Rational and Behavioral Economics Applied to Episode-Based Incentives

3rd National Bundled Payment Summit

June 2013

Three complementary models for care delivery and payment

Care delivery and payment model	Most applicable	Role of provider
Population-based models ▪ Medical homes, ACOs, capitation	▪ Primary prevention ▪ Care for chronically ill (e.g., managing obesity, CHF)	**Partner:** maintain and improve patient health
Episode-based models ▪ Prospective bundled payments ▪ Retrospective models	▪ Acute procedures (e.g., CABG, hips, stent) ▪ Most inpatient stays including post-acute care, readmissions ▪ Acute outpatient care (e.g., broken arm, URI)	**Healer:** lead team of providers to deliver a specific outcome at the lowest possible cost
Fee-for-service ▪ Including "pay for performance"	▪ Discrete services correlated with favorable outcomes or lower cost	**Component provider:** deliver a high-quality service at the lowest possible cost

The bigger picture: payment innovation at scale

Pilots

- Many models
- Limited volume/ providers
- Voluntary

At scale in places

- Substantial shifts in select markets/ service lines
- Enough volume and value at stake for providers
- Still, many models

Full scale adoption

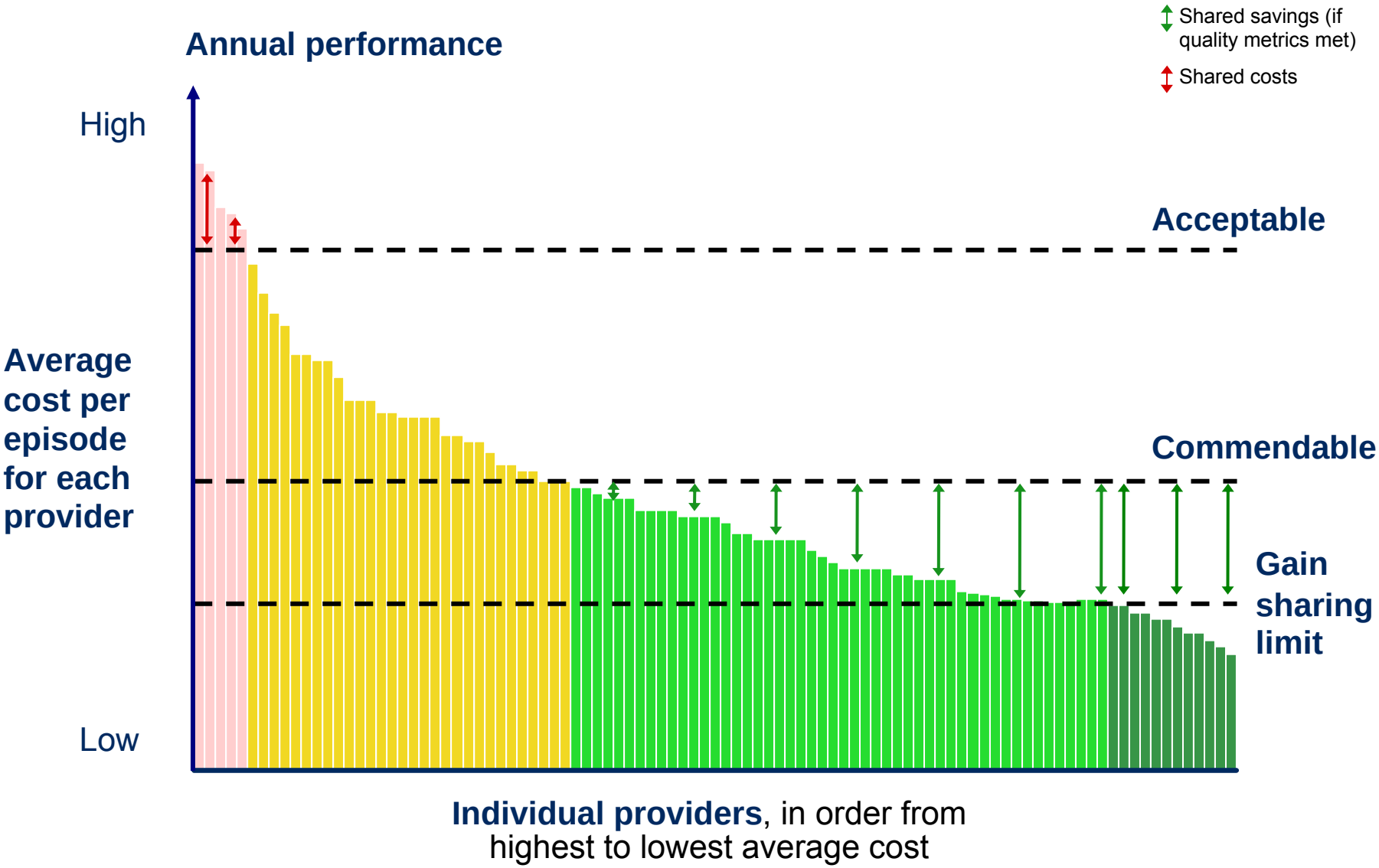
- Common set of payment models adopted across markets/ service lines (e.g., DRGs)
- Sufficient standardization to allow for common tools to be developed across markets

- Today: at the tipping point of getting to scale in multiple markets/ service lines
- Imperative: how do we demonstrate impact from at-scale implementations to support move to full scale adoption

Requirements for payment to drive cost-reducing innovations

	**Significant**	Maximize the proportion of provider revenue and earnings subject to outcomes-based payment
	**at Scale**	Ensure that a critical mass of providers transition to outcomes-based reimbursement
	**Stable**	Clarify long-term vision and make a long-term commitment to providers
	**Striving but practical**	Design the new approach so that it is effective in current regulatory, legal, and industry structures
	**Sustainable**	Ensure that providers that adapt thrive financially
	**Supportive**	Champion innovation with information, insights, and infrastructure
	**Synch with consumers**	Align payment with benefits, network design, and consumer engagement

Recall: Arkansas model for episodes



Rational *AND* behavioral economics both have a role in designing an effective payment model for providers

Rational economics

- Individuals seek out relevant information and make rational decisions to maximize utility
- Individuals understand temporal and risk/reward tradeoffs, and leverage this information to maximize long-term outcomes

Reality in behavior economics

- Cognitive biases often prevent people from making rational decisions, despite their best efforts

> If humans were comic book characters, we'd be more closely related to Homer Simpson than to Superman
>
> *Harvard Business Review*

SOURCE: Harvard Business Review

Our discussion today

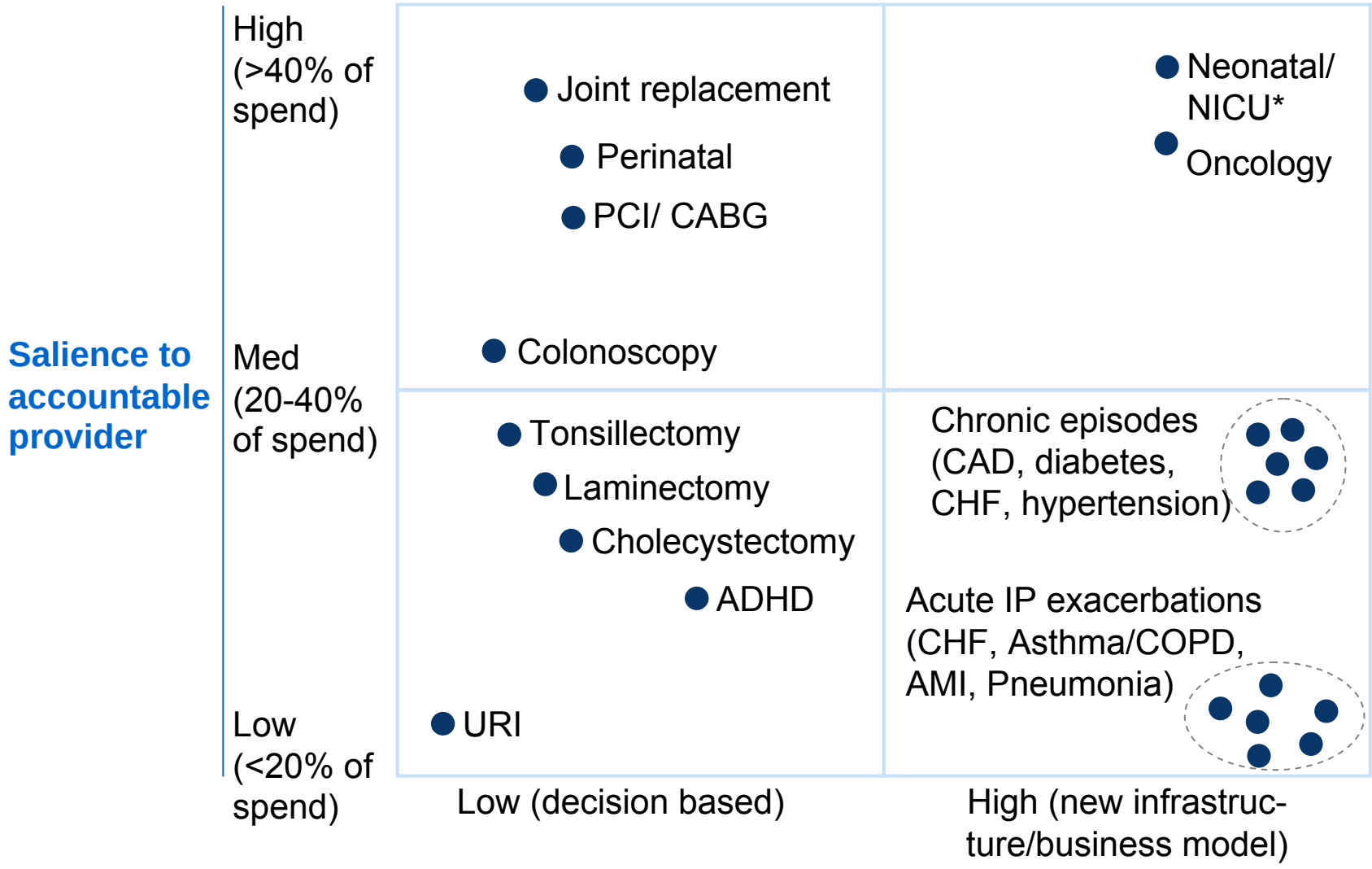
How do we design payment models to effectively reward and influence providers for episode-based performance?

- What **rational economic elements** are required (e.g., amount of value or rewards at stake for a provider)?
- What **behavioral economic elements** will "make or break" the payment model?
- How should these **vary across different types** of episodes and providers?

Two dimensions to consider in designing an effective episode-based payment model

	Description
Salience	▪ How significant is the episode to the accountable provider? ▪ Ex: % of the provider's reimbursement or case volume impacted
Episode-based models	▪ How "easy" are the types of practice changes required? ▪ Low risk: decision-based changes (e.g., C-section rates for OB/GYNs) ▪ High risk: – Major investments in new capabilities/ infrastructure (e.g., new post-acute care management for CHF) – Shifts in practice business model

Effective payment model design will account for differences in salience and type of behavioral change required across episodes



Note: mapping contingent on what type of provider at risk; for the purposes of this analysis, an * indicates a facility at risk; all other placements based on the physician/group

Economic principles for an effective payment model will vary based on these two dimensions

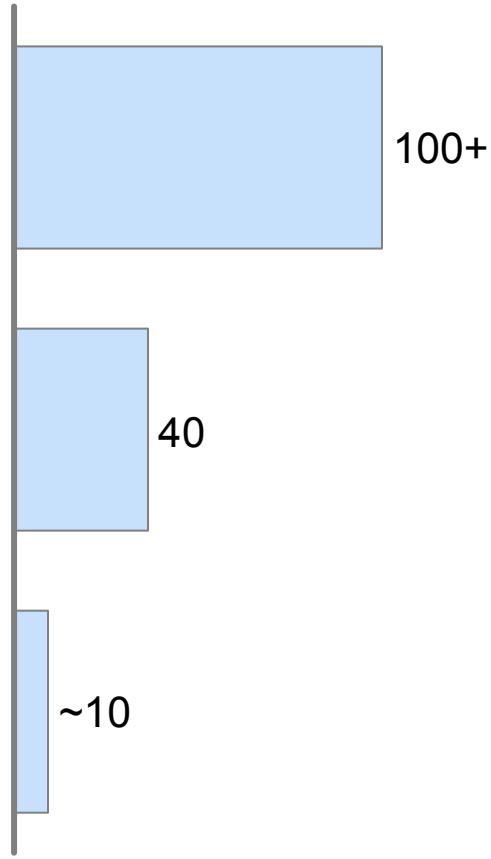
Salience to accountable provider		Low (decision based)	High (new infrastructure/ business model)
	High (>40% of spend)	*High salience, low risk* **"Lowest hanging fruit"**	*High salience, high risk* **Must have economics for the business case in place**
	Med (20-40% of spend)	*Low salience, low risk* **Importance of behavioral economic approaches in "nudging" behavior**	*Low salience, high risk* **Difficult individually; must be part of broader roll out** under (1) episodes or (2) total cost of care reimbursement with episode-level reporting
	Low (<20% of spend)		
		Type of practice pattern changes	

Example: the amount of value at stake depends on selection of who is at risk and care delivery patterns for a given episode

3 examples with the physician at risk

Care delivery patterns today	Examples
Procedure with high facility costs and facility price variation ▪ Physician has minority of reimbursement ▪ Majority of savings come for facility spend	Joint replacement (Commercial)
Procedure with high facility costs, limited facility price variation ▪ Limited unit cost variation may come from normalization of fee schedules	Joint replacement (normalized facility unit cost)
"Lower leverage" model ▪ Physician reimbursement is a substantial component of the episode	Perinatal URI

% increase on today's reimbursement for a top performer



Influencing behavior change: understanding the role of behavioral biases

For discussion today

Behavioral biases

Individuals make decisions relative to a particular reference point or context	A	▪ **Anchoring to a reference point** – Individuals make decisions and assess gains and losses based on relative points of references
	B	▪ **Framing effects** – Way in which options are presented dramatically changes decisions
Individuals often end up not making any decision at all or defaulting to familiar options in confusing or uncertain situations		▪ **Choice overload** – Individuals tend to do nothing or to default to familiar solutions as choices increase ▪ **Status quo bias** – Individuals typically default to the status quo in confusing situations
	C	▪ **Loss aversion** – Individuals tend to be risk averse to avoid losses
Individuals have a distorted ability to assess future risks/reward tradeoffs	D	▪ **Probability assessment** – Individuals underestimate the probability of common risks and overestimate salient but uncommon events
	E	▪ **Present-biased preference** – Individuals preference the immediate and over-discount future gains and losses

Framing effects: presenting potential rewards and penalties

Which statements are more likely to engage and trigger responses?

For a medical home/population health model

A

You will receive a $2 per patient per month payment for coordinating each patient's care

or

B

You will receive $48,000 a year to coordinate the care of your 2000-patient panel"

For a knee replacement …

A

You will share in 50% of the gains

or

B

You could more than double your current take home income

or

C

You can gain $3,000 per episode by performing at this level

Loss aversion: structuring incentives that will effectively influence behavior change

- Many episode pilots across the country are voluntary pilots with upside only (relative to historical performance)
- Upside-only models may gain some traction when focused on a small group of committed and motivated providers
- However, at scale across a mix of providers, our research and behavioral economic literature suggest effectiveness is greatest with some form of downside/ loss aversion
- Some examples
  - Arkansas model (poor performers are put into a “red” zone with downside risk)
  - BPCI
  - Warranty model (ProvenCare)

Closing thoughts

- Where we are on the journey to scale
- Designing payment models that motivate real behavioral change – rational and behavioral economic principles
- Hitting the tipping point: applying these principles to at-scale implementations