, but they may also spend more time with sicker, more complex patients. Salaried arrangements may benefit from productivity incentives, but if there is too much pressure from the employer to maintain high productivity, there is a risk that complex patients will not get the time they need for optimal care, or that physicians will have an incentive to avoid caring for sicker, more complex, and less compliant patients. There can be a tendency to introduce too many incentives to modify salaried arrangements, making payment unnecessarily complex and expensive to administer, and interfering with optimal clinical judgment. This is what we are seeing with the current pay-for-performance fad.

Salaried arrangements do require an employer, so they tend to be used in large group practices, for hospital-based physicians, and for physicians working in community health centers and government programs. They work best if physician pay is commensurate with the training and expertise required for each specialty, and incentives are kept simple.

The "Value-Based" Payment Model

"Value-based" payment assumes a lot of unnecessary care due to the incentive under fee-for-service payment to deliver more "volume" of care in order to increase reimbursement.[5] This assumption never had much validity in Hawaii, as evidenced by Hawaii's low rate of per capita Medicare spending.[6] The "value-based" solution is to pay doctors and hospitals up front for an episode of care or for the total cost of health care for a population (capitation), effectively shifting insurance risk to providers of care so that their incentive is to deliver less care, or less expensive care. The hope is that they will strive to delivery only care that has value, hence the label "value-based" payment.

The proponents of this model acknowledge that "value-based" payment can introduce unwanted incentives[5] to skimp on necessary as well as unnecessary care, and to "cherry pick" healthier, wealthier, more straightforward, and more compliant patients and avoid sicker, poorer, and more complex patients. Therefore, the model includes pay-for-quality (P4Q) incentives (preferably based on outcomes) to discourage skimping on necessary care, and risk adjustment so that doctors, hospitals, and health plans taking on sicker patients get paid more. However, outcomes depend more on patient characteristics [7] and social determinants of health [8] than physician effort, so financial incentives based on outcomes add to the incentives to "cherry pick."[9] Both P4Q and risk adjustment require detailed data on diagnosis and severity of illness and on exactly what treatment is being provided, hence the reliance on detailed documentation and procedure codes and conversion to a much more detailed and complex diagnostic coding system, ICD-10, in 2016. Other countries use ICD-10, but most don't require its full specificity for payment, as is now required by both CMS and most private health insurers in the U.S.

There are serious problems with the validity of the quality measures on which P4Q depends. Much of health care is too complex for simple metrics, so the metrics used are narrow and chosen for ease of measurement, and often have little validity or relevance to patient priorities and actual quality.[10, 11, 12,13]

Another unintended consequence of P4Q and risk adjustment is the incentive to game documentation, including over-documentation to increase reimbursement, mindless "cloning" of information from older notes into newer ones, use of electronic health records to generate "structured data" that can be captured in computerized reports, and over-diagnosing patients to beat risk adjustment formulas. There is extensive evidence of gaming of documentation at all levels,[14] by doctors,[15] hospitals,[16] and health plans [17]. Electronic health records and the demand for more structured data have also led to medical records with volumes of irrelevant, meaningless, and often inaccurate information [18] and very little coherent narrative, so that a doctor reading a progress note may have little idea about what is actually going on with the patient. The electronic health record has improved legibility at the expense of coherence, and the data on which P4Q and risk adjustment depend is often seriously corrupted.[19]

"Value-based" pilots: The Medicare Pioneer and Shared Savings ACO Programs

CMS has sponsored extensive pilot programs on the Accountable Care Organization (AC0) model, intended to facilitate a transition from fee-for-service to payment for "value," which means capitation, bundled payments, shared savings, and pay-for-quality. The Medicare Shared Savings ACO's can earn bonuses if they reduce Medicare health care spending, but do not take on risk if they fail to do so. The Pioneer ACO's were considered to be the most advanced and ready to assume risk, with an eventual goal of capitation, under which the full insurance risk of health care would be transferred to the ACO.

A series of articles on the results of both these CMS ACO programs[20,21] have shown some reduction in health care spending in a minority of ACO's, particularly those in areas that were high spending to begin with[22], but savings were more than offset by administrative costs to CMS and the cost of bonuses,[23,24,25] for a small net loss to the Medicare program[26]. CMS costs also do not take into account the substantial administrative cost required to run an ACO.[27] As a result, a large number of the ACO's have dropped out of the program and progress toward more risk bearing contracts seems to be stalling.[26,27]

Effect of "Value-Based" Payment on Physicians

The data demands of "value-based" payment, including pay-for-quality and risk adjustment, are a severe burden on practicing physicians.[28] Dealing with quality measures requires an average of more than 15 hours per week per doctor, at a cost of over $40,000 per physician per year. Lost productivity due to quality measures means that on average a doctor can see 9 fewer patients per week. Doctors report they are forced to spend less time with patients, and a large majority believe measuring quality in this way is a waste of time and does not improve patient care. Rushed physician schedules and reduced time with patients are also a major factor in diagnostic errors, [29,30] compromising quality of care.

The administrative costs of compliance with demands from CMS and health plans for computerization, documentation, and data reporting are having the effect of driving doctors out of private practice,[31,32,33] and into employment by hospitals and health systems, into administrative positions, or into early retirement. These burdens are also a major reason for the extremely high rate of physician "burnout,"[34] at around 55% nationwide in 2014, an increase of 10% between 2011 and 2014.

Reduced physician productivity and loss of physicians providing clinical care, plus the trends toward narrow networks and increased patient cost-sharing, are having the effect of reducing patient access to care. At the same time, physicians are being expected to participate in payment models that hold them accountable financially for quality of care and population health, goals that are directly undermined by increasing constraints on access to care for patients. Physicians are responding by adopting practice models that enable them to avoid these risks,[33] but that further restrict access to care for poorer and sicker patients, such as concierge care, direct primary care, and refusal to accept patients with Medicare and Medicaid.

Imposition of "value-based" payment reforms may lead to a smaller number of physicians with "cherry picked" patient populations demonstrating high quality scores, while many other patients lose access to out-patient care, ER and hospital usage increases, the health of the whole population deteriorates, and overall healthcare costs continue to rise. These trends are simply not sustainable and will lead to widespread failure to achieve policy goals.

Implications for Hawaii

So far in Hawaii, preparations for "value-based" payment have been associated with doubling of commercial health insurance premiums in the past 9 years. Measures intended to improve quality and coordination of care are resulting in a marked increase in administrative costs and burdens, while actual access to care is deteriorating. Hawaii has a serious physician shortage of about 800 full-time equivalent doctors, a shortage of 24 percent, projected to continue to worsen.[32] Although there has been a little improvement in some quality measures, the effects of P4Q on overall quality and population health are probably detrimental due to reduced access to care, diversion of attention away from the majority of health care quality that is not measurable, and loss of physician productivity and attention to patients due to administrative burdens.

Capitation for Individual Primary Care Physicians

Since everyone should have a primary care physician, it is possible to pay primary care physicians by capitation, with a per-member-per month payment based on the size of their patient panel.

This idea has been implemented in the "Direct Primary Care"[35] (DPC) model, in which primary care physicians refuse all insurance, and charge patients directly a monthly subscription fee that covers all their primary care needs. This eliminates the need for billing, collections, prior authorizations, pay-for-documentation, and all the other administrative costs associated with health insurance as a payment system. As a result, a primary care physician can run a moderately sized practice with just one medical assistant and very low overhead, making the subscription fee affordable. Hospital care, specialist care, lab services and pharmaceuticals are generally not included since they are outside the doctor's control. DPC has flourished in areas where there are a lot of uninsured and under-insured. Since the doctor knows his or her patients often cannot afford expensive care, every effort is made to manage problems without referrals or unnecessary tests and procedures, including liberal use of phone calls, and DPC doctors do very well at minimizing preventable hospitalizations and reducing total cost of care.[36]

However, when an insurance company pays primary care physicians (PCPs) with capitation, the doctor may no longer feel a direct obligation to the patient to minimize outside costs. Many health plans, including HMSA in Hawaii, are therefore planning incentives based on total cost of care, which is often not in the control of the PCP. This generates an incentive to "cherry pick" and avoid sicker, more complex patients, so that risk adjustment is also required. As a result, this version of insurance-based primary care capitation has all the administrative burdens and costs of "value-based" payment and little of the savings of the DPC model.

Capitation by a health plan provides a guaranteed income for primary care physicians based on panel size, and they can improve their income further by meeting quality metrics. They can also save something on their billing and collections costs, but they will still be burdened with extensive, time-consuming documentation and reporting requirements that require higher staffing and overhead. The only way a PCP can successfully reduce total cost of care under insurance-based capitation is if he or she can achieve substantial reductions in utilization. If there is not a lot of unnecessary care, as in Hawaii, then the administrative cost of documentation, data reporting, pay-for-performance, quality incentives, and risk adjustment will outweigh any possible savings and the model will result in an increase in total cost to the health insurer and the health system.

Capitation does not work well for specialists because not everyone in the population needs a specialist, and capitating them would create a strong incentive to avoid the sicker, more complex patients who need a specialist the most. Specialists may participate to some degree in bundled payments for certain conditions, but otherwise they must either be paid with FFS or salary. In either case, implementing pay-for-quality for specialists is problematic because specialists are the experts in their fields and know the protocols well, and they also deal with the most complex cases where deviation from protocols is often necessary. Health plans relying on standardized protocols have little to offer specialists in encouraging quality, and P4Q for specialists becomes a senseless administrative burden for both the health plans and for the doctors.

On the other hand, some specialists may respond to the skewed incentives toward procedures in the RBRVS fee schedule by providing unnecessary procedures. The usual response from health plans is utilization management, which is administratively burdensome and expensive all around. A better

approach would be to design specialist pay to be as incentive-neutral as possible, so that there would be no incentive except to do what is best for the patient.

Part III of this article will consider a new proposal for a fee-for-time system designed to be as incentive-neutral as possible, minimizing administrative costs and burdens. This proposal would follow the experience of Hawaii and of other countries, using administrative savings to lower health care prices and relying on negotiated price controls and budgeting as the primary means of controlling cost, instead of competition, utilization controls, and financial disincentives directed at doctors and patients.

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Physician Payment Options for Effective Reform

Part III: Proposal for reducing cost via simplified, incentive-neutral payment of physicians and hospitals

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Abstract:

Part I reviewed general health care cost control strategies and what is known about effective strategy to enlist physician motivation in controlling health care cost. Part II considered the implications of various payment options, and the increasingly apparent problems with "value-based" payment strategies. Part III introduces a new proposal for a fee-for-time system designed to be as incentive-neutral as possible, minimizing administrative costs and burdens. This proposal would follow the successful experience of Hawaii and of other countries, maximizing access to care and using administrative savings to lower health care prices, while relying on negotiated price controls as the primary means of controlling cost, instead of the current U.S. strategies of competition, utilization controls, and financial incentives and disincentives directed at doctors, hospitals, and patients. This proposal would make micromanagement of utilization by government and health plans much less necessary and documentation would be uncoupled from payment, returning the focus of documentation to care-related priorities and quality improvement instead of "pay-for-documentation." Substantial administrative savings would then be possible for both payers and providers of care. This proposal would provide a realistic pathway to achieve the "quadruple aim" goals.

Proposal for Reform – A Universal System with Physicians Paid "Fee-for-Time" or with Salaries

Guiding principles are to promote intrinsic motivation for physicians, minimize perverse incentives and counter-incentives, keep administrative costs as low as is feasible, and also encourage cost-effective care and quality improvement.

Effective payment reform should strive for incentive neutrality so that physicians are freed to base treatment decisions on patient need, with an eye to population health, instead of being driven by financial incentives. Physicians are by far the most highly trained participants in health care delivery, and their autonomy needs to be restored and preserved if we are to take advantage of this expertise. Physicians should rely on intrinsic motivation and professional ethics [1] instead of clumsy financial incentives and commercial ethics that are not appropriate to health care.[2] Administrative burdens and costs must be minimized to stem the epidemic of physician "burnout" and the flight of doctors from clinical practice. Administrative simplification is also crucial if we want to attract doctors to practice in rural and under-served areas.

Single-payer countries have the lowest administrative costs.[3] At minimum, significant administrative savings would require a universal "all-payer" system, with all health plans required to use the same

network of physicians, pay the same fees, offer the same benefits, use the same formulary and prior authorization policies, and pool resources so as to pay hospitals with global budgeting.

Incentive-Neutral Payment for Physician Services

1) Fee-for-Time:

Physicians in independent practice could be paid with a simplified form of fee-for-service that replaces the Resource Based Relative Value System (RBRVS) and Evaluation/Management (E/M) coding with a fee-for-time system.[4] This is familiar fee-for-service, but revised so as to be as incentive-neutral as possible. Each procedure, including both procedural and cognitive services, would be associated with the time usually required for that service. Physicians would be paid the same hourly rate for procedural services as for cognitive services and care coordination. Instead of actual time spent, they would usually be paid for the average time scheduled for that procedure in the community, so as not to reward inefficient doctors. For exceptionally complex or crisis situations, the physician could bill for actual time spent with supporting documentation. Fees would be adjusted for years of training and the overhead required to practice each specialty, but would be the same for all doctors practicing the same specialty in a community. With reduced administrative costs, fees could be lowered in proportion to administrative savings.

Fee-for-time based on time scheduled is not an untried idea. U.S. Psychiatrists were paid in exactly this way before they were put on E/M coding in January 2013, and it worked well. It was much simpler and less time consuming than E/M coding, and documentation was focused on clinical priorities, with no meaningless documentation inserted just to maximize payment. The Swiss are successfully using a similar physician payment system for primary care.[5]

For procedures such as surgery, "time" would generally not be the time actually spent, but the average time scheduled for that procedure in the community. For example, consider a physician who is doing a generally predictable procedure such as cataract extractions, which might take an average of 20 minutes of an ophthalmologist's time. A more efficient surgeon might be able to do 4 an hour instead of 3, and would get paid somewhat more, and a less efficient surgeon might only manage 2 an hour and get paid somewhat less. For more complex or high-risk procedures the physician could schedule the time expected for the procedure. In cases with unexpected complications, billing would be for time actually spent with supporting documentation.

For cognitive services such as E/M by an internist, the doctor and patient would usually have an idea of how much time would be needed for a given patient with a given collection of problems. They might have options for 15, 30, and 45 minute visits, and they would choose in advance which to schedule. Doctors would not be pressured to shorten visits for complex patients because they would be paid the same hourly rate whether they scheduled a longer or shorter visit.

This system would reward efficiency in performing procedures, and it would pay doctors more who worked longer hours. The only element of documentation relevant to payment would be the time associated with the procedure, so there would be no justification for payers to micromanage documentation and utilization, or to interfere in physician-patient decisions.

A fee-for-time payment system would be much less susceptible to fraud and abuse, because total time billed by a provider could be easily tracked. If a doctor were billing for 20 hours a day every

day, that would strongly suggest fraud. Patients would get an "explanation of benefits" statement, and could complain if the doctor were billing for significantly more time than actually spent.

2) Salaries for Employed Physicians:
Alternatively, physicians employed by hospitals, integrated delivery systems, and other institutions such as community health centers could be paid by salary, perhaps with a simple productivity incentive. Complex pay-for-performance schemes should be avoided because they increase administrative burdens and cost and because they undermine intrinsic motivation, demoralize doctors, and do not actually improve overall quality of care.[6,7] (See also the British experience.[8,9])

3) Government Subsidy of Medical Education:
U.S. physicians must finance their own education, and they often complete training with debt of several hundred thousand dollars. They must recoup this cost when they enter practice, so education costs are baked into physician payment, and higher fees then continue throughout a physician's career. Medical education debt is also a major incentive for physicians entering practice to bypass primary care and proceed to more highly paid specialties and sub-specialties, contributing to our primary care shortage.

Government subsidy of medical education would eliminate physician educational debt and allow commensurate lowering of fees, with savings for the entire healthcare system. A major deterrent to physicians entering primary care would also be eliminated. Government now pays about 60% of total U.S. healthcare costs,[10] and savings from lower fees and an expanded primary care work force would exceed the cost of the educational subsidies.

4) Negotiated fees:
In order to assure that physician pay remains adequate to maintain physician buy-in and a stable work force under a unified fee schedule, physicians would be allowed to organize and bargain collectively with payers to establish the fee schedule and training and overhead modifiers. All practicing physicians should be required to join a professional organization as a condition of licensure, in order to assure full representation in fee negotiations. Peer review and disciplinary actions would become much more effective, since expulsion from the professional organization would mean expulsion from practice.

The difficulty with standardized fees would be in getting all the specialties to agree on the conversion factors that determine the hourly rate for each specialty. Basing this on "complexity of decision making" as in E/M, or on the perceived difficulty of newer procedures compared to established ones, result in skewed incentives that compound over time. Basing the conversion factors on years of training required for each specialty, necessary overhead costs, and regional cost-of-living is a lot simpler and more objective.

The conversion factors should be calculated to assure that a physician with 3 years of post-graduate training and with 50 scheduled hours per week would be left with a gross personal income, after office overhead and adjusted for regional cost-of-living, commensurate with the training and expertise required for a primary care practitioner. For illustrative purposes, let's assume this would be $200,000 per year in a particular region. For each additional year of fellowship training needed for a sub-specialty, the hourly rate might be adjusted to generate an additional $50,000 in personal

income after overhead for a 50-hour week. Of course, doctors working 60-80 hours a week would make more, and doctors working 30-40 hours a week would make less.

5) Documentation Requirements:
Documentation requirements would follow the medical model, including reason for visit, interval history and relevant review of systems, exam, diagnoses, assessment, and treatment plan with rationale. Each procedure code would be associated with a time scheduled, and this would be the basis for billing and payment. An ICD-10 diagnosis code would be required for payment, but the full complexity of the ICD-10 system would not be necessary.

6) Quality Improvement:
A fee-for time system would eliminate "top-down" pay-for-performance and invest in "bottom-up" quality improvement projects that target identified problems and unreasonable variations in practice patterns, with metrics developed locally by the providers of care and modifiable by them, following the Intermountain model.[11] The incentive for quality improvement should be based on intrinsic motivation to provide better patient care, not complex financial incentives.

7) Care Management by Health System:
Utilization management of physicians by a health system would be limited to physician outliers with aberrant practice patterns, identified from claims data. The large majority of physicians who are trying to practice good care within community norms would not be micromanaged. Health systems would provide supportive case management in collaboration with treating physicians for complex, high-utilizer patients. All payers in a health care region would contribute funding for specialized services for specific populations such as the seriously mentally ill, substance abusers, and high-risk medical patients managed in the community. These programs would be funded with global budgets from the health system, with employed professionals paid by salary. Their services would be available to the entire community based on patient need, not insurance status.

Incentive Neutral Payment for Hospitals

Hospital payment can be considered separately from physician payment, but if we apply the same principles of incentive neutrality, administrative simplification, and reduced prices in proportion to reduced administrative costs, then we could design more effective reforms than diagnosis related groups, bundled payments, and denial of payment for early readmissions. A single-payer health system or health plans in an all-payer system could pool hospital funds and pay hospitals a global operating budget for all care, eliminating or at least drastically reducing hospital billing and collections, which can be around 10% of a hospital's budget.[12] Maryland has already achieved significant hospital cost savings from implementing an all-payer system with global budgeting[13].

Global budgeting eliminates incentives for hospitals to encourage highly reimbursed procedures at the expense of services that are not so highly paid, and it eliminates problems with payer mix and incentives to target wealthier, better insured patients and avoid those with Medicaid or who are uninsured. Under global budgeting, the primary incentive for hospitals is to deploy resources within their budgets so as to meet the needs of patients in their community.

Capital improvement budgets for building or expanding hospitals and other health care facilities should be funded separately from operating budgets and allocated according to community needs, to assure appropriate distribution of hospitals and other healthcare resources.

Pharmacy Benefits Management

Contracting pharmacy benefits out to third parties has not achieved the hoped for reductions in drug prices, and in fact quite the opposite has happened.[14,15] Pharmacy benefits managers and pharmaceutical companies [16] have been competing to see which can extract the most money from health care,[17] at the expense of health insurers and patients.[18] Arbitrary formulary restrictions and prior authorizations are becoming an intolerable burden on physicians attempting to care for their patients.[19] There is no good reason for insurers to continue to outsource pharmacy benefits, formularies, and prior authorization policies to third parties.

Prior authorizations should be limited to drugs and procedures that offer no advantages over existing similar drugs or that are clearly shown to be susceptible to abuse or use for non-medically necessary purposes. Prior authorization lists should be reviewed regularly by a panel of local practicing physicians and pruned regularly to eliminate PA's that are almost always approved.

Our problems with runaway drug prices in the U.S. are best addressed with negotiated prices at the regional or national level.

Implications

Fee-for-time is a more incentive neutral way to pay for physician services. It would minimize perverse incentives and counter-incentives, minimize opportunities for fraud and abuse, and minimize the need for "medical management." It would not discourage care for sicker, more complex patients. Physician autonomy, professional ethics, and morale would be supported and encouraged instead of undermined.

Incentive-neutral payment via fee-for-time or salary does not rely on "big data" and pay-for-documentation, returning the focus of documentation to patient care priorities and quality improvement, instead of complex payment schemes. Physicians would not even need to computerize to participate in this proposed payment system, and we could stop driving older physicians out of practice prematurely.

Administrative savings for both hospitals and doctors would allow reductions in fees in proportion to savings on overhead without hurting providers of care. Further reduction in physician overhead could be achieved with public subsidies for medical education and training, so that doctors starting out in practice would not be burdened with large education debt.

Independent physician practice is in fact the most cost-effective model of care [20] and has been shown to beat hospital ownership of physician practices [21,22] on both cost and quality measures. A fee-for-time system would encourage independent practice by minimizing overhead and practice startup costs. Equalized pay regardless of practice location would reduce barriers to independent practices in rural and under-served areas. A universal, unified care delivery system would eliminate disparities in access to care based on insurance status.

Global operating budgets for hospitals would eliminate almost all of their billing and collections costs. Improved access to outpatient care would lead to reduced ER and hospital care, but with global budgeting reduced utilization need not harm hospitals the way it does in a fee-for-service environment.

Fee-for-time would achieve substantial administrative savings for both payers and providers due to markedly simplified billing and collections, elimination of most "medical management" and utilization management, and eliminating the expenses and perverse effects of pay-for-quality, pay-for-documentation, and risk adjustment. Specialized billers, coders, and scribes would not be necessary. The universal payment system would only be concerned with adding up the time required for procedures billed, and there would be no need to micromanage medical decisions except in the case of clear outliers with aberrant practice patterns, and those could be easily identified with claims data.

Quality improvement would be based on locally generated data targeting identified problems and unreasonable variation in practice patterns. Outcomes would be measured at the population level and by total spending of the health care system, not individual metrics tied to payment that punish doctors who take on sicker, poorer, and more complex patients.

Under a universal system, insurance risk would be managed primarily with risk pooling, not competition to avoid covering or paying for the care of sicker patients and populations, shifting cost onto patients, or shifting risk onto providers of care. Capitation or budget setting at the population level, instead of for individual practices, would be much simpler and less expensive to administer.

A fee-for-time system would have to be implemented broadly in order to work. A pilot project would not enable any administrative savings, either in money or time, as long as physicians had to maintain all the administrative structures and costs of the current system alongside the pilot program. However, with full implementation the administrative savings would be immediate, and could be calculated based on the current cost of administrative systems that would become unnecessary.

Other savings would take time to be realized, including savings from quality improvement projects, eliminating perverse incentives for procedures compared to cognitive services, eliminating gaming of documentation for payment, and reduced opportunities for fraud and abuse.

Estimated savings for the whole health care system if all these proposals were implemented could easily be 30-40% of current U.S. health care spending, more in line with per capita spending in other advanced countries with universal health care systems.

Conclusion

A universal single-payer or all-payer system that paid doctors with fee-for-time or salary and hospitals with global budgeting would be a new kind of alternative payment model (APM), although not the kind envisioned by the architects of the Affordable Care Act. It would benefit doctors, hospitals, health care payers, and most of all patients in need of care. Unlike "value-based" payment, it would be capable of actually achieving the "quadruple aim" goals of improved quality of care, improved population health, lower total cost of care, and improved physician morale.

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