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Physician practices need help to adopt new payment models, study finds

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Physician practices are engaging in new health care payment models intended to improve quality and reduce costs, but are finding that they need help with successfully managing increasing amounts of data and figuring out how to respond to the diversity of programs and quality metrics from different payers, according to a new joint study by the RAND Corporation and the American Medical Association.

Both the federal government and private payers are changing the way they pay physicians and other health professionals, moving to innovative models intended to improve quality and reduce costs.

Many physician practices are responding by partnering or merging with other medical practices or hospitals in order to better support the investments necessary to succeed in new payment models, such as care managers and information technology. Practices say that realigning their operations to the goals of the new payment strategies can be challenging when necessary data are not available or different payment models conflict with each other.

"We found that changing the payment system probably isn't enough to ensure that patient care will improve," said Dr. Mark W. Friedberg, the study's lead author and a senior natural scientist at RAND, a nonprofit research organization. "For alternative payment methods to work best, medical practices also need support and guidance. It's the support that accompanies a new payment model, plus how well the model aligns with all of a practice's other incentives, that could determine whether it

succeeds."

Researchers performed case studies of 34 physician practices in six diverse geographic markets to determine the effects that alternative health care payment models are having on physicians and medical practices in the United States.

The payment models include episode-based and bundled payments, shared savings, pay-for-performance, capitation and retainer-based practices. Accountable care organizations and medical homes, two new organizational models, also were examined.

The findings are intended to help guide system-wide efforts by the AMA, the study's sponsor and co-author, and other health care stakeholders to improve alternative payment models and help physician practices successfully adapt to the changes.

"The AMA is committed to ensuring physicians in all specialties and practice sizes can participate successfully in new payment models that allow them to efficiently provide the best care to patients," said AMA President-elect Dr. Steven J. Stack. "Progress toward the high goals of payment reform requires a clear path forward, and insights from the new AMA-RAND report will provide missing information on the real-world impact of payment reforms on busy physician practices that can help improve current and future alternative payment programs."

The report found the effect that alternative payment models have on practice stability, including the overall financial impact, ranged from neutral to positive. Among the practices surveyed, none had experienced financial hardship as a result of involvement in new payment models.

There was general agreement among physicians that the transition to alternative payment models has encouraged the development of

collaborative team-based care to prevent the progression of disease. Additional benefits for patients include increased access to care and physicians through tele-health or community-based care.

Most physician leaders were optimistic about alternative payment models, while physicians not in leadership roles expressed some apprehension, particularly with regards to certain new documentation requirements. For example, physicians were supportive of new patient registries that list patients with certain health conditions as a way to improve care. But they had concerns about documentation requirements where the link to better care was less clear.

Researchers concluded that the operational details of alternative payment models can either help or hinder practices' efforts to improve their own processes.

For example, practices are investing significantly in information systems to analyze large amounts of data about practice patterns. But when crucial data (like quality performance feedback and drug prices) are missing or inaccurate, it is difficult for physician practices to use data analysis to improve care and reduce spending.

While physician practices are making substantial investments in information systems, payers also should consider investing in the capability of physician practices to manage the information. Such investments could enhance the effectiveness of new payment models, and help medical practices make the best use of computerized health records and other health information technology, according to researchers.

In addition, payers should consider ways to harmonize key components of alternative payment models, especially performance measures. Medical practices usually contract with many payers, who each may have

different performance measures tied to payment rewards. So medical practices must cope with how to address hundreds of performance measures and create a coherent response.

If the cacophony of requirements can be eased—and if government regulations can be aligned with alternative payment models—physician practice leaders can devote their attention more fully to making meaningful changes to processes that benefit patient care.

Researchers also found that most medical practices have shielded individual physicians from direct exposure to the new financial incentives created by payers. While practices are paid more for improved performance, practices generally use nonmonetary incentives to encourage physicians to change their decision making. Those methods include efforts such as providing performance feedback to individual doctors and are intended, in many cases, to appeal to physicians' sense of professionalism.

"Practices seem to feel more comfortable using nonfinancial incentives to encourage physicians to provide more-efficient, lower-cost care," Friedberg said. "Despite the pressure to contain costs, practice leaders are trying to avoid creating situations where doctors are paid more when patients do not get the services they need."

The study found that alternative payment models generally have not changed the core content of physicians' clinical work. Efforts to improve efficiency by delegating some tasks to non-physicians has had the unintended consequence of increasing the intensity of physicians work, raising concerns about burnout.

The project conducted interviews between April and November 2014, speaking with 81 people from 34 physician practices in six markets throughout the country: Little Rock, Arkansas; Orange County,

California; Miami, Florida; Boston, Massachusetts; Lansing, Michigan; and Greenville, South Carolina. Researchers also spoke to leaders of 10 payers, nine hospitals or hospital systems, seven local medical societies and five Medical Group Management Association chapters.

More information: The report, "Effects of Health Care Payment Models on Physician Practice in the United States," is available at www.rand.org

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