

Effects of payment models on U.S. physician practices

Is the U.S. making progress in value-based care models?

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Washington, DC



Where to begin...

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Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy

by Mark W. Friedberg, Peggy G. Chen, Kristin R. Van Busum, Frances Aunon, Chau Pham, John P. Caloyeras, Soeren Mattke, Emma Pitchforth, Denise D. Quigley, Robert H. Brook, F. Jay Crosson, Michael Tutty

RESEARCH REPORT
Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy
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AMA/Rand Report 2013

Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy

When physicians perceived themselves as providing high quality care, they reported better professional satisfaction

Factors that lower professional satisfaction

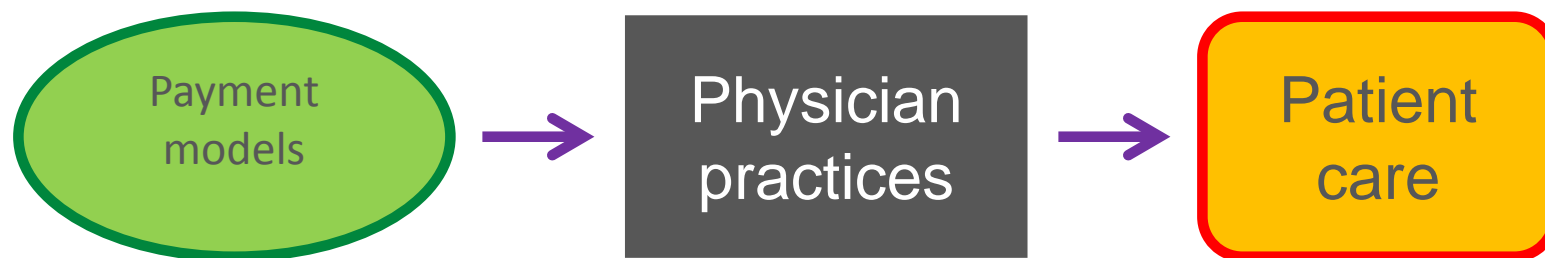
- Perceived barriers to high-quality care
- Electronic health records
- Lack of faith in practice leadership
- Worries about practice sustainability as a business
- Work volume: too little or too much
- Regulatory burden: many small things adding up

Source: Friedberg, et al., *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy*. Rand Health.

AMA/RAND Report 2014

Effects of New Payment Models on Physician Practice

- Purpose: Describe events within the black box



- How do alternative payment models affect:
 - Physician work experience
 - How practices deliver patient care
 - Practice organizational structure, sustainability, and help needed
- How do payment models interact with regulations and with each other?

Key findings of 2014 study

- At the organizational level, alternative payment models...
 - ...encouraged practices to merge or become affiliated with hospitals and large provider organizations
 - ...encouraged practices to develop team approaches to care, new access options for patients, new referral patterns
 - ...increased the importance of data and data analysis (and data deficiencies and inaccuracies)
 - ...sometimes conflicted with each other, complicating practices' abilities to respond in a constructive manner

Key findings of 2014 study

- For individual physicians, alternative payment models...
 - ...were not passed through to individual physicians without significant alteration by practices. No individual physicians in the study faced financial incentives, based on personal performance, to contain costs of care. Instead, practices applied non-financial incentives and interventions to encourage cost containment.
 - ...generally did not change physicians' core clinical work but increased other activities (e.g., documentation). Physicians in leadership positions were more enthusiastic about these changes than other physicians.
- Features of payment model implementation:
 - Problems with data integrity and timeliness, errors in payment model execution (including inaccurate measure specification and patient attribution), incomprehensible incentives, and concerns about measure validity were reported as limiting the effectiveness of new alternative payment models

Effects of Health Care Payment Models on Physician Practice in the United States: Follow-up Study October 2018

Study Aims

- Describe evolution (or lack thereof) in 2014 findings
 - Stable/progressing payment models
 - New or changing payment models
- Describe changes in physician work content, professional satisfaction
- Describe changes in what help practices need

Friedberg M, Chen P and colleagues. Effects of Health Care Payment Models on Physician Practice in the United States: Follow-up Study October 2018. Available at:
https://www.rand.org/content/dam/rand/pubs/research_reports/RR2600/RR2667/RAND_RR2667.pdf

Same six markets as in 2014



→ Same practices and interviewees, to extent possible



Data collection primarily via semi-structured interviews

- Market context interviewees: 24 interviews
 - Medical societies, MGMA chapters
 - hospitals & health plans with significant market share
- Physician practice interviewees: 84 interviews in 31 practices (18 in 2014 study)
 - 25 with non-clinician practice leaders
 - 59 with clinicians (some were practice leaders)
- Supplemented by financial questionnaires

Current study: persistent findings since 2014

- General openness to VBP as a concept despite challenges in real-world implementation, such as:
 - Data issues (timeliness, accuracy)
 - Operational errors in payment models
 - Conflicting payment models
- Strategies used by practices:
 - New capabilities & patient care models
 - Investment in data & analysis
 - Incentives modified within practices

Current study: new findings

- Pace of change has increased
 - Overwhelming to some practices
 - Unexpected APM reversals problematic
 - Some APMs reversed due to leadership changes (rather than model performance)
 - Affects practices' ability to invest, morale, willingness to participate, financial position

Current study: new findings

- Complexity of models has increased
 - Understandability a more prominent issue
 - One pathway to success: investing in ability to understand each model
 - Better understanding → new strategies to earn bonuses & avoid penalties
 - MACRA QPP a good example of complexity

Current study: new findings

- Practices expressed more risk aversion
 - Especially when burned by prior experience
 - Avoiding downside risk, in general
 - Transfer of downside risk to partners
 - Shifting risk back to payers, in some categories (e.g., drug spending)
 - Willing to forego some upside bonus potential to reduce downside risk



Persistent challenges

Data issues

- Timeliness and accuracy

*We've had three months in this year...[and] they're supposed to give us a list of what we need to do this year for our patients... [but] we still don't know what we're supposed to do on these patients. Are we supposed to get mammograms on them? Because they're supposed to give us a list of who needs what, and it was supposed to be done two days ago, and they said "Oh, it's not going to be done until the next refresh, which is next month." **So we're going to go a quarter of the year into the program, without really having the data to actually do what we were supposed to do.** So all we can do is guess. ...It just would be nice at the beginning of the year, at the very beginning, the first of the year, or let's say in December of the previous year, if they just said, "This is what we're measuring. So as you're seeing your patients here, why don't you start working on this?"*

--Physician owner of a small primary care practice participating in PFP programs

Operational errors

- Errors in 2014 had consequences for participation in later APMs

[In 2014] the real issue was ...they had incorrect data. Because to qualify for a bonus, you had to make certain all the patients were on an ACE inhibitor or an angiotensin receptor blocker. And they said we were hitting the target like 75 percent of the time, or 50 percent of the time, and then you could also see what the data was for all the other aggregated hospitals and I saw that they were even lower than us ...so I was suspicious that something was wrong, and then we audited some of our charts. And that's when we reported to, you know, we brought this to the attention of the state. And they said, "Yeah, we'll get on top of it. We'll correct it." But nothing ever happened. And we would keep getting the reports back, and they'd say the target wasn't met. **It was never fixed... I gave up, and I think the hospital leadership gave up.**

...[Regarding Medicare bundled payments,] I was probably one of the most anxious about that and said, "Guys, you know, we got to get together on this and get going." ...**Perhaps because everything fell apart with the state initiative before, I wasn't getting a lot of traction...** They put it on hold

--subspecialist physician, hospital-affiliated small single-subspecialty practice

Conflicting models

- The cacophony of measures persists, even for large practices with market power

Administrative simplicity means two completely different things whether you're looking at it from the payer's side or from the provider's side. And they're almost antithetical. So administrative simplification to us complicates matters for the payer, and administrative simplification for the payer... complicates things for us. ...The quality side of value-based payment is really a disaster, I would say, and actually MIPS is going to make it worse. **And so, the big thing that we did, which we actually had done by 2014, is we just decided to accept that fact and that we were never going to be able to change it, that everybody was going to make up their own quality measures and they wouldn't be the same across payers.** And we tried and are still trying to get the commercial payers to kind of go more towards the Medicare model of using clinical data that's derived from actual clinical records. But so far, we haven't been successful...

--Physician leader of a large multi-specialty practice participating in ACOs, capitation, PFP

A photograph of three healthcare professionals, two women and one man, all wearing white lab coats and stethoscopes. They are gathered around a tablet computer, looking at the screen with focused expressions. The image has a purple and blue color overlay. The text "Practices' strategies for alternative payment models (persistent)" is overlaid in white, bold, serif font.

Practices' strategies for alternative payment models (persistent)

New capabilities

- Primary care practices becoming more comprehensive

*So we have a **medical home care coordinator program** at the clinics, those are expanding, but also their job roles are expanding to include things like **social determinants of health assessment** and dealing with issues like transportation and referral to agencies. We're **embedding behavioral health providers in the primary care clinics**, so we have an entire training program online and in person for both therapy folks, as well as the pediatricians, to prescribe medications. **We even have a substance abuse program**, where we're prescribing medications for opioid withdrawal in some of our primary care practices, that's like world changing.*

--physician leader of large multispecialty practice

New capabilities

- New informatics capabilities

When my patient goes to the emergency room, I receive an alert via the ACO's app. It's going to tell me Mr. Smith is in the emergency room at Hospital [X]. Mr. Smith has been discharged from Hospital [X]. So once I get that, I can talk to the patient or the family and say I am aware that they are there, that I can help. I can provide the doctors with more information. And once I know that the patient was discharged, then me or my staff can call the patient and say, "You've been discharged from Hospital [X]. I'd like you to come Thursday so we can review your medications.

--Physician in a primary care practice participating in a local ACO

Investment in data & analysis

- Internal tracking capabilities

*We follow our own measures... I have the target goals right here ...it's in the system. **We have a scorecard that we're able to look at, and it's updated on a weekly basis.** So I can see where we fall. I can see what measures we're doing really well on, I can see what measures we're still struggling with, **and I can dive down to the provider and I can see which provider is struggling with which measure.** I can also identify the missed opportunities that the provider had. So, you know, of these patients that walked in to see you in the month of March, or in the month of February... hypothetically speaking, 200 were in need of these screenings and only 100 got screened. So what happened to the other 100? ...I'm able to get that report to that level.*

--clinic administrator within a large multispecialty practice participating in capitation and PFP

Incentives modified within practices

- Quality incentives passed through, but only after modification in most cases
- Cost incentives almost never passed through as individual physician financial incentives

*There's no differential payment of individual member practices, according to their [total medical expenditure] or quality performance, but **every one of us got A's in college, at least, and a lot of us got A's in medical school**, and if you send me a report that says that I'm a bottom feeder, I'm pretty bent out of shape, and I want to get those A's.*

--physician leader and practicing physician in a primary care practice within large organization

A close-up photograph of a hand typing on a laptop keyboard. A silver stethoscope is resting on the keyboard, its chest piece positioned over the spacebar area. The image is overlaid with a semi-transparent purple filter. The text "New: Accelerating Pace of Change" is centered over the image in a white, serif font.

New: Accelerating Pace of Change

Accelerating pace of change

- Multiple interviewees described current pace as being greater than in prior periods of change

*[HMOs and HIPAA each] were just kind of like one big pill we had to swallow. Whereas, with the ACA now ...and PQRS going from an incentive to becoming punitive...and Meaningful Use and ICD-10 and now with MIPS this year we have clinical practice improvement activities and then next year we have the resource use piece of MIPS coming in. And the rules for leaving MIPS to join the APM—or now they're calling them AAPMs—**the rules are changing multiple times during the year** and all of the different measures that they're following and they care about and the requirements for submitting them. ...What we're seeing right now is just a lot of these what I would call like big pills to swallow all in a very short time period of the seven to eight years, where **it seems like almost every year there's a major shift that you have to make.***

--local medical society leader

Accelerating pace of change

- Some vendors are having a tough time keeping up
 - Makes it harder for practices to get advice

With a lot of the so-called experts that are out there, there's a lot of mismanagement of information. The solo docs especially, I mean, they can't even afford to have their own front-office people go out to get educated at places like the MGMA. ...I was on the phone earlier today with the owner of a billing company in my area and she was telling me, "I never got involved in any of this stuff because I'm about five years away from retirement, so why would I get involved with all this new ACA, the PQRS, the Meaningful Use, MACRA, and all this stuff? It's just not worth it. It's so complex, it's so complicated. And I know how to do what I know how to do, so I'm gonna stick with the specialties that don't really depend on that."

--MGMA chapter leader

Accelerating pace of change

- Some practices explicitly wished for a pause in the pace of change

We need to call a time out. We need to create a moratorium ... Nothing against academics, nothing against new ideas, but before you implement new ideas, let the old ideas get into effect. Many of my colleagues, including me, really have to keep up to understand what is HEDIS, what is MACRA, what is Meaningful Use, when is Meaningful Use phased out, when is MACRA phased in? We don't even have time to take a deep breath in order to digest what is important.

--physician owner of primary care solo practice

Unexpected APM reversals

- Sudden or unexpected changes in payment models due to discontinuities across administrations

*Oh, this is just kind of crazy. Let me think back on it. We were in the bundled payment system for Medicaid [in 2014], and that was proposed by the surgeon general at the time, who was under [the previous] governorship. And the [new] governor came in, he fired the surgeon general. So we have a new surgeon general ...and so some of those episodes of care have kind of dwindled. ...[However], **it improved care anyway** because we strictly forbade the residents to give antibiotics for upper respiratory infections. So I think [bundled payment] made a big difference...[But] it's hard in this day and time to keep anything going and, as you know, with like TV, the focus is about 30 seconds and then you're off to something else.*

--physician owner of a small primary care practice

Unexpected APM reversals

- Effects on investments, practice finances, relationships

[Under mandatory cardiac bundled payments, hospitals] were really after the cardiologists. And some people have sold and so people were promised to buy or promised they'd be bought and that kind of went on hold and halted. Of course, a lot of people have bad blood because of that. [Cardiologists said], "You promised me to do this and now you're not going to do it," and the hospital said, "Well, I wanted to do it but now I can't do it because it's changed." Same for the orthopedic surgeons.

--medical society leader, describing effects of discontinuing mandatory bundled payments in Medicare

Unexpected APM reversals

- There were also notable shifts back to FFS in two markets
 - Possibly due to employers increasingly using HDHPs instead of managed care plans
 - Effects on morale for physicians accustomed to VBP

[Our practice has become] almost exclusively and primarily concerned with volume because of this change [to FFS], which is nothing like we ever were before. And what I am seeing with that change is a decrease in quality, a decrease in patient satisfaction, a decrease in all things that I hold most important, and that's part of why I'm leaving.

--primary care physician within a large multispecialty practice that swung back toward FFS since 2014 (involuntarily)



New: Complexity of Payment Models

Complexity of payment models

- Practices making significant investments to understand & comply with APM requirements

Finding qualified people to run this program has been awful and especially with what the physicians would want to pay to get that quality. You've got to know IT. You've got to know some medicine. You've got to know how to put documents together. You've got to know how to work Excel. You've got to know how to do presentations. You've got to know how to do all of it, you know, the blah-blah—I mean it goes on and on and on—if you're going to do it right. You have to do budgets for CPC. You have to show them how you spent the money. You've got to make sure you're legal doing this or they can come in and take all of your money back from you that you've already used to pay people...

--office manager of medium-sized primary care practice, discussing CPC+

Complexity of payment models

- Some practices have delegated their APM engagement strategies to vendors

*Our EHR is the one that basically does MACRA for us. So in the licensing terms that we have with our EHR, [the vendor] is the one that basically runs the reports, submits the data for MACRA, all that kind of stuff. It tells us, basically, what the new measurements are going to be, what packages that they have to assist the doctors and meeting those measurements and whether we're interested or not—you know, that type of sort of thing. **I've done MACRA research on my own just to get prepared but it hasn't been in-depth, again because [EHR vendor] is the one who does who does everything for us.***

--office manager of a medium-sized single-subspecialty practice

Complexity of payment models

- Understanding APM rules has enabled new strategies
 - Example: actively managing patient attribution, without changing care

One of the things that we did early in the ACOs was offload the cost of skilled nursing care. *It's almost always the primary care physician that's responsible for that if that person is also in the ACO. All of the costs for the [most expensive] patients, even with a high risk-adjustment factor, are saddled back to the ACO. ...[Savings seemed to come from] people managing the cost of nursing home care better, and that's why they stayed in the green, the shared savings. What they are kind of missing is that most of that occurred because somebody created a separate tax ID for the work in the nursing home so that it didn't impact the ACO. **Didn't change cost structure. Didn't change the acuity of the patient. It just subtracted that ugly cost from the ACO.***

--leader of MSSP ACO



New: Risk aversion more prominent

Risk aversion

- Affecting model choice
 - Avoiding downside risk, if inexperienced with taking on such risk or had past losses

We did an upside only, an MSSP Track 1. We didn't take a risk contract. ...[W]e did an operating analysis and felt like we had the systems in place so we could handle it. But when we did the financial analysis, and we looked at the shared savings and the shared risk models, the shared risk models offered very little additional upside, but the downside was dramatic. And we just said for \$2 million more, we're not willing to take \$17 million [potential] hit, right? So it just didn't make sense. Now CMS is going to—they're going to force the hand.

--administrative leader of large multispecialty practice

Risk aversion

- Practices offloading downside risk to partners
 - Example: device manufacturers

*We're looking at BPCI-A, the advanced version. ...So [hospital and device manufacturers] have been doing bundled payment stuff as a facilitator or convener for a long time. We got what seemed like reasonable proposals from both of them. **The [device manufacturer] one, for example, they'll take all the downside risk, and they want a 30 percent cut of the upside.** So okay, that seems reasonable, since we're getting into stuff that we don't know...and wouldn't be doing on our own. So if it's a downside, it's their problem; if it's an upside, it's found money for us.*

--physician leader of small orthopedic practice

Risk aversion

- Shifting risk back onto payers
 - Practices learning from past losses
 - Willing to forgo some bonuses to get protection

*If you can cure Hepatitis C, and there's a cohort of tens of thousands of people out there with Hepatitis C, you're not seriously going to ask us to withhold those drugs because we're not going to. That's unethical. And yet you will hold us accountable for the cost of those drugs. So, let me get this right, and this is what happened two years ago, is Sovaldi, **we lost in our commercial contracts because of Sovaldi**, we paid penalties to the commercial payers who had to purchase those drugs, right? So, we are then paying pharma for their price escalations.... **[But] the payers are negotiating with pharma, right?** So that's just wrong. That is just completely wrong. Makes us furious. We have negotiated, we have made it clear how we feel about this and that is definitely not risk we should be taking on. **...[Now] we have some protection.** It's some complicated thing, which is sort of a retrospective if certain price trends hit certain thresholds...**we don't pay a penalty, but we don't get any of the shared savings [if we save on drugs]**.*

--physician leader of large multispecialty practice, regarding a shared savings payment model

Conclusions

- Simpler APMs might help practices focus on improving patient care
- Practices would benefit from a stable, predictable, moderately-paced pathway for APMs
- Practices need new capabilities and timely data to succeed in APMs
- Reducing practices' access to upside-only APMs risks disengaging them
- Designing APMs to encourage clinical changes that individual physicians see as valuable might improve their effectiveness

Effective Models of Physician Compensation

