EDITORIAL

Can Alternative Payment Models Save Primary Care?
Lessons From Hawaii for the Nation

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The concept of "primary care" became widely accepted in the 1960s as part of a broader acknowledgment that as medical care migrated from the once-dominant setting of the home to offices and hospitals, a surge of programs that promoted the value of general medical care was needed to help the generalist whose role was both economically and politically marginalized by specialties with higher compensation and stronger presence within academic departments. Medicare was introduced in 1965, the same year several reports were published by the Association of American Medical Colleges and the American Medical Association calling for generalist physicians to be at the center of the health system.[1] Concomitantly, as the complexity of medical care increased, there was an important need for a trusted clinician who could have an important role in prevention and wellness, accurate diagnosis and treatment, and coordination of complex care and who could maintain an emphasis on high-quality, person-centered care.

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However, as fee-for-service matured over the decades that followed, the pressure to see more patients and increase the income generated from Relative Value Units of work intensified, and the concept of a 15-minute visit became the norm. Increasing time pressures and decreasing reimbursements have challenged primary care significantly, to the point where the supply and retention of primary care practitioners is a national policy priority.

These and other factors created the opportunity in the early 2000s to try to align patient, clinician, and payer goals through payment models that used direct financial incentives to promote patient-centered principles.

These models have taken many forms, starting with early pay-for-performance models, patient-centered medical home demonstrations, and accountable care organizations. Large public payers including Medicare have also launched efforts including, in 2017, the Comprehensive Primary Care Plus Initiative (CPC+). In CPC+, more than 14 000 clinicians volunteered to take part in a payment model for advanced primary care initiatives with agreements from commercial payers to match the federal payments.

However, evaluations of alternative payment models such as CPC+ have been disappointing, with the CPC+ evaluation demonstrating successful practice transformation but minimal effects on quality and cost savings to the Medicare system.[2] More broadly, it has seemed as though the intense and unanimous calls to move from paying for volume to paying for value have yielded little concrete evidence of success, particularly in primary care. But perhaps the key takeaway should not be that alternative payment models in primary care have generally been modestly successful but that the expectations, evaluation standards, and outcomes are misaligned—that is, what has been counted does not reflect the goals of these programs.

In this issue of *JAMA*, Navathe and colleagues[3] describe the first year of implementation of a novel capitated primary care program, Population-based Payments for Primary Care (3PC), in the state of Hawaii. The 3PC program has design features similar to those of the new Primary Care First program from the Center for Medicare and Medicaid Innovation, scheduled to launch in January 2020. Specifically, 3PC uses risk adjusted monthly population-based payments along with design aspects that allow for varying degrees of practice types and sizes to have meaningful participation.[4] Incentives are also incorporated to motivate meaningful engagement, with up to 20% of monthly payments at risk if certain practice engagement characteristics are not met.

In this observational study, the authors used claims data and clinical registry data from January 2012 to December 2016 and a propensity-weighted difference-in-differences method to compare 77 225 members of the Hawaii Medical Service Association (ie, the Blue Cross Blue Shield of Hawaii) attributed to 107 primary care physicians and 4 physician organizations participating in the first wave of the 3PC with 222 233 members attributed to 312 primary care physicians and 14 physician organizations that continued in a fee-for-service model in 2016 but started participation in the 3PC at dates thereafter.

Despite this careful design, results at 1 year were modest at best, with only a 2.3% improvement in a composite quality score (primary outcome of interest) (ie, the risk-standardized composite measure scores from 2012 to 2016 changed from 75.1% to 86.6% [+11.5 percentage points] in the 3PC group vs 74.3% to 83.5% [+9.2 percentage points] in the non-3PC group). In addition, there were no statistically significant savings in the total cost of care (ie, mean total cost of care from 2012 to 2016 changed from $3344 to $4087 in the 3PC group vs $2977 to $3564 in the non-3PC group; adjusted differential change, 1.0% [95% CI, −1.3% to 3.4%]).

Despite these initial findings, there is intense pressure to continue the pace of movement toward value. Payers still need to find ways to control costs, physicians and other health professionals remain frustrated with the electronic health record and high administrative burden, and, perhaps most importantly, patients are still not receiving optimal care. It is in this environment that Hawaii Medical Services Association,

which launched 3PC in 2016, is in good company with many regional payers such as Blue Cross Blue Shield of Massachusetts as well as Medicare, the Veterans Administration, and others that continue to seek ways to achieve the quadruple aim: better care for the patient, and the population, at a lower cost, while improving the work of clinicians.[5] In this regard, several important lessons can be gleaned not only from the first year of this attempt in Hawaii to transform health care but also from many of the other large national programs.

First, evaluations of alternative payment models require a new approach. There needs to be a focused effort to develop more flexible approaches to evaluating such models that balance traditional standards of rigor while also allowing for iterative evaluations with a goal of improving programs in a nimble fashion. For example, as Navathe et al discovered through subgroup analyses, important milestones were achieved in promoting advanced care plans and better management of blood pressure in patients with diabetes; such progress is not trivial. In fact, these initial improvements can often be the foundational element that leads to broader changes in behavior and cultural adoption of new practices, eventually transcending a payer or a particular program and simply becoming second nature to practice. These behavior changes take time and require social acceptance—for example, primary care physicians becoming more comfortable managing higher-acuity issues or certain specialty conditions when the prior norm might have been to refer to specialty care or hospital settings.

However, to drive toward such behavior change, evaluations need to have shorter intervals, with differentiation as time progresses. Earlier evaluations should emphasize infrastructure investments common to the initiation of all alternative payment models, such as building data capacity, clinician engagement, and patient enrollment strategies. Intermediate evaluations should focus on process improvements, for example, working toward improvement in existing quality measures, while introducing novel measures. For example, alternative payment models should encourage measurement of clinician satisfaction, so that these data can be used to help determine the best way to adapt the health infrastructure to support clinicians in these significant changes. Evaluations closer to the end of the initial implementation period of a program should have a stronger focus on elements of cost and clinical outcomes and, where feasible, should include measurement of behavior or culture change. Such information, drawing from social science, could help clinicians and leaders better understand how to scale and sustain improvements beyond the initial effort.

Second, the results of the study by Navathe et al also support the concept that alternative payment models initiated by a payer are likely less effective than those co-created or initiated by clinicians. The 3PC payment model was initiated by an innovative payer and had creative additional elements, such as the use of behavioral economics and financial risk associated with engagement, but the model could potentially be improved with stronger elements of clinician-focused payment models. Nationally, the Physician-focused Payment Model Technical Advisory Committee was created through the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to encourage clinicians to engage in the development of alternative payment models.[6] To date, 22 alternative payment models have been submitted to the committee; recommendations on each have subsequently been made to the Secretary of Health and Human Services on all of the models, and model features have been adopted in several Capability Maturity Model Integration programs. While payers certainly have a significant degree of leverage in terms of information, capital (financial and social), and scale, the emergence of models developed by clinicians hold great promise. Co-creation could lend strength to areas of weakness, such as consideration for more meaningful patient engagement as well as identifying ways to improve primary and specialty care interactions to achieve the quadruple aim.

The 3PC program in Hawaii represents important progress in the journey toward a vision of primary care that will be effective and long-lasting. Perhaps looking for cost savings after 1 year is less important than reaching a better understanding of how to identify and scale aspects of the program associated with near-term improvements and finding ways to change models in a continuous fashion. Primary care physicians and patients are looking for ways to recapture the human elements of care: time, personalization, and dignity. Payment models should accelerate this process and not hinder its progress.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: Dr Patel reported serving as a board member for Paladina Health and as a member of the Physician Focused Payment Model Technical Advisory Committee (PTAC), a US Government Accountability Office–appointed committee that serves to advise the secretary of Health and Human Services on alternative payment models.

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