Practices Make Progress on Alternative Payment Models, But Some Struggles Remain

April 24, 2015 04:35 pm Jill Sederstrom (mailto:aafpnews@aafp.org) – Physician practices are embracing change and adopting new organizational models and team approaches to care management as they navigate innovative payment options, but the road to those alternative payment models isn't without bumps along the way.

These challenges and early successes were highlighted in a new study report by the RAND Corp. that takes an in-depth look at the impact alternative payment programs are having on physician practices across the United States.

Changing the Practice Landscape
Alternative payment models are already changing the structure of physician practices, with multiple physician practice leaders and health care stakeholders reporting that they've seen changes to the organizational structure of their own practice or others in their market. Most often, these changes have meant affiliating or merging with other physician practices, aligning with a hospital or being bought by a hospital.

Such was the case with the Vanguard Medical Group, a New Jersey-based group formed 3 1/2 years ago when three private practice groups decided to merge. Since then, the group has grown to include six practice sites and 26 physicians.

Robert Eidus, M.D., M.B.A, president of the Vanguard Medical Group and a member of the AAFP Commission on Quality and Practice, said he and other practice leaders made the decision to join together to add scalability to practice operations but also because they realized they weren't going to be able to stay both small and independent any longer.

"Even if we came together independently, we couldn't function autonomously as six separate sites," he said. "We had to really come together to develop a common IT platform, a common disease registry, a common database, a fairly uniform patient experience, and common clinical and administrative processes."

Another trend being ushered in by alternative payment models is the development of team approaches to care management. According to the RAND report, which was sponsored by the AMA, more practices are dividing responsibilities among physicians and allied health professionals, with many in shared-savings programs or patient-centered medical homes (PCMHs) adding care managers to help monitor patients between appointments.

Aligning with an accountable care organization (ACO) has helped one small independent practice in Ohio make the shift to team-based care. James Dom Dera, M.D., co-owner of The Ohio Family Practice Centers in Fairlawn, said as a three-physician independent practice, he and his partners may not have been able to make significant changes to care delivery. However, by aligning with a local ACO, they were able to earn PCMH recognition from the National Committee on Quality Assurance and now have access to additional support staff.

"We have access to nurse care managers now, and clinical communication centers staffed by RNs to help us manage patients after hours -- things we didn't have before that are driving toward a higher-quality outcome that we just couldn't have done on our own as a small independent practice," said Dom Dera, who is also an AAFP member.
But ensuring that allied health professionals practice at the top of their license and delegating responsibilities aren't the only examples of team work. According to the report, primary care physicians participating in global capitation or shared savings models are also collaborating more often with specialists to better manage patient care.

Adopting alternative payment models has also meant significant investment in data management capabilities, whether it's in the systems themselves or the staff required to run them. Although practices report these systems are vital to operating alternative payment models, the report notes there have also been concerns about the accuracy and timeliness of the data within them.

"The data systems are not reliable, and so, for example, one of the largest payers has given up now on trying to get data from medical records and they are just going back to using purely administrative data, which limits you in terms of what you can measure," said Eidus, whose medical group was an early adopter of the PCMH and continues to use that model today.

Another challenge that has emerged for practices is the array of pay-for-performance and other incentive programs. Practices may now find themselves carrying a large administrative burden as they try to keep track of the requirements for multiple incentive programs.

"Many practices find they are collecting the same pieces of data on the same patient for two or three different customers or they are collecting data that is slightly different -- everyone has their favorite way of managing diabetes that is not uniform," said Eidus, who frequently speaks on the topic of practice transformation and the PCMH across the country.

According to Harold Miller, president and CEO of the Center for Healthcare Quality and Payment Reform in Pittsburgh, physician practices are now juggling multiple payer-directed payment systems. He said he thinks the market is too much of a top-down payment reform system, with health plans deciding what the incentives should be without physician input.

"Ask the people who are actually delivering the care, who know," said Miller, "what they think makes sense in terms of patient care and what they can actually make a difference on."

**Finances Largely Holding Steady**

But although alternative payment models may be ushering in significant change for physician practices, some things remain the same. For instance, those in the study reported that the new models either had a neutral or positive impact on practices' financial stability, with no practice reporting any major financial difficulties as a result of payment reform.

The study also found that the way physicians are delivering face-to-face care has remained virtually unchanged, although respondents reported an increase in intensity and quantity of work.
Individual physicians are also not seeing significant changes to their aggregate income as a result of new payment models. The study found that in most cases, the financial incentives outlined in the alternative payment models were not making their way down to the individual physician.

Dom Dera said he's seen this trend in the industry, particularly for larger practices.

"For us personally in our practice, we just divide our value-based resources based on our panel size," he said.

As practices navigate new payment models and responsibilities, attitudes about the new responsibilities may depend on an individual's role within a practice. According to the study report, physician leaders continue to be optimistic about new alternative payment models, while those who aren't in leadership roles were more apprehensive and resigned.

"There is definitely a disconnect there between what leadership sees and what the average provider and physician on the ground sees and it's a hard connection to make," Dom Dera explained.

As a small practice owner himself, Dom Dera said he has been able to see the issue from both sides. He says there are days when he feels overwhelmed by the day-to-day physician responsibilities, but he is also able to see the value that aligning with the ACO and becoming a PCMH have had on the overall practice.

Eidus said he's been extremely pleased with the care aspects of the PCMH but hasn't been happy with the payment side of the equation because in many ways, the practice is still locked into the fee-for-service model.

"Although 85 percent of our patient population, theoretically, is under a PCMH payment model where we would be getting care-coordination fees, only 38 percent of our population is actually attributed to us, so we're only getting paid care-coordination fees on 38 percent of our patients," he said.

To ease the transition into new payment models, the report's authors outlined several recommendations that could help smooth the way. These recommendations included providing physicians with support and guidance to manage alternative payment model workloads, addressing operational concerns from physicians about the models, and making sure that practices have the data and resources necessary for data management.

In addition, they noted, consistency among key components of various payment models, especially in terms of performance measures, will allow physicians to operate in a more streamlined environment.

However, Eidus and Miller both think there also needs to be payment reform to ensure physicians are getting the reimbursement they need to deliver a higher level of care.

"I think the problem is people are gravitating too much toward the idea that we have to provide more help to physicians to enable them to succeed in these new models rather than saying maybe these new payment models, the way they are being done right now, aren't structured in the best way," Miller said.
JOHN BRADY  
4/28/2015 1:59 AM  
"We had to really come together to develop a common IT platform, a common disease registry, a common database, a fairly uniform patient experience, and common clinical and administrative processes."

Dr. Eidus made an intelligent and logical decision based on the rapidly changing marketplace. But this quote leaves me sad. Is there really no room for solo practices? The Casalino study in Health Affairs last year showed both that practices with 1-2 docs had a 33% lower rate of preventible hospitalizations compared to 10+ doc practices AND PCMH components did not make a difference. Yet we continue to press forward with massive administrative requirements requiring teams and technology and large amounts of money and time. Small practices cannot afford these resources and so they have to consolidate and/or sell out. So the ironic result of the push for quality is the destruction of the very practices who were providing the best quality to begin with.

As we settle on "a fairly uniform patient experience" we need to recognize something is being lost. We can only hope it is not the heart and soul of our profession.

DONALD BROWN  
4/28/2015 2:48 AM  
I read nothing here that has anything in common with what my patients say they want from their medical care. This is a 100% payer-centered model, in which the highest goal of the physician is now to maximize profits for United and Aetna. The AAFP needs to give up the sham of calling this "patient-centered:" that's the last thing it is.

PERRY WILLIAMS  
5/3/2015 2:44 PM  
"The AAFP needs to give up the sham of calling this "patient-centered:" that's the last thing it is."

I'd say "payment-centered".
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