PO Collaborative Summary
April 6, 2017
5:30 to 7:30 p.m. HMSA Center, Koa & Hau Rooms

Physician Organizations

- Ekahi-CMC: Celeste Oshiro Wong, Keith Katano
- Hawaii IPA: Dr. David Saito, Dr. Josh Green, Victoria Page
- MSMP: Dr. Joel Kobayashi, Dr. Lance Taniguchi, Tracy Fujita
- Castle: Kate Saavedra, Dr. Brit Reis
- East Hawaii IPA: Dr. Lynda Dolan, Dr. Kevin Kurohara, Susan Mochizuki
- PMAG: Dr. Donna Mah, Dr. Gregg Shimomura, Michael Chang
- Hawaii Health Partners: Dr. Liana Peiler, Dr. Andy Lee
- Queen's Akoakoa: Dr. John Houk, Dawn Asano, Eugenia Bonoan
- Hawaii Filipino: Dr. Sorbella Guillermo, Dr. Aurora Mariani, Connie Seronio
- Maui Medical Group: Cliff Alakai

HMSA: Dr. Mark Mugiishi, Jayme Puu, Emily Oshima Lee, Dr. Jeff Tom, Justin Yoshimoto, Isaac Yuen, Matthew Kanemura, Jessica Santos, Renee Oshiro, Victoria Mizumoto, Alyson Kusatsu

I. Welcome. Jayme Puu welcomed the 10 Physician Organizations to the PO Collaborative.

II. PMPM adjustment for 2018
Emily Oshima Lee, Director of the Office of Payment Transformation, presented on the model currently under discussion for adjusting the primary care Payment Transformation PMPM rates in 2018. Band adjustments are tentatively being considered for July 2018, but we're still discussing whether this will apply to all PCPs, or a subset. The purpose of Emily's presentation was to share the framework for the rate adjustment methodology for 2018, and receive provider feedback and concerns. At a high level, these are key points:

- Rates in 2016 and 2017 were based on historic fee for service payments, but beyond 2017, HMSA would like to have an increasing proportion of the PMPM be value-based.
- The goal is to invest more dollars into primary care.
- HMSA wants to distinguish by PMPM rate high performing providers vs. lower performing providers. Limits need to be in place to protect both providers and HMSA.
- HMSA is exploring a methodology that gradually moves from the historic FFS PMPM rate to a value-based PMPM anchored to a national compensation rate that is adjusted for:
  - Panel risk
  - Quality
  - Scope of service
  - Total cost of care
- HMSA intends to use a national benchmark (MGMA or AMGA blend) that will be considered a "target" or anchor rate, which varies by specialty.

A. Transition

- For 2018, HMSA would use 66% of the PCP's FFS historic PMPM rate and 33% of the "target" rate, which would be subject to the above-referenced adjustment factors.
- For 2019, HMSA would use 33% of the PCP's FFS historic PMPM rate and 66% of the "target" rate, subject to adjustment factors.
- For 2020, HMSA would use 100% of the "target" rate.
- There would be separate calculations for each line of business.

B. Adjustment factors

Risk

- Largest of the four factors. Uses the ERG methodology and enables HMSA to reimburse doctors who care for sicker patients more than for those with less complex patients. Most PCP panels have stable ERG scores and scores do not fluctuate drastically over time.
- HMSA would create risk networks by specialty, so pediatricians and adult med doctors would be in different groups.
- Dr. Mugiishi said HMSA may also look at other factors beyond ERG, such as patients ages 0 to 2 for pediatricians.

Scope of service

- In response to feedback from PCPs, HMSA proposes to carve out facility-based care (services rendered at a hospital, skilled nursing facility, rehab facility billed with facility place of service) from the historic PMPM rate, and pay those services fee for service. This is to encourage PCPs to continue to provide care at facilities. Urgent care would not be included in this carveout.
- Because of variability among providers, HMSA is struggling with how to handle medical procedures and labs. Should we continue to include these services in the basic PMPM, establish a separate PMPM for procedures/labs, or carve out and pay FFS?
    - PMAG said that this is an individual matter, as doctors practice differently with respect to procedures and labs. Asked whether doctors could opt in or out for the PMPM for hospital services or labs.
    - Queen's observed that every adjustment variation for an individual provider would require separate contracting.
    - Hawaii IPA asked if procedures can be done in an office or a facility, would the FFS payment result in more services being moved to the higher-costing facility?
    - Castle said two doctors who do most of the SNF work should be paid fee for service. But she has concerns if they are seeing their own attributed patients for whom they are receiving a PMPM. Emily acknowledged that this begins to chip away from panel management and whole patient care. But HMSA believes that facility services are less likely to have churn because the patients are hospitalized for a reason.
    - Castle commented that perhaps procedures and labs could be left in the PMPM as is, since it's worked well in the pilot.

- PMAG and Castle asked if there was a way to accommodate innovation, such as a process to apply for upfront payment to enable purchase of a machine or new technology that would bring value.
- Emily asked if providers could recommend a data source of primary care-focused labs and procedures so there'd be a defined list of recognized services.

Quality

- Quality is separately recognized and paid for through the performance measures. The intent is to adjust rates upward for stellar performers and down for PCPs who are really underperforming.

Total Cost of Care

- All PCPs in a PO would score the same on the factor, which would be weighted minimally.
- Maui Medical Group suggested an alternative approach that would consider total revenue and total cost of care for the patients within the PO.

C. MGMA/AMGA target

- Challenge of using national salary data is that salaries are reported as all revenue (all lines of business, all payers) a provider makes, so HMSA would have to make assumptions to calculate a PMPM (e.g., panel size, panel mix and risk, overhead costs). Also includes immunization and facility based services that HMSA will pay FFS, so the calculation is complex.

III. Other Feedback about the Payment Transformation Program

- PMAG: The 20% Provider Engagement component is ridiculous and will drive doctors over the edge. Dr. Mugiishi and Castle responded that the Engagement measures (use of Cozeva, Sharecare provider profile) are relatively simple and straightforward.
- Maui Medical Group: Poor performing providers will go backwards if their PMPM stays the same or is reduced because other costs, such as staff and rent, cost more. When HMSA keeps someone flat, they are falling behind because of inflation.
- PMAG asked when the ecosystem and support services will be addressed, as these have been discussed and promised for a while. Providers need support to take care of their populations, with behavioral health and complex care management especially needed as part of an integrated system of care. Dr. Mugiishi said HMSA is trying to integrate the health care system, align financial incentives and engage the consumer/patient – and all three need to be aligned.
- Queen's: The whole transformation has been based on the fact that FFS is bad and variation needs to be managed. If you accept that, and we're all going to do payment transformation, part of me says keep it as simple as possible, set goals and let's work to get there.

PO leaders were invited to reflect on the framework and to provide feedback to Emily Oshima Lee (Emily_Oshima_Lee@hmsa.com).

Next PO Collaborative Meeting: Thursday, June 1, 2017 at Ala Moana Hotel (more to come!)