Policy Research Perspectives

Payment and Delivery in 2014: The Prevalence of New Models Reported by Physicians

By Carol K. Kane, PhD

Introduction

Using data from a nationally representative survey of physicians, this Policy Research Perspective (PRP) assesses the extent to which new models of care delivery and payment have taken hold across the U.S. It examines physician participation in medical homes and Accountable Care Organizations (ACOs) and how that participation varies across key practice attributes. It also looks at the prevalence of alternative payment models (APMs) and the extent to which they are used in different types of practices. To date, a national perspective on physician participation in alternative payment and delivery models has been lacking.

In 2014, 23.7 percent of physicians worked in practices that were part of a medical home and 28.6 percent in practices that were part of an ACO. Although 59.0 percent of physicians said their practice received revenue from at least one APM (capitation, pay-for-performance, bundled payments, or shared savings), it was clear that fee-for-service (FFS) payment was still the dominant payment method used by insurers to pay physician practices. An average of 71.9 percent of practice revenue came from FFS. In contrast, the maximum average share from an APM was 9.0 percent, for capitation. Despite the shallow penetration of APMs overall, there are pockets of the physician population where those methods represent a substantial share of practice revenue.

The passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is expected to increase physician participation in APMs. MACRA repealed the Sustainable Growth Rate Formula, and established a framework that will reward physicians for quality and value rather than volume.

Data and methods

The data used in this PRP are from the AMA's 2014 Physician Practice Benchmark Survey. First conducted in 2012, the Benchmark Survey is a nationally representative online survey of post-residency physicians who provide at least 20 hours of patient care per week, are not employed by the federal government at the time of the survey, and practice in one of the 50 states or the District of Columbia. The sample for the 2014 survey was drawn from the M3 Global Research Panel. The

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survey response rate was 35 percent and 3500 physicians completed the survey. Weights for the survey were constructed and all estimates presented here are weighted.[1]

Physicians who participated in the 2014 Benchmark Survey were asked whether their practice had been "accredited" or "recognized" as a medical home. In the questionnaire, survey participants read that medical home accrediting and recognizing bodies included a number of organizations such as the NCQA, URAC, the Joint Commission, and the Accreditation Association for Ambulatory Health Care. Survey participants were also asked whether their practice was participating in one of the two Medicare Accountable Care Organizations (ACO), either the Shared Savings Program or the Pioneer Model. They were not specifically asked about their participation in non-Medicare (private) ACOs.

To gather data on practice payment, physicians were provided with a short definition of five payment methods: FFS, pay-for-performance, capitation, bundled payments, and shared savings programs. For each, they were asked to indicate whether their practice received any payment from that method from the insurers it had contracts with. For each payment method that was received, physicians were asked to estimate the percentage of practice revenue from that method.

In designing the survey, it was clear that capturing the extent of physicians' awareness of participation in emerging payment and delivery models was as important as capturing their practice's participation itself. Focus groups conducted prior to the 2012 survey indicated that there was a high degree of unfamiliarity with this topic, particularly among younger, employed physicians. Therefore, we designed the survey so that physicians could respond with an affirmative, a negative, or a "don't know" response to the questions about participation in medical homes and ACOs, and about whether their practices received particular payment methods and how much revenue was received from those methods. While the figures in this PRP depict only the percentage of physicians who said "yes" to a particular question, the appendix tables include the distribution of all responses and subsequent discussion focuses on the "don't know" responses where appropriate.

Existing literature

While there is an emerging literature on the numbers of medical homes and ACOs in operation, there is little information available that puts physician participation in those models into perspective. Similarly, there is scant information on the percentage of physicians that work in practices where payment incentives are shifting from those that reward quantity to others that reward quality and efficiency.

Rittenhouse et al. (2011) examined the medical home processes in place in small practices (defined as those with fewer than 20 physicians). They developed an index score for each practice based on the processes in place and found that larger practices, and practices owned by hospitals or HMOs rather than physicians, were more likely to use more medical home processes. In contrast, after controlling for other variables, they found little difference between primary care and multi-specialty practices.

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[1] See Kane (2015) and Kane and Emmons (2013) for more information on the Benchmark Survey and its methodology.

In similar work a group of overlapping authors looked at larger practices (at least 20 physicians) whose care included the treatment of four chronic illnesses (Rittenhouse et al. 2008). They also found that ownership by a larger entity, rather than physicians, was associated with increased medical home infrastructure.

Auerbach et al. (2013) examined the factors associated with ACO formation in 2012. In that year, 2.3 million Medicare FFS beneficiaries (7 percent) were enrolled in a Medicare ACO. Looking at ACO formation at the hospital referral region level, they concluded that increased provider integration (e.g., hospital risk sharing, integrated hospital systems, and large primary care groups) was a key marker of where ACOs were forming.

Leavitt Partners has been tracking the formation of ACOs since their formal introduction as part of the Affordable Care Act in 2010 (Muhlestein 2015). They estimate that in January 2015 there were 744 ACOs in operation that covered 23.5 covered lives, up from 64 ACOs and 2.6 million covered lives in 2011. Although they noted the presence of ACOs in every state (but certainly not every hospital referral region) the percentage of the population enrolled in an ACO varied greatly from 3 percent or less of the population in Alabama, Oklahoma, and Wyoming to more than 20 percent in Iowa, Maine, and Oregon. Despite the comprehensiveness and the unique historical perspective offered by this data, it does not include estimates of the number of physicians who provide care under the Medicare ACO programs.

In a survey of physician practice organizations, Shortell et al. (2014) found that 23.7 percent were part of an ACO. Larger practices, those receiving patients from an integrated practice association (IPA) or a physician hospital organization (PHO), and those with greater patient-centered medical home processes in place were more likely to be part of an ACO. In contrast to the conclusions of some of the work discussed above, they found that physician-owned practices were more likely to be part of an ACO than those owned by a hospital or health system.

Although medical homes and ACOs are often avenues for the implementation of APMs, the literature suggests that FFS remains an important source of payment even when those new models of care delivery have been put into place. Edwards, Bitton, Hong, and Landon (2014) identified 172 medical home initiatives in place in 2014, 114 of which included payment reform. They estimated that those initiatives covered almost 21 million patients. All but two of them used standard or enhanced FFS payments for office visits. More than 90 percent augmented those FFS payments with pay-for-performance (8 percent), capitated payments (29 percent), or both (55 percent). Medical home initiatives that served only the Medicaid population were outliers. In that category, only 65 percent had augmented FFS payments (35 percent used FFS only). Forty-four percent of the initiatives used a shared savings model in addition to the other payment structures in place. They reported that this was up from 0 percent in similar research conducted based on 2009 data.

Physician participation in medical homes and Medicare ACOs

Based on data from the AMA's Benchmark Survey, in 2014, 23.7 percent of physicians worked in a practice that was part of a medical home (Figure 1). Twenty-nine percent worked in a practice that

was part of a Medicare ACO. Participation in these two types of delivery models varied greatly across practice type, specialty, and ownership structure.

Differences across practice type

Not surprisingly, physicians in solo practice were less likely to be part of a medical home and less likely to be part of a Medicare ACO than physicians in other practice types. Only 7.0 percent of physicians in solo practice were part of a medical home and 13.0 percent were part of an ACO (Figure 1). In contrast, 19.4 percent of physicians in single specialty practice worked in practices that were part of a medical home and 24.9 percent worked in practices that were part of an ACO. The participation of physicians in multi-specialty practice was even higher, with 36.4 percent in a medical home and 41.4 percent in an ACO. Physicians in other practice types also had high involvement in medical homes and ACOs relative to physicians in single specialty practice.[2]

Differences across specialty

There were some specialties in which the medical home and Medicare ACO participation of single specialty practices approached that of multi-specialty practices. As expected, for medical homes, primary care practices stood out. Internal medicine physicians (26.0 percent), pediatricians (28.2 percent) and family practice physicians (36.6 percent) had the highest rates of medical home participation among physicians in single specialty practice (Figure 2). Internal medicine and family practice physicians in single specialty practices also had relatively high rates of ACO participation (33.1 percent and 38.5 percent), but the most involved were surgeons, with a participation rate of 39.2 percent (Figure 3).

Differences across practice ownership

Figures 4 and 5 examine participation in medical homes and Medicare ACOs among physicians in single and multi-specialty practices according to whether their practice was physician-owned or hospital-owned. For single specialty practices, ownership structure appears to be a key factor that is correlated with participation. Medical home participation was twice as likely among physicians in single specialty practices that were hospital-owned as among physicians in practices that were physician-owned, 31.4 percent compared to 14.9 percent (Figure 4). A similar pattern was apparent for ACO participation. Thirty-six percent of physicians in single specialty practices that were hospital-owned said their practice was part of an ACO compared to 21.7 percent of physicians in physician-owned practices (Figure 5).

It is possible that the higher participation observed among physicians in hospital-owned practices is related to specialty. Prior research indicates that when looking at single specialty practice, hospital ownership is most often reported by internal medicine and family practice physicians (Kane and Emmons 2013). Therefore, it could be the case that medical home and Medicare ACO participation are more prevalent among physicians in hospital-owned practices because those practices are

[2] In 2014, 17.1 percent of physicians were in solo practice, 42.2 percent worked in single specialty practices, and 24.7 percent worked in multi-specialty practices (Kane 2015). The remaining 16.0 percent worked in other practice types including faculty practice plans, ambulatory surgery centers, urgent care facilities, HMOs/MCOs, and medical schools or were directly employed by a hospital (the largest category, at 7.2 percent).

skewed toward primary care. However, even when we looked only at *primary care* single specialty practices, physicians in practices that were hospital-owned were still more likely to participate in medical homes and ACOs than physicians in practices that were physician-owned (data not reported).

In contrast, practice ownership did not appear to be a key factor affecting the participation of multi-specialty practices. Although the participation rates reported by physicians in hospital-owned practices were higher than that of physicians in physician-owned practices, the differences were not statistically significant.

Awareness of delivery models

For both medical homes and Medicare ACOs, about 25 percent of physicians did not know their practice's participation status (Appendix Table 1). Due to their role as the sole business owner (and practitioner) in the practice, physicians in solo practice expressed less uncertainty than physicians in single specialty practices. Twelve percent and 10.8 percent of solo practice physicians said "don't know" to participation in medical homes and ACOs, compared to 22.2 percent and 23.7 percent of their single specialty colleagues, respectively. For medical homes, physicians in multi-specialty practices and in other practice types expressed a higher level of uncertainty than single specialty physicians, with 27.9 and 36.2 percent saying "don't know." For Medicare ACO participation, results were similar but only the difference between other practice types and single specialty practices was statistically significant, not that for physicians in multi-specialty practices.

Multi-specialty practices are larger[3] than single specialty practices and have a higher percentage of physicians who are employees. Those characteristics suggest a greater disconnect between individual physicians in the practice and practice management decisions which may explain the greater lack of awareness among those in multi-specialty practices. Other practice types have an even higher employee percentage than multi-specialty practices. In addition, employees tend to be younger than owners and have a shorter tenure within their practice.[4] Tenure differences may be another factor behind the higher levels of uncertainty in multi-specialty and other practice types.

There were also differences in physician awareness across practice ownership type (Appendix Table 2). Physicians in practices that were physician-owned were generally more knowledgeable than physicians in practices that were hospital-owned. Less than 25 percent of physicians in single and multi-specialty practices answered "don't know" to practice participation in a medical home or Medicare ACO. In comparison, "don't know" responses in hospital-owned settings reached a high of 32.0 percent for medical home participation among physicians in multi-specialty practices.

Payment models

The remainder of this Policy Research Perspective examines the extent to which APMs are being used in physician practices and how that participation differs across practice characteristics.

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[3] Thirty-seven percent of physicians in multi-specialty practices are in practices with 50 or more physicians. In contrast, only 4.5 percent of physicians in single specialty practices are in practices of that size (Kane 2015).
[4] Based on data from the 2014 Benchmark Survey, 11.5 percent of owners are under the age of 40 compared to 23.4 percent of employees. The average tenure of owners is about six years longer than that of employees.

Physicians' responses to the 2014 Benchmark Survey suggest that although practice participation in APMs is not uncommon, those models still account for only a small share of revenue (Figure 6). Approximately one-third of physicians worked in practices that received revenue from pay-for-performance. The percentage that received bundled payments was similar. Twenty-six percent of physicians worked in practices that received capitated payments. Nonetheless, pay-for-performance, bundled payments, and capitated payments accounted for only 5.5 percent, 9.0 percent, and 7.3 percent of practice revenue, respectively.[5] FFS payment is still the dominant payment method used by insurers to pay physician practices. Eighty-six percent of physicians worked in practices that received FFS in 2014, and FFS accounted for 71.9 percent of revenue.

As was the case for delivery models, physicians also expressed uncertainly about the receipt of certain payment models (Appendix Table 3). While less than 10 percent of physicians were unsure of whether their practice received FFS payment, uncertainty about other payment methods was higher, ranging between 16 and 19 percent for capitation, pay-for-performance, and bundled payments, and up to 27.3 percent for shared savings programs.

Use of alternative payment models

Relatively little is known about whether practices participate in only a single APM or whether they receive multiple APMs from the insurers they have contracts with. Data from the Benchmark Survey suggest that they are often used in combination. In 2014, 59.0 percent of physicians worked in practices that received payment through at least one APM. Thirty percent worked in practices that received payment from at least two, 12.8 percent from at least 3, and 4.7 percent from four (data not shown). Because some physicians were unaware of whether their practice had contracts that included the use of an APM, those estimates should be regarded as lower bounds. To that point, one-third of the group that reported at least one APM also indicated that they were not sure of the status of some other APM. In addition, about 37 percent of the group that didn't respond affirmatively to any APM indicated that they were not sure of the status of at least one. In total, about 35 percent of physicians said "don't know" to at least one APM.

Even when practices participate in APMs, very few physicians report that their practice has completely severed its ties with the FFS payment structure. As Figure 7 shows, even in practices that were involved with four APMs, more than 90 percent of physicians said that their practice received revenue from FFS.[6] That percentage was similar regardless of how many APMs were in place.

In contrast, the *share* of practice revenue from FFS varied greatly according to how many APMs a practice was involved with. Among physicians whose practice received only a single APM, an average of 72.5 percent of practice revenue came from FFS and the remaining 27.5 percent from

[5] Average revenue shares for each method include positive shares as well as zero shares (for physicians in practices that did not receive that particular method). Revenue shares don't sum to 100 percent across the five payment methods because some physicians answered "don't know" to one of more payment methods or shares.
[6] The analysis in Figure 7 is limited to physicians who knew their practice's participation status in each of the four APMs.

that APM. FFS revenue shares declined steadily with the number of APMs reported. At the other end of the spectrum, among the 4.7 percent of physicians in practices that received payment from each of the four APMs, FFS accounted for only 40.1 percent of practice revenue. The other 59.9 percent was earned through a combination of the four APMs.

When only a single APM was in place, the one that accounted for the *greatest share* of practice revenue was capitation, with an average share of 32.9 percent. The APM that was *most often* used alone was bundled payments, accounting for nearly half of physicians in practices that received a single APM (data not shown).

The relationship between medical home and Medicare ACO participation and practice payment

While there is recognition that the key features of a medical home cannot be successfully implemented without significant payment reform, medical home accreditation programs generally do not include requirements that medical home initiatives incorporate specific payment methods. Therefore, the extent to which the payment methods received by medical home practices differ from those of other practices is an open question. To the same point, while practices that participate in one of the Medicare ACO programs may receive shared savings payments for meeting financial targets and performance standards, even when received they may account for only a small share of practice revenue. The Centers for Medicare and Medicaid Services reported that 11 of 20 Pioneer ACOs qualified for shared savings payments of $82 million in 2014. Ninety-two of 333 Shared Savings Program ACOs qualified for payments of $341 billion (CMS 2015).

We found that physicians in practices that participated in medical homes or ACOs were more likely to report the use of alternative payment models than physicians whose practices were not in medical homes and Medicare ACOs (Figures 8 and 9). Participants were about twice as likely as non-participants to report that their practice received pay-for-performance revenue or capitated revenue in 2014, roughly 50 percent compared to 25 percent for pay-for-performance, and 40 percent compared to 20 percent for capitation. For bundled payments, the differences were smaller but still substantial and statistically significant. About 44 percent of physicians in medical home and ACO practices reported bundled payments compared to 30 percent for physicians in practices that were not part of medical homes or ACOs. Twenty-five percent and 29.9 percent of physicians in medical home and ACO practices, respectively, said their practice received payments from a shared savings contract. In contrast, the report of shared shavings was 10.3 percent for physicians not in medical homes, and 6.8 percent for physicians not in ACOs.

Although medical homes and Medicare ACO participants were less likely than non-participants to report the use of FFS payment in their practices, the percentages whose practices received FFS were still notably high. Eighty-five percent of physicians in medical home practices and 88.0 percent of physicians in Medicare ACO practices said their practice received FFS. As noted by other research (Edwards, Bitton, Hong, and Landon 2014), medical homes and ACOs make the use of APMs more likely, but don’t break the connection with FFS.

To that point, well over half of practice revenue in medical home (Figure 10) and Medicare ACO (Figure 11) practices was earned through FFS—an average of 60.8 percent and 62.3 percent,

respectively. Still, these revenue shares are much lower than those received by physicians in practices not part of medical homes and Medicare ACOs where they reached 78.4 percent and 80.1 percent.

Accordingly, average shares received from APMs were higher in medical home and Medicare ACO practices, as Figures 10 and 11 illustrate.[7] Average revenue shares from pay-for-performance, capitation, and bundled payments were each close to 10 percent for physicians in medical homes and ACOs. Shares ranged from 9.1 percent (pay-for-performance in Medicare ACOs) to 12.4 percent (capitation in medical homes). Revenue shares for those methods in practices that were not part of medical homes and ACOs ranged from 3.4 percent (pay-for-performance for physicians not in Medicare ACOs) to 7.5 percent (bundled payments for physicians not in medical homes).

Because our data are not retrospective in nature, we can't estimate the degree to which participation in medical homes and ACOs *changed* the payment structure in place in medical practices. We observed that APMs were used more often and that their revenue shares were greater in medical home and ACO practices. While it is reasonable to surmise that the dependence on FFS fell after those practices joined those delivery models, it may have been their already existing involvement with APMs and lower dependence on FFS that enabled their participation in medical homes and ACOs in the first place.[8] We can't say which came first, the delivery model or the payment structure.

Discussion

Nationally representative data on physicians suggest that in 2014, about one-quarter of physicians worked in a practice that was part of a medical home and that close to 30 percent worked in one that was part of an ACO. Participation in both models of care varied widely across practice type. Just under 20 percent of physicians in single specialty practices were part of a medical home compared to 36.4 percent of physicians in multi-specialty practices. Similarly, ACO participation was just under 25 percent for physicians in single specialty practices compared to 41.4 percent in multi-specialty practices. For physicians in solo practice—who still represent 17.1 percent of the physician workforce—participation in medical homes and ACOs was even lower.

Despite the lower overall participation of single specialty practices relative to multi-specialty practices, there were particular specialties in which involvement was high. For medical homes, primary care physicians had the highest participation. Twenty-six percent of internists, 28.2 percent of pediatricians, and 36.6 percent of family practice physicians in single specialty practices were part of a medical home. For ACOs, participation of general surgeons in single specialty practices was highest (39.2 percent), followed by family practice physicians at 38.5 percent and internists at 33.1 percent.

[7] As in Figure 6, revenue shares don't sum to 100 percent across the five payment methods because some physicians answered "don't know" to one of more payment methods or shares.

[8] Out of the eight provider groups that were participating in Massachusetts' Alternative Quality Contract in 2009, three groups, and some of the practices in a fourth group, had already contracted with Blue Cross on a risk-sharing basis prior to signing the Alternative Quality Contract (Chernew, Mechanic, Landon, and Safran 2011).

For single specialty practices, whether the practice was physician-or hospital-owned appeared to be an important factor driving medical home and ACO participation. Thirty-one percent of physicians in hospital-owned practices said they were part of a medical home, more than double the rate for physicians in physician-owned practices (14.9 percent). For ACO participation, the rates were 36.0 percent and 21.7 percent, respectively. Although there was a higher concentration of primary care physicians in hospital-owned practices, this didn't appear to explain the higher participation rates—even among primary care physicians, medical home and ACO models were reported more often by physicians in hospital-owned practices. The findings that medical home and ACO participation occurs more frequently among hospital-owned practices is consistent with earlier work on this topic that looked at data at the practice, organization, medical home initiative and even regional level.

Data from the Benchmark Survey also revealed that FFS was still the dominant payment method in place in 2014. Despite the fact that at least 59.0 percent of physicians worked in practices that received at least some revenue outside of the traditional FFS payment system, FFS accounted for 71.9 percent of practice revenue on average. The most common APM was bundled payments, which was received by the practices of 34.5 percent of physicians, followed by pay-for-performance at 32.7 percent, capitation at 26.1 percent, and shared savings at 13.6 percent. MACRA, which established incentives for the use of certain APMs starting in 2019, is expected to increase their use (Conway et al. 2015).

Even in practices where APMs were in place, it was almost always the case that the practice also received FFS. Regardless of whether physicians reported that only one or as many as four APMs were received by their practice, more than 90 percent indicated that FFS was received as well. However, dependence on FFS as a revenue source (measured by the share of practice revenue by FFS) decreased consistently as the number of APMs increased. While physicians whose practice was involved with one APM received 72.5 percent of revenue from FFS, physicians in practices with four APMs received about 40 percent of practice revenue from FFS and the remaining almost 60 percent of revenue from a combination of the APMs.

This Perspective also found that FFS remained an important source of revenue even in practices that were participating in medical homes and Medicare ACOs. More than 85 percent of physicians in medical home and ACO practices said their practice received FFS, and it contributed more than 60 percent of practice revenue, on average. This is consistent with other research which found that medical homes and ACOs make the use of APMs more likely, but don't break the connection with FFS.

One question this report cannot address is the degree to which participation in medical homes and Medicare ACOs *changed* the payment structure of practices. We observed that APMs were used more often and that their revenue shares were greater in medical home and Medicare ACO practices. Although the dependence on FFS in those practices might have decreased after they joined those delivery models, it may have been their already existing involvement with APMs, and lower dependence on FFS, that enabled participation in the first place.

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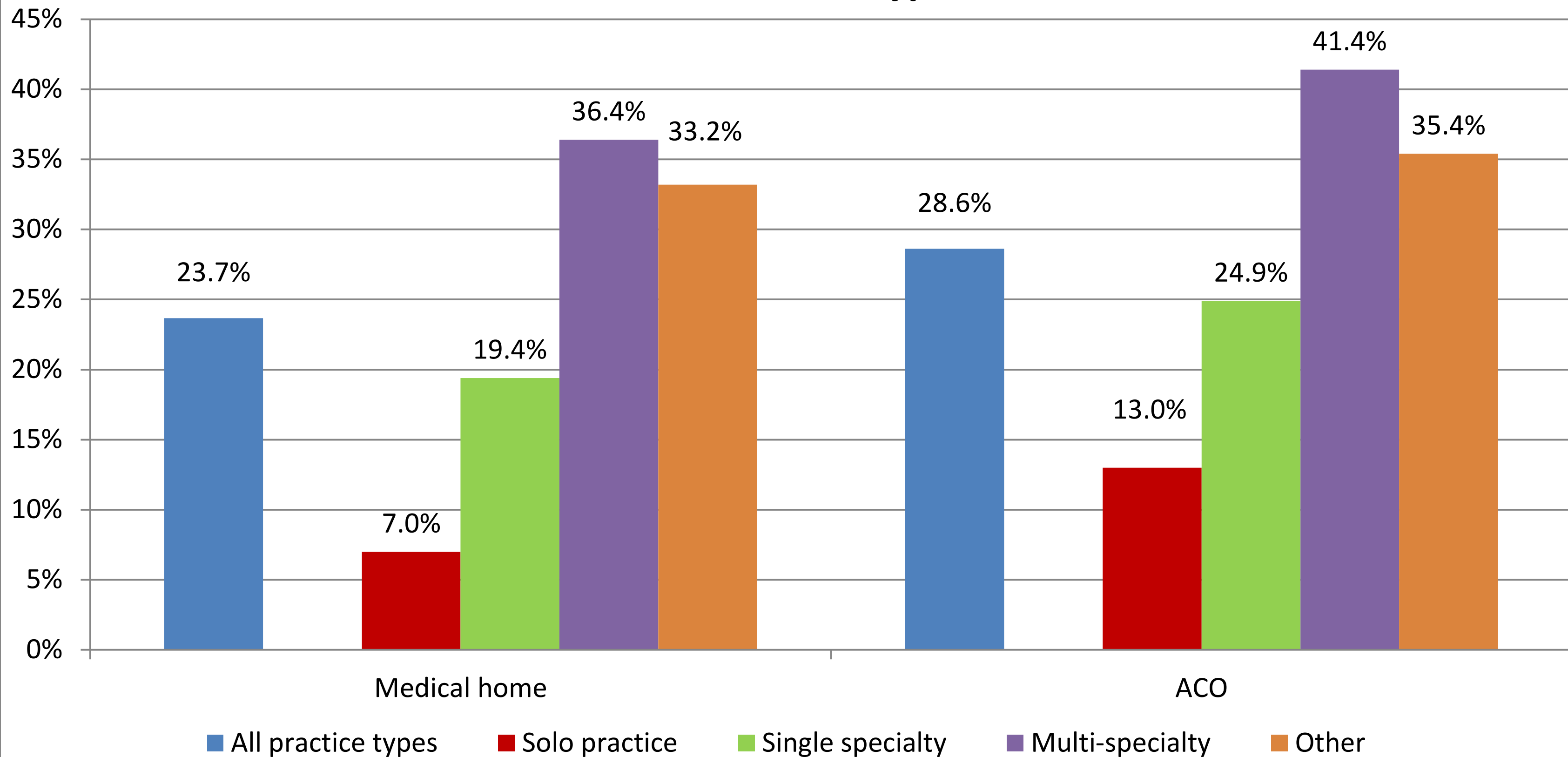
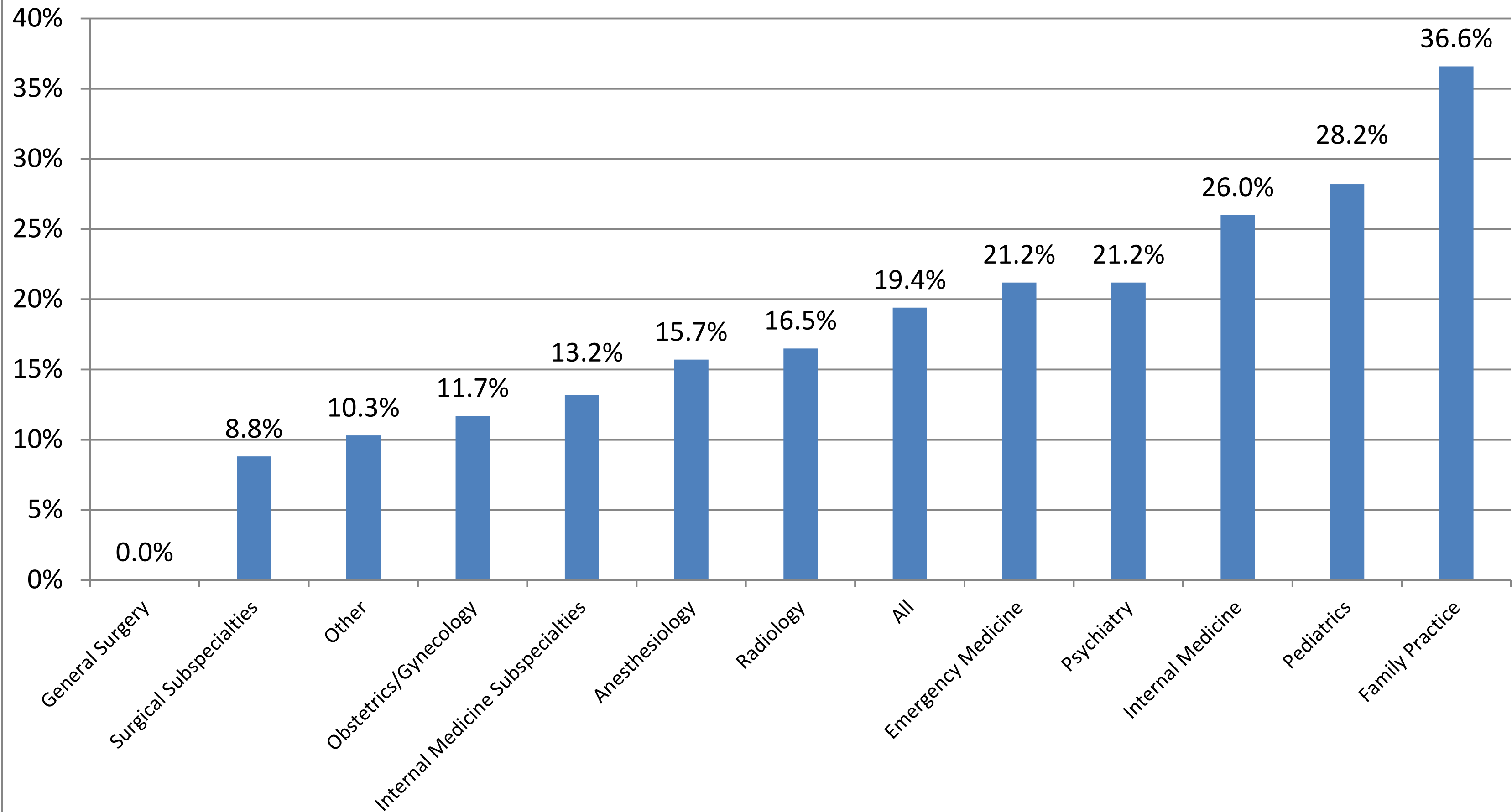


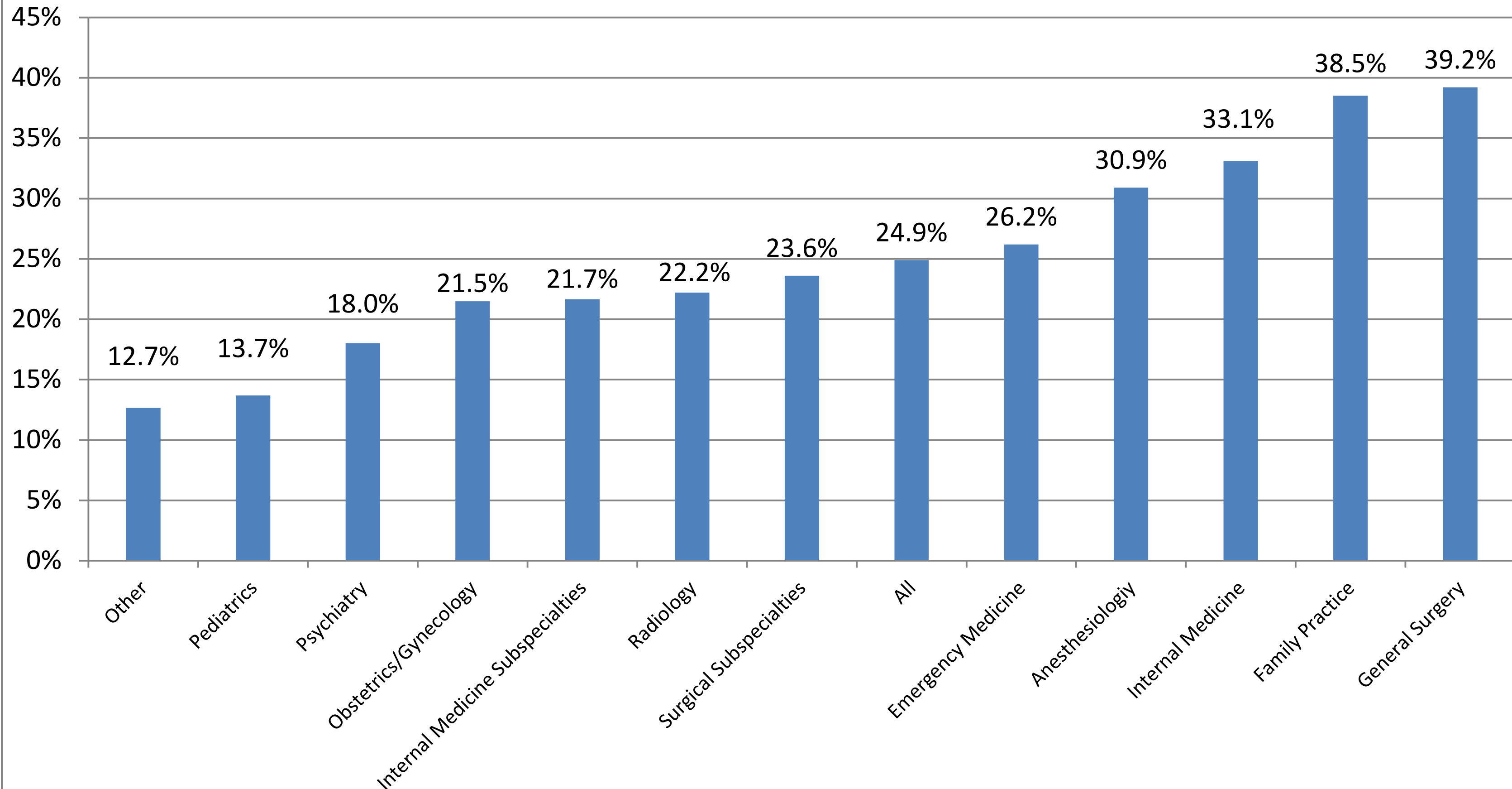
Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Responses to whether part of a medical home or a Medicare ACO (yes, no, don't know) are both statistically different across practice type ($p<0.01$) using a chi-squared test. See Appendix Table 1 for t-tests.

Figure 2. Medical Home Participation Among Physicians in Single Specialty Practices



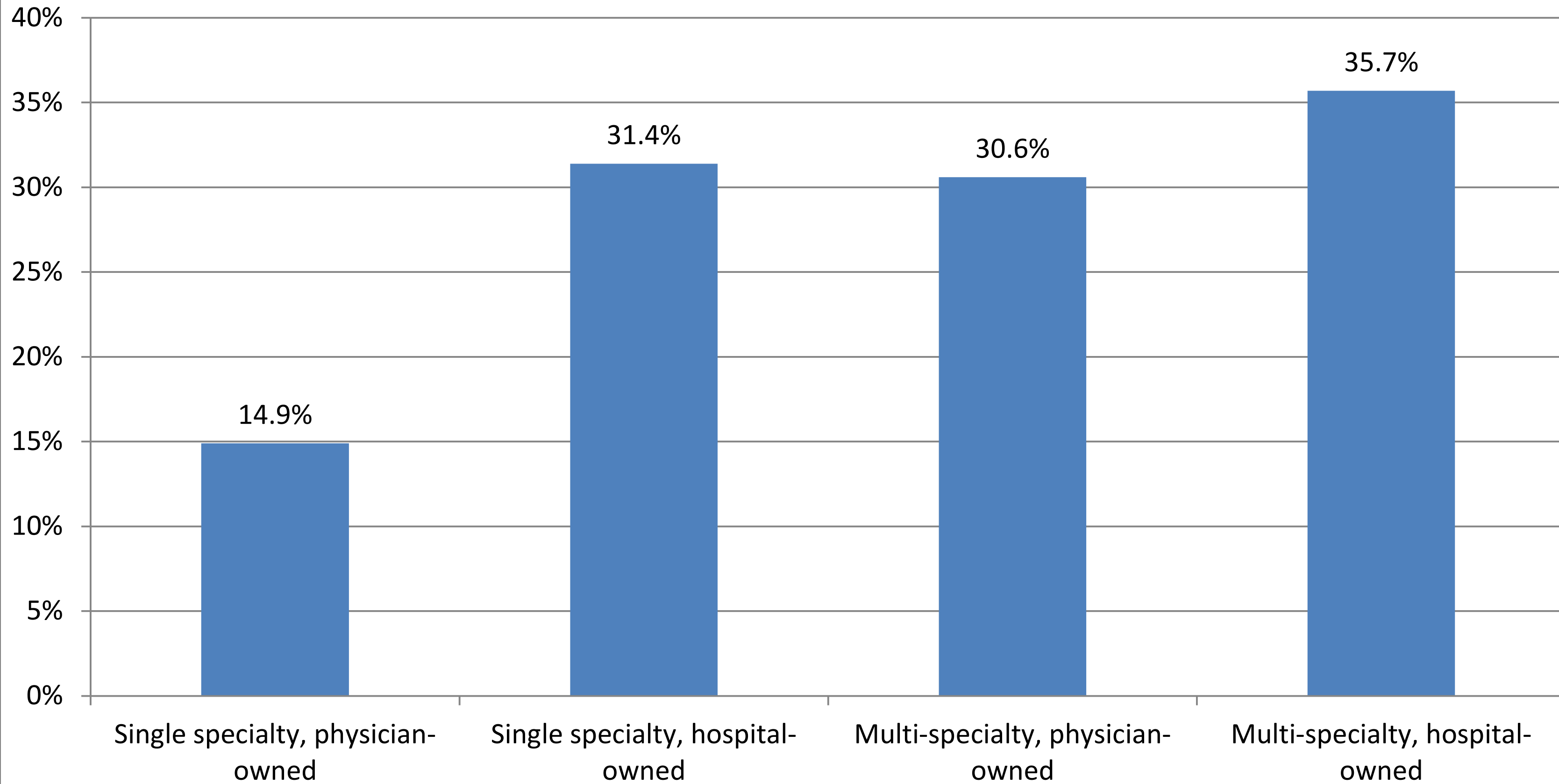
Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Responses to whether part of a medical home (yes, no, don't know) are statistically different across specialty ($p<0.01$) using a chi-squared test.

Figure 3. Medicare ACO Participation Among Physicians in Single Specialty Practices

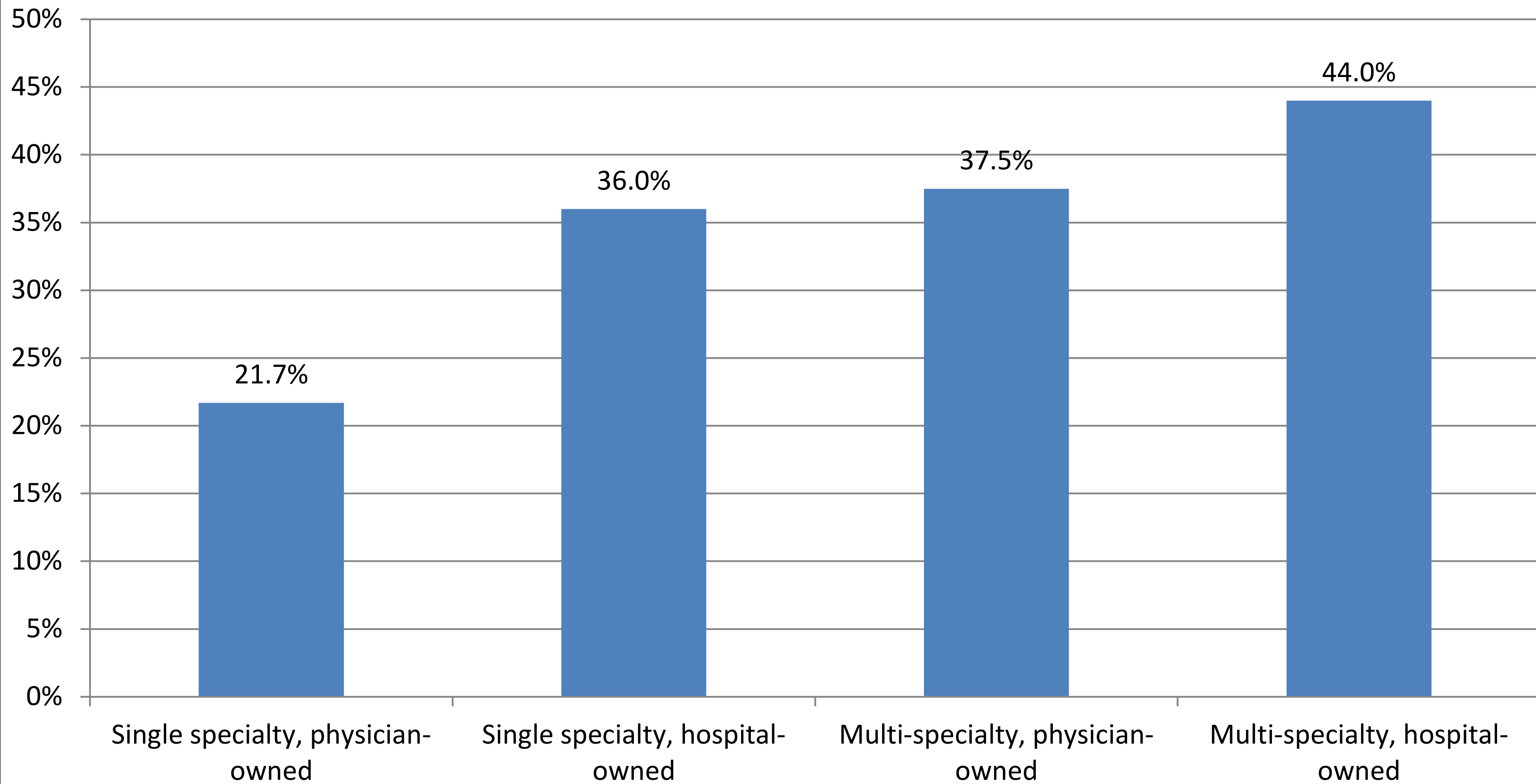


Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.

Note: Responses to whether part of a Medicare ACO (yes, no, don't know) are statistically different across specialty ($p<0.01$) using a chi-squared test.



Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Responses to whether part of a medical home (yes, no, don't know) are statistically different across ownership type ($p<0.01$) for both physicians in single specialty and in multi-specialty practices using a chi-squared test. See Appendix Table 2 for t-tests.



Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Responses to whether part of a Medicare ACO (yes, no, don't know) are statistically different across ownership type ($p<0.01$) for both physicians in single specialty and in multi-specialty practices using a chi-squared test. See Appendix Table 2 for t-tests.

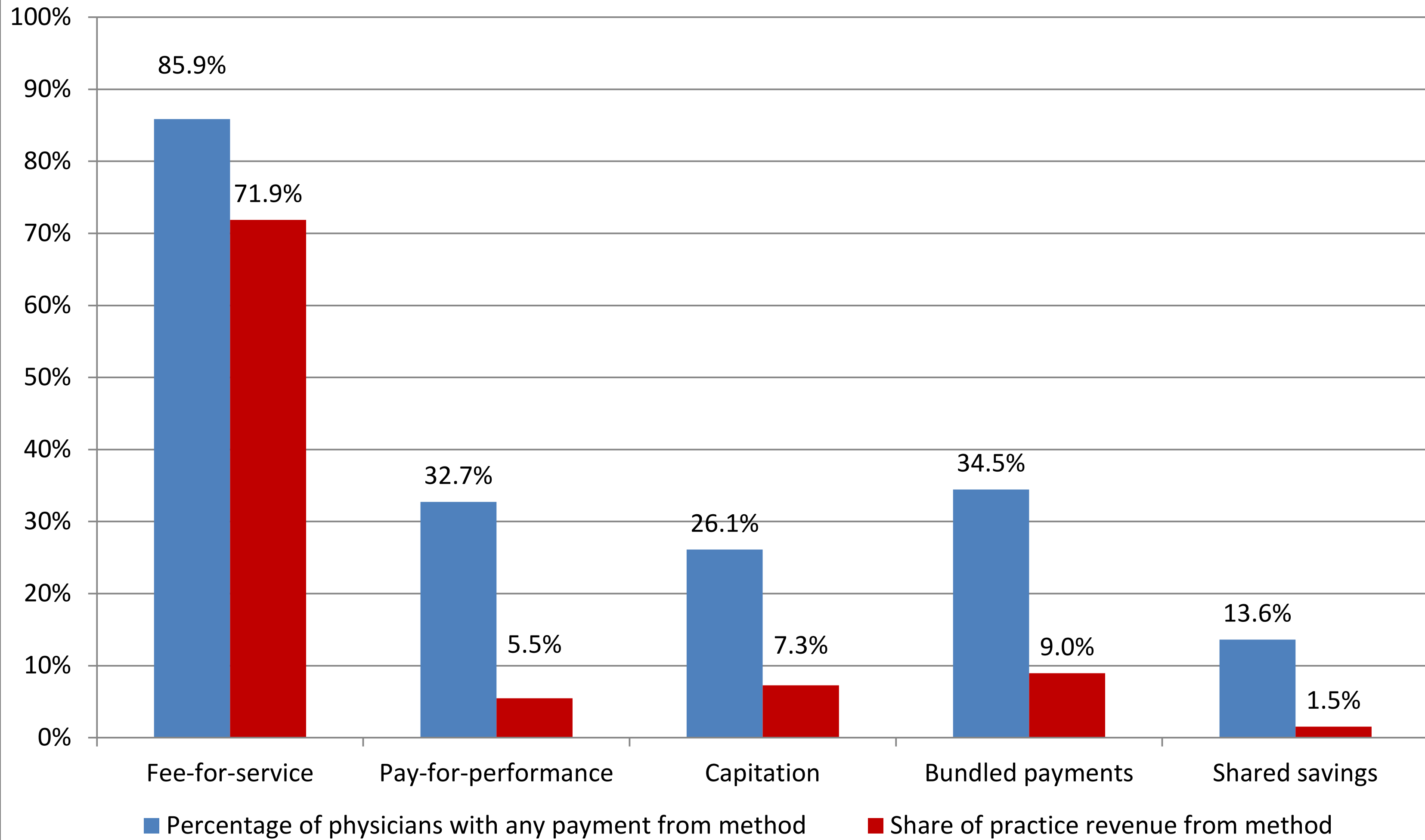
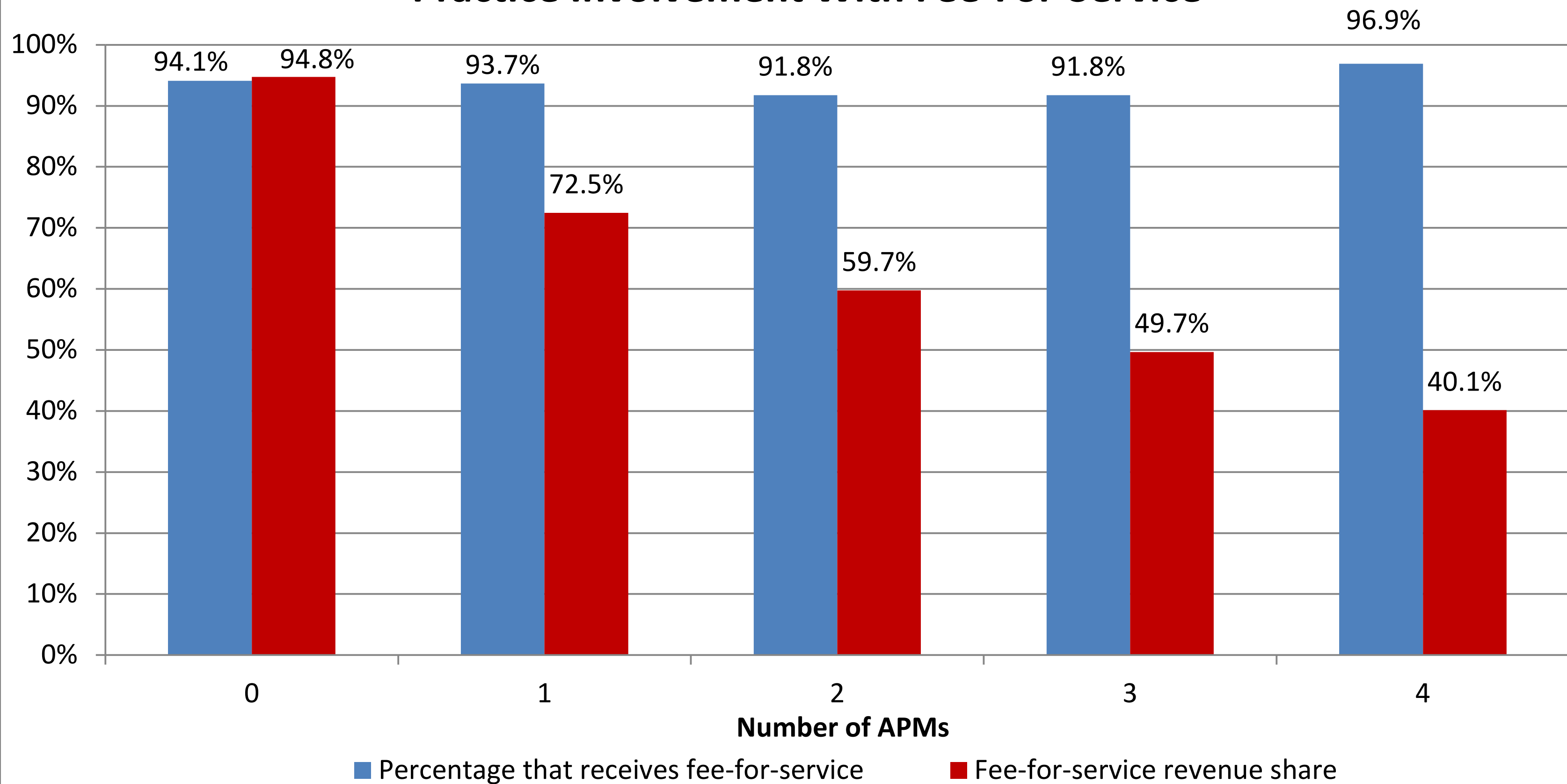
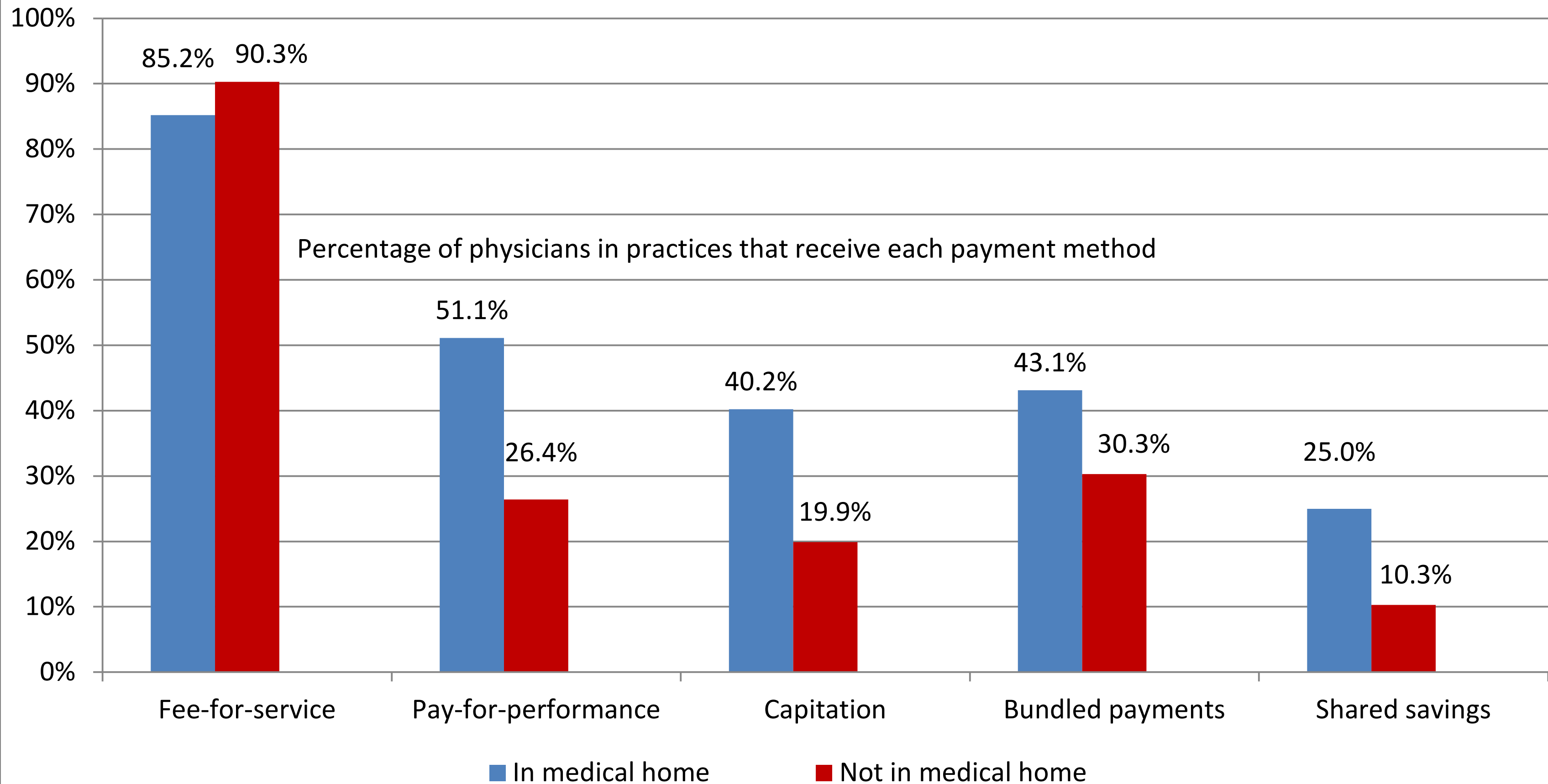


Figure 6. Payment Methods Reported by Physicians
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
85.9%
71.9%
32.7%
5.5%
26.1%
7.3%
34.5%
9.0%
13.6%
1.5%
Fee-for-service
Pay-for-performance
Capitation
Bundled payments
Shared savings
Percentage of physicians with any payment from method
Share of practice revenue from method
Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.



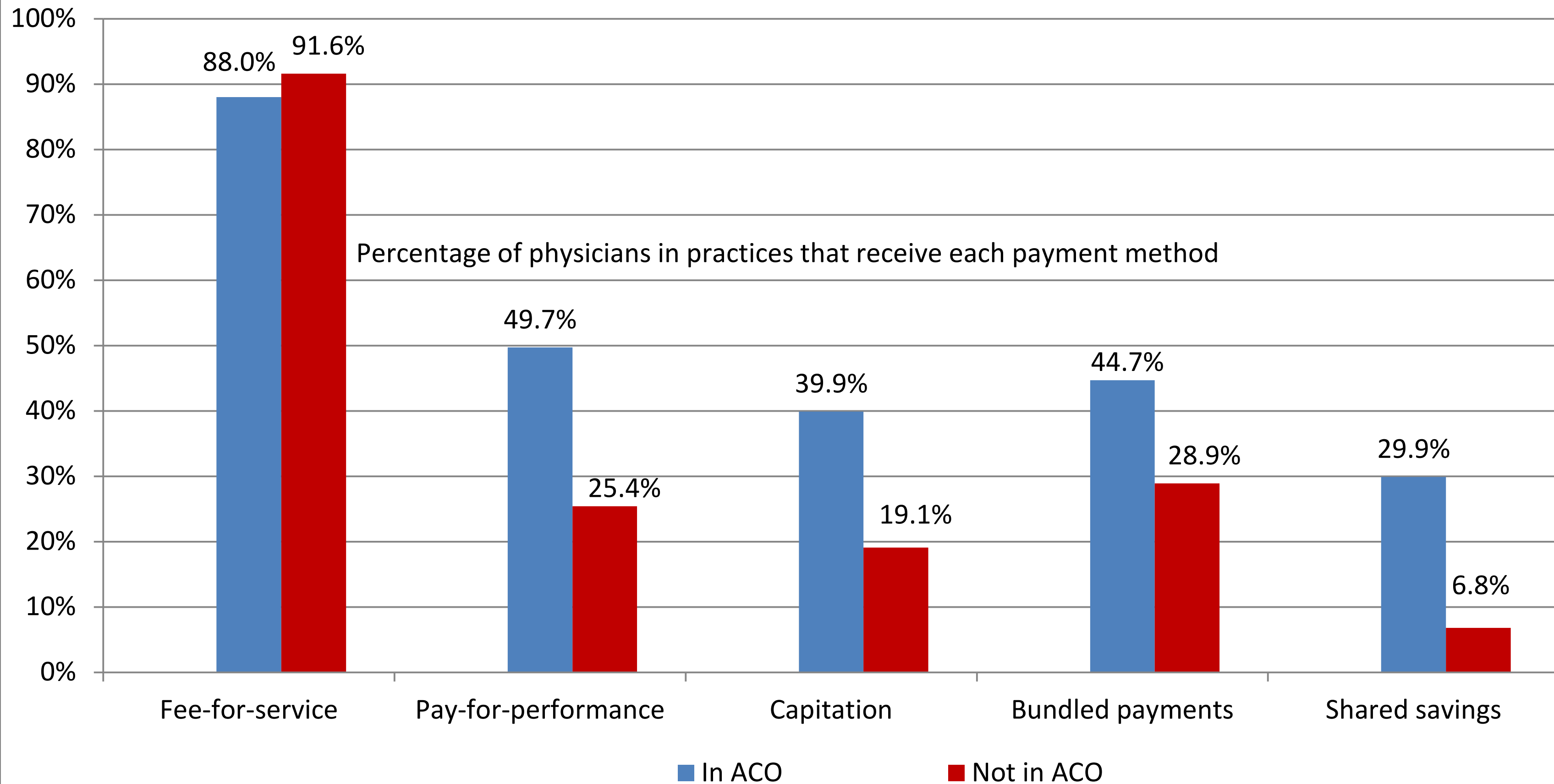
Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: The estimates in this Figure are calculated among only physicians who responded "yes" or "no" to each one of the APM questions. Those who said "don't know" to any one were excluded.

Figure 8. The Receipt of Payment Methods: How Do Medical Home Practices Differ?

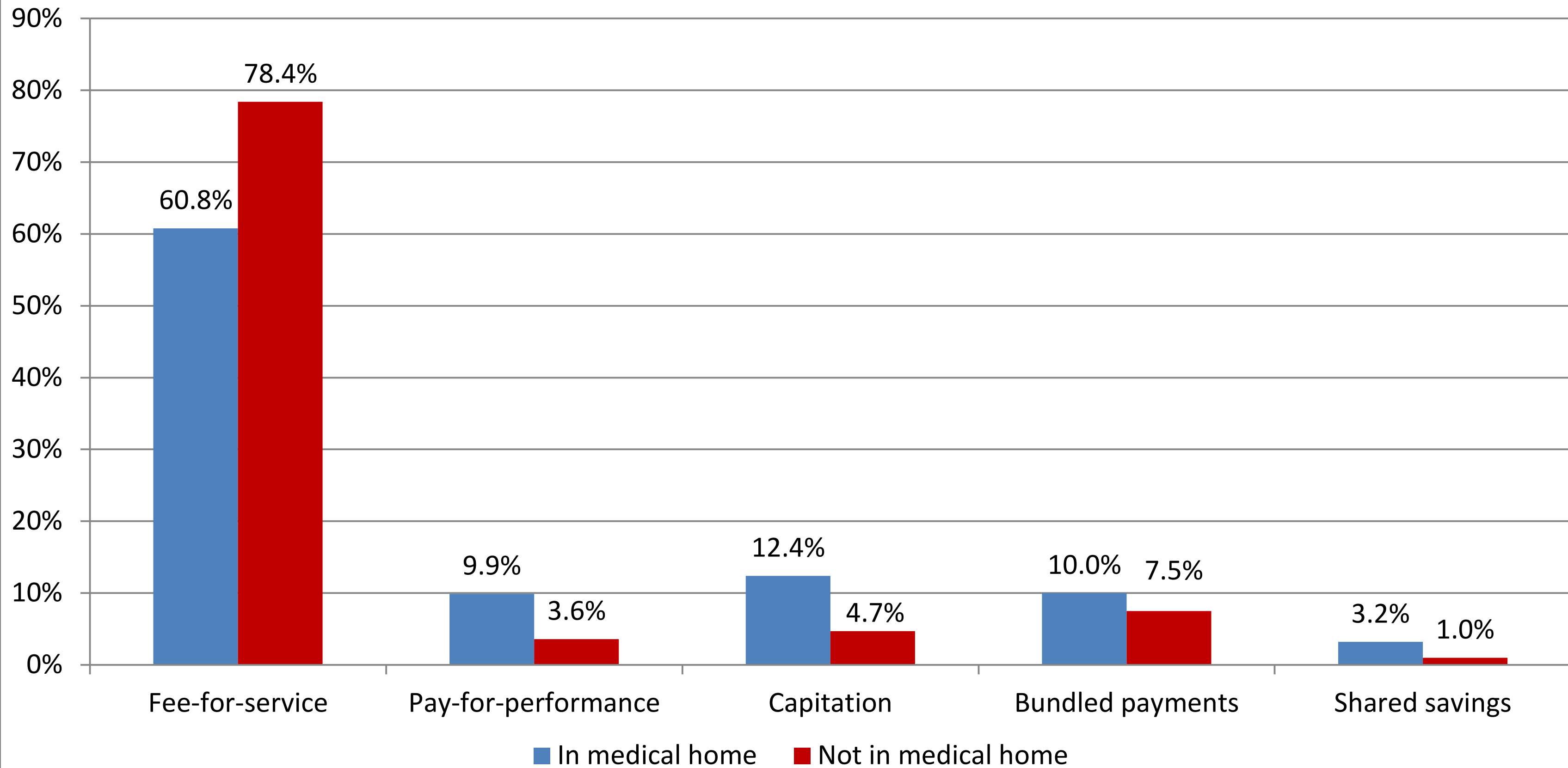


Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Differences in the receipt of each payment method (yes, no, don't know) according to medical home status are statistically significant ($p<0.01$) using a chi-squared test. See Appendix Table 4 for t-tests.

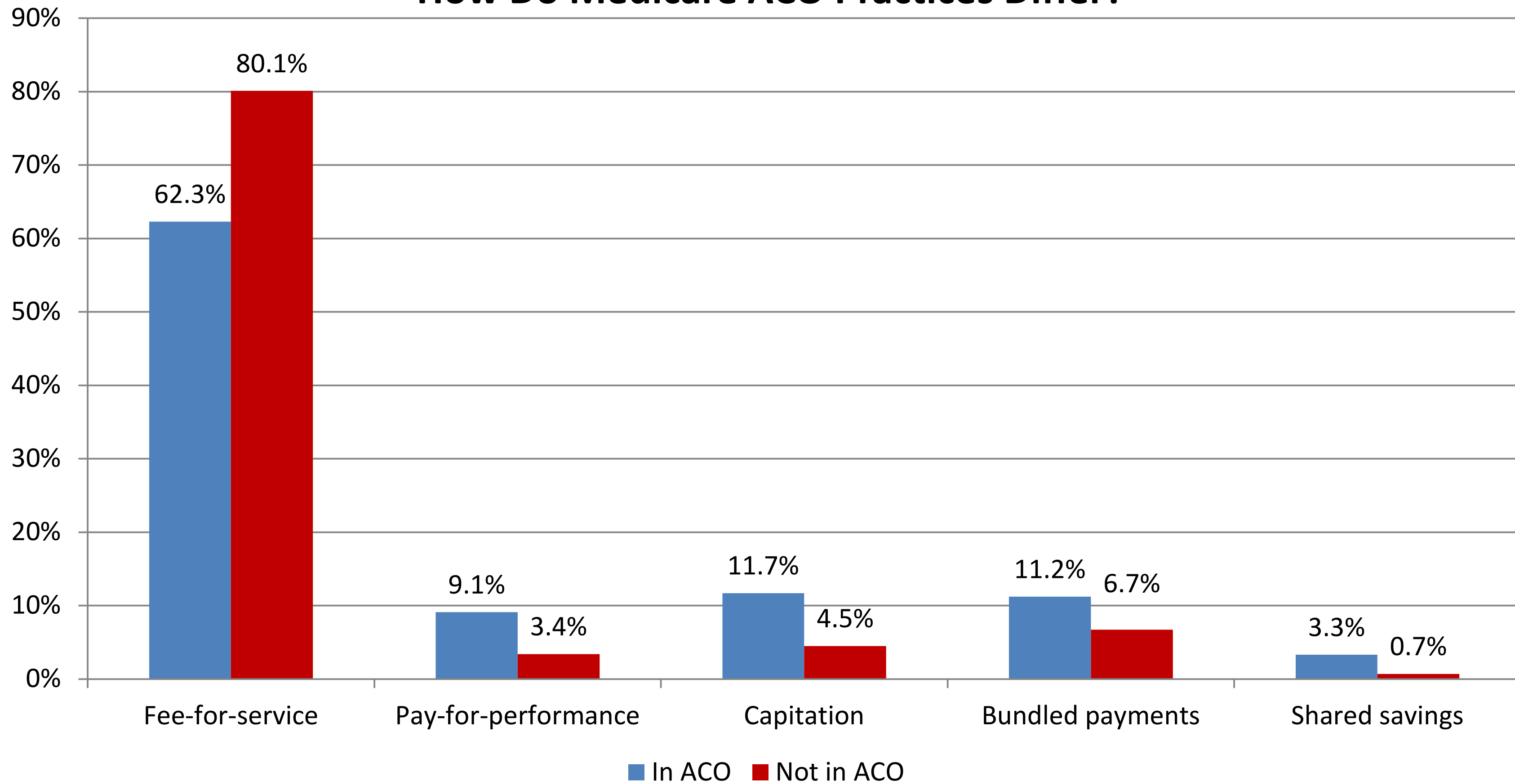
Figure 9. The Receipt of Payment Methods: How Do Medicare ACO Practices Differ?



Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Differences in the receipt of each payment method (yes, no, don't know) according to Medicare ACO status are statistically significant ($p<0.01$) using a chi-squared test. See Appendix Table 4 for t-tests.



Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Differences in the mean revenue share from each payment method according to medical home status (yes or no) are statistically significant ($p<0.01$).



Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Note: Differences in the mean revenue share from each payment method according to Medicare ACO status (yes or no) are statistically significant ($p<0.01$).

Appendix Table 1. Medical Home and Medicare ACO Participation by Practice Type[1,2,3]

Is your practice part of a medical home?

	Solo practice	Single specialty practice	Multi-specialty practice	Other	All physicians
Yes	7.0[a]	19.4	36.4[a]	33.2[a]	23.7
No	81.0[a]	58.4	35.8[a]	30.6[a]	52.2
Don't know	12.0[a]	22.2	27.9[a]	36.2[a]	24.1
	100%	100%	100%	100%	100%

Is your practice part of a Medicare ACO?

	Solo practice	Single specialty practice	Multi-specialty practice	Other	All physicians
Yes	13.0[a]	24.9	41.4[a]	35.4[a]	28.6
No	76.2[a]	51.4	31.9[a]	24.5[a]	46.5
Don't know	10.8[a]	23.7	26.7	40.1[a]	24.9
	100%	100%	100%	100%	100%
N	619	1466	875	540	3500

Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Notes: [1] Chi-squared test for medical home participation (yes, no, don't know) and practice type (solo, single, multi-, other) is statistically significant at $p<0.01$. [2] Chi-squared test for ACO participation and practice type is statistically significant at $p<0.01$. [3] T-tests are run separately for the percentage who said yes, no, and don't know to medical home and ACO, respectively. They are pairwise comparisons between single specialty practice and each of the three other practice types. [a] indicates $p<0.01$; [b] indicates $p<0.05$.

Appendix Table 2. Medical Home and Medicare ACO Participation among Physicians in Single and Multi-specialty Practice by Ownership Structure[1,2,3]

Is your practice part of a medical home?

	Single specialty practice		Multi-specialty practice	
	Physician-owned	Hospital-owned	Physician-owned	Hospital-owned
Yes	14.9	31.4[a]	30.6	35.7
No	63.9	46.3[a]	46.4	32.3[a]
Don't know	21.3	22.2	23.0	32.0[a]
	100%	100%	100%	100%

Is your practice part of a Medicare ACO?

	Single specialty practice		Multi-specialty practice	
	Physician-owned	Hospital-owned	Physician-owned	Hospital-owned
Yes	21.7	36.0[a]	37.5	44.0
No	57.8	35.4[a]	40.4	26.2[a]
Don't know	20.6	28.6[a]	22.1	29.8[b]
	100%	100%	100%	100%
N	1012	349	326	390

Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Notes: [1] The hospital-owned category includes physicians in practices that are partially hospital-owned. [2] Chi-squared test for medical home participation (yes, no, don't know) and ownership structure is statistically significant at $p<0.01$ for single and for multi-specialty practices. [3] Equivalent chi-squared tests for ACO participation and ownership structure were also statistically significant at $p<0.01$. [4] T-tests are run separately for the percentage who said yes, no, and don't know to medical home and ACO, respectively. They are pairwise comparisons between physician-owned and hospital-owned practices. [a] indicates $p<0.01$; [b] indicates $p<0.05$.

Appendix Table 3. Receipt of Five Different Payment Methods

Does your practice receive any revenue from:

	Fee-for-service	Pay-for-performance	Capitation	Bundled payments	Shared savings programs
Yes	85.9	32.7	26.1	34.5	13.6
No	5.2	50.5	57.8	46.6	59.1
Don't know	9.0	16.8	16.1	18.9	27.3
	100%	100%	100%	100%	100%
N	3500	3500	3500	3500	3500

Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.

Appendix Table 4. Receipt of Five Different Payment Methods by Medical Home and Medicare ACO Participation Status[1,2,3]

Does your practice receive any revenue from fee-for-service?

	Medical home participation			Medicare ACO participation		
	Yes	No	Don't know	Yes	No	Don't know
Yes	85.2[a]	90.4	76.9[a]	88.0[a]	91.6	72.9[a]
No	5.8	4.6	5.7	5.8	4.1	6.4[b]
Don't know	9.0[a]	5.1	17.4[a]	6.3[b]	4.3	20.7[a]
	100%	100%	100%	100%	100%	100%

Does your practice receive any revenue from pay-for-performance?

	Medical home participation			Medicare ACO participation		
	Yes	No	Don't know	Yes	No	Don't know
Yes	51.1[a]	26.4	28.5	49.7[a]	25.4	26.9
No	32.2[a]	62.8	41.9[a]	35.5[a]	64.4	41.6[a]
Don't know	16.8[a]	10.9	29.6[a]	14.8[a]	10.2	31.5[a]
	100%	100%	100%	100%	100%	100%

Does your practice receive any revenue from capitation?

	Medical home participation			Medicare ACO participation		
	Yes	No	Don't know	Yes	No	Don't know
Yes	40.2[a]	19.9	25.7[a]	39.9[a]	19.1	23.4[b]
No	42.9[a]	69.8	46.5[a]	45.2[a]	72.0	45.6[a]
Don't know	16.9[a]	10.4	27.9[a]	14.9[a]	9.0	31.0[a]
	100%	100%	100%	100%	100%	100%

Does your practice receive any revenue from bundled payments?

	Medical home participation			Medicare ACO participation		
	Yes	No	Don't know	Yes	No	Don't know
Yes	43.1[a]	30.3	35.1[b]	44.7[a]	28.9	33.2[b]
No	35.8[a]	57.8	33.0[b]	38.2[a]	60.6	30.0[a]
Don't know	21.1[a]	12.0	31.9[a]	17.1[a]	10.5	36.8[a]
	100%	100%	100%	100%	100%	100%

Does your practice receive any revenue from shared savings programs?

	Medical home participation			Medicare ACO participation		
	Yes	No	Don't know	Yes	No	Don't know
Yes	25.1[a]	10.3	9.7	29.9[a]	6.8	7.7
No	44.2[a]	72.7	44.2[a]	40.9[a]	78.7	43.3[a]
Don't know	30.8[a]	17.0	46.1[a]	29.3[a]	14.5	48.9[a]
	100%	100%	100%	100%	100%	100%
N	843	1807	850	978	1655	867

Source: Author's analysis of AMA 2014 Physician Practice Benchmark Survey.
Notes: [1] For each payment method, the chi-squared test for receipt of that method (yes, no, don't know) and medical home participation (yes, no, don't know) is statistically significant at $p<0.01$. [2] For each payment method, the chi-squared test for receipt of that method and Medicare ACO participation was also statistically significant at $p<0.01$. [3] T-tests are run separately for the percentage who said yes, no, and don't know to each of the five payment methods, respectively. They are pairwise comparisons between physicians not in medical homes and each of the other two medical home categories (yes, don't know). T-tests for Medicare ACOs are similar. [a] indicates $p<0.01$; [b] indicates $p<0.05$.