

6 ways fast-evolving pay models are affecting physician practices

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In terms of moving toward new models of physician payment, doctors support the overall direction in which the industry is moving, but not its speed, complexity or unpredictability.

Those are key findings of a new report from RAND and the AMA that examines how physicians are adapting to alternative payment models (APMs), including bundled payments and shared savings, as well as new private, state and federal programs such as Medicare's Quality Payment Program (QPP).

The report, "Effects of Health Care Payment Models on Physician Practice in the United States: Follow-Up Study," follows up on a 2014 study of 31 physician practices in six markets. It includes qualitative data from physician practice leaders, front-line physicians and industry observers from the same six markets that were previously examined. Whenever possible, the same individuals were re-interviewed.

The passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided one of the main health policy differentiators between the research reports, as it repealed the Medicare sustainable growth-rate payment formula, created the QPP and accelerated the already rapid rate of change.

For the AMA, the biggest point reinforced by the report's findings is that the growing complexity of payment models means a higher volume of administrative burdens that take physicians away from patient care, AMA President Barbara L. McAneny, MD, said when introducing the report today in Washington.

"It is more difficult for physicians and practice staff just to understand all the different models, and payers are not making the needed investments in educating them," Dr. McAneny said. "These findings underscore the need for adequate transition periods as new payment systems are implemented, as well as the need to allow exemptions for small practices that cannot afford to understand or adopt

complex new models.”

Here are five other key points to understand about this new research on health care payment models’ effects on physician practice.

Data is driving performance. APMs have raised the importance of data analysis, and issues related to data deficiencies and inaccuracies continued to constrain practices’ ability to improve performance.

“Data analysis was not a part of med school for most physicians,” said Mark Friedberg, MD, RAND senior physician policy researcher and lead author of both reports. “But now, if you don’t have it, you’re flying blind.”

Practices of all sizes and specialties needed to make considerable investments to understand the complex new payment models—either by hiring consultants or building internal capabilities, according to the report. Larger practices or those affiliated with large health systems could do this, while smaller or independent practices lagged behind in creating a data infrastructure and were more likely to express confusion and disengagement.

Individual practice pay strategies unaffected by APM status. While practices might participate in multiple APMs, they generally simplify the financial incentives rather than pass them on to individual physicians, for whom modest quality performance bonuses remain common.

Practice leaders instead use nonfinancial strategies to influence physician performance, such as internal report cards, which Dr. Friedberg said can be very effective.

“Doctors are used to being ‘A’ students,” he said.

There is also a problem with “whiplash,” Dr. Friedberg said, when changes are implemented and then withdrawn after practices have made investments and partnerships based on what they were previously told they needed to do. He cited how changing Medicare cardiology and joint-replacement bundled-payment programs from mandatory to voluntary had consequences.

Hospitals were in the process of acquiring cardiology practices as part of their preparation. This involved sharing financial data and other confidential or proprietary information. Then the deals were put on hold as the program became voluntary.

“But they had already showed their hands,” Dr. Friedberg said. “Hospitals revealed which cardiac practices were their favorites and which ones weren’t and now have to pretend it never happened.”

Past early adopters wary of new promises. The study found that early adopters bought into promises of financial upsides that didn’t always materialize and are reluctant to engage in new programs—especially those with downside risk attached.

The reaction runs along these lines: “It sounds great—but it sounded great the last time,” Dr. Friedberg said.

Physicians are still optimistic. Despite the perceived chaos, physicians see an opportunity to provide value and quality care under new payment models. Some practices, though, are calling for a pause, so they can implement the model they are building.

“They are looking for a long-term glide path to follow,” Dr. Friedberg said.

This path would include fewer and more harmonized measures across multiple payers and payment models that are aimed at improving patient care. And if physicians must take any downside risk, it would only be for what they can control.

The AMA continues to advance physician-developed APMs that produce meaningful improvements to patient care and are financially sound, aligned across payers and work for practices and patients. Tools for navigating these new models are available at the AMA Physician Payment Resource Center.