

Family Physician Readiness for Value-Based Payments: Does Ownership Status Matter?

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Abstract

Value-based payments are rapidly replacing fee-for-service arrangements, necessitating advancements in physician practice capabilities and functions. The objective of this study was to examine potential differences among family physicians who are owners versus employed with respect to their readiness for value-based payment models. The authors surveyed more than 550 family physicians from the American Academy of Family Physician's membership; nearly 75% had made changes to participate in value-based payments. However, owners were significantly more likely to report that their practices had made no changes in value-based payment capabilities than employed physicians (owners 35.2% vs. employed 18.1%, $P < 0.05$). This study identified 3 key areas in which physician owners' value-based practice capabilities were not as advanced as the employed physician group: (1) quality improvement strategies, (2) human capital investment, and (3) identification of high-risk patients. Specifically, the employed physician group reported more quality improvement strategies, including quality measures, Plan-Do-Study-Act, root cause analysis, and Lean Six Sigma ($P < 0.05$ for all). More employed physicians reported that their practices had full-time care management staff (19.8% owners vs. 30.8% employed, $P < 0.05$), while owners were more likely to report that they had no resources/capacity to hire care managers or care coordinators (31.4% owners vs. 19.4% employed, $P < 0.05$). Owners were significantly more likely to respond that they do not have the resources/capacity to identify high-risk patients (23.1% owners vs. 19.3% employed, $P < 0.05$). As public and private payers transition to value-based payments, consideration of different population health management needs according to ownership status has the potential to support the adoption of value-based care delivery for family physicians.

Keywords: value-based payment, physician readiness, practice capabilities, value-based care

Introduction

PHYSICIANS WILL BE INCREASINGLY required to move away from fee-for-service reimbursement to a value-based system that ties payment to quality and outcomes. The Affordable Care Act, the US Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) value-based payment goals, and the Medicare Access and Children's Health Insurance Program Reauthorization Act have accelerated the move of the health care system away from a volume-based system to one that focuses on population health, care coordination, and health outcomes.¹ This

change is occurring rapidly, as CMS reached the first milestone in its value-based payment goals 11 months ahead of schedule.² As of January 2016, an estimated 30% of Medicare payments are now tied to alternative payment models compared with 20% in January 2014.

Primary care is a cornerstone of care models that support value-based payments, such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs). Family medicine is among the most common specialties (13.1% of all practicing physicians), second only to internal medicine (13.4%), according to the most recent physician specialty study from the Association of American Medical

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Colleges (2013 data).³ There are critical elements necessary for family physicians to thrive under these alternate payment models. Prior research has suggested that high-performing physicians under value-based payments tend to have dedicated quality improvement staff, more care management processes, use order sets and clinical pathways for measured areas, and to engage in more external quality improvement initiatives.^{4,5} The study hypothesis was that these practice functions and capabilities may differ by physician ownership status, and thus the objective of this study was to examine potential differences among family physicians who are owners and those who are employed with respect to their readiness for value-based payment models.

Methods

A 32-question survey was distributed to a randomly selected sample of 5000 active members of the American Academy of Family Physicians (AAFP) in June 2015. Respondents could complete either a printed copy or an online version of the survey. The survey contained questions to assess AAFP members' perceptions, attitudes, and adoption of value-based payment modes, as well as related practice functions and capabilities. There were 4 Likert-scale attitudinal questions, 3 open-ended questions to collect qualitative data, and 25 multiple-choice questions. Only questions related to practice functions and capabilities were analyzed for the purpose of this study. The study protocol and survey instrument were approved by the Institutional Review Board of Indiana University.

Each respondent's owner/employed status was assigned according to self-reported data in AAFP's membership records, which are updated every 3 years. Respondents to "Which of the following best describes your role in the ownership of your primary clinical practice?" were classified as *owners* if they selected "you are the sole owner of your practice" or "you are a partial owner or shareholder in your practice." Respondents were classified as *employed* if they selected "you have no official ownership stake in your practice (100% employed)." The owners category includes physicians who have any level of ownership in their practices (ie, full ownership or partial ownership as part of a group).

Responses between owners and employed physicians were compared using independent sample *t* tests for continuous variables and a chi-square test of independence for categorical variables. To account for differences in the demographic makeup of the survey sample, weights were applied during the calculations.

Results

The survey yielded a 15.6% response rate. The final study sample was comprised of 572 surveys (Fig. 1). More than half (55.9%) of the respondents were employed and 44.1% were physician owners. Relative to AAFP's membership, the survey sample population had a slightly higher proportion of males and tended to have more years of practice.

Physicians in the owner group reported a significantly higher number of patients in their panel (Table 1). About 40% of both groups had an ACO or similar affiliation at their primary practice location; however, the owner group was more likely to be part of an independent provider association or health maintenance organization than the em-

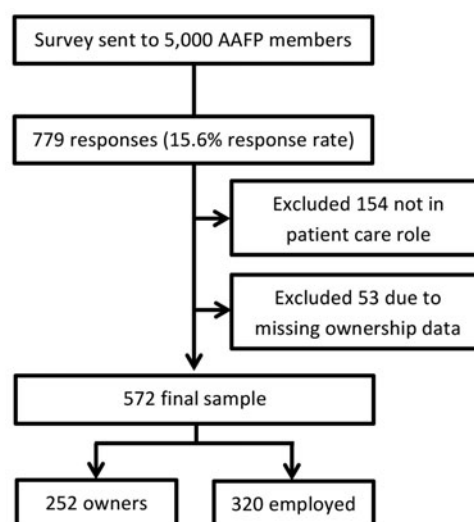


FIG. 1. Sample flowchart. AAFP, American Academy of Family Physicians.

ployed group. More than half of the owners group reported receiving payment from more than 10 payers compared to one third in the employed group. The employed group was significantly more likely to have PCMH recognition as well as interprofessional collaborative staff at their primary location (eg, physician specialists, care managers, behavioral specialists, pharmacists). A higher proportion of the employed group had nurse practitioners than the owner group, but the difference was not statistically significant.

Nearly 75% of respondents reported that their practices had made changes to participate in value-based payments. The most common change for both owners and employed was updating health information technology infrastructure, owner: 54.1% vs employed: 58.5%, $P=0.22$ (Fig. 2a). (All text results are presented as owner% vs. employed%, P value). Employed physicians were significantly more likely than owners to have hired care managers/coordinators, quality support staff, and particularly behavioral health staff. Owners were significantly more likely to report that their practices had made no changes in value-based payment capabilities (35.2% vs 18.1%, $P<0.05$). The employed physician group reported employing strategies to identify quality improvement opportunities, including quality measures, Plan-Do-Study-Act, root cause analysis, and Lean Six Sigma (Fig. 2b).

Overall, 78% of respondents reported access to complete clinical/medical record data and half (50%) had access to claims. With 2 exceptions, there were no differences in data access between the owner and employed groups (Fig. 2c). Owners were significantly more likely to have access to claims data (61.7% vs. 45.2%, $P<0.05$), while employed physicians reported greater access to hospital cost data (18.9% vs. 27.4%, $P<0.05$). The primary source of data in both groups was the electronic health record (EHR), although the employed group reported significantly higher access to the EHR, 71.1% vs. 80.1%, $P<0.05$ (Fig. 2d).

With respect to identifying high-risk patients, there were largely no differences between the owner and employed groups with 1 exception; owners were significantly more likely to respond that they do not have the resources/capacity to identify high-risk patients (23.1% vs. 19.3%,

TABLE 1. SAMPLE CHARACTERISTICS

Sample characteristics	Physician ownership status	
	Owner, n = 252	Employed, n = 320
Female, n (%)	67 (26.6)	128 (40.0)
Number of patients in panel	Mean = 2303 Median = 2250	Mean = 1994 ^a Median = 1750 ^a
Years out of residency, n (%)		
Valid responses, n	252	320
1–7 years	4 (1.6)	60 (18.8)
8–14 years	37 (14.7)	60 (18.8)
15–21 years	54 (21.4)	57 (17.8)
>21 years	157 (62.3)	143 (44.6)
Number of payers, n (%)		
Valid responses, n	244	305
≤10 payers	86 (35.2)	136 (44.6)
>10 payers	131 (53.6)	103 (33.8)
Don't know	27 (11.1)	66 (21.6)
Affiliations for primary location, n (%); check all that apply		
Valid responses, n	246	301
ACO or similar population	95 (38.6)	122 (40.5)
IPA	99 (40.2)	44 (14.6) ^a
HMO	64 (26.0)	55 (18.3) ^a
Academic health center	10 (4.1)	59 (19.6) ^a
None of the above	80 (32.5)	98 (32.6)
PCMH status, n (%)		
Valid responses, n	246	304
Accredited/recognized	67 (27.2)	143 (47.0) ^a
Application pending	21 (8.5)	45 (14.8) ^a
None of the above	158 (64.2)	116 (38.1) ^a
Staff at primary location, n (%); check all that apply		
Valid responses, n	252	320
Nurse practitioner or physician assistant	151 (59.9)	243 (75.9)
Specialist physicians	35 (13.9)	93 (29.0) ^a
Care manager/coordinator	38 (15.1)	111 (34.7) ^a
Behavioral specialist (LSW, clinical psychologist or psychiatrist)	32 (12.7)	106 (33.1) ^a
Pharmacist	23 (9.1)	84 (26.3) ^a
Other PCP (pediatrics, internal medicine)	72 (28.5)	133 (41.5) ^a
Other	27 (10.7)	27 (8.4) ^a

Ns for each row do not sum to the total n of the sample because (1) results are limited to surveys with valid responses and (2) some questions allowed respondents to select more than 1 response.

^aStatistically significant versus owner at $P < 0.05$.

ACO, accountable care organization; HMO, health maintenance organization; IPA, independent provider association; LSW, licensed social worker; PCMH, patient-centered medical home; PCP, primary care physician.

$P < 0.05$) (Fig. 2e). Similarly, owners were more likely to report that they had no resources/capacity to hire care managers or care coordinators (31.4% vs. 19.4%, $P < 0.05$), while more employed physicians reported that their practices had full-time care management staff (19.8% vs. 30.8%, $P < 0.05$ (Fig. 2f).

Respondents also were asked whether they used a registry for population health management. Employed physicians were significantly more likely to have a registry (38.2% vs. 54.3%, $P < 0.05$).

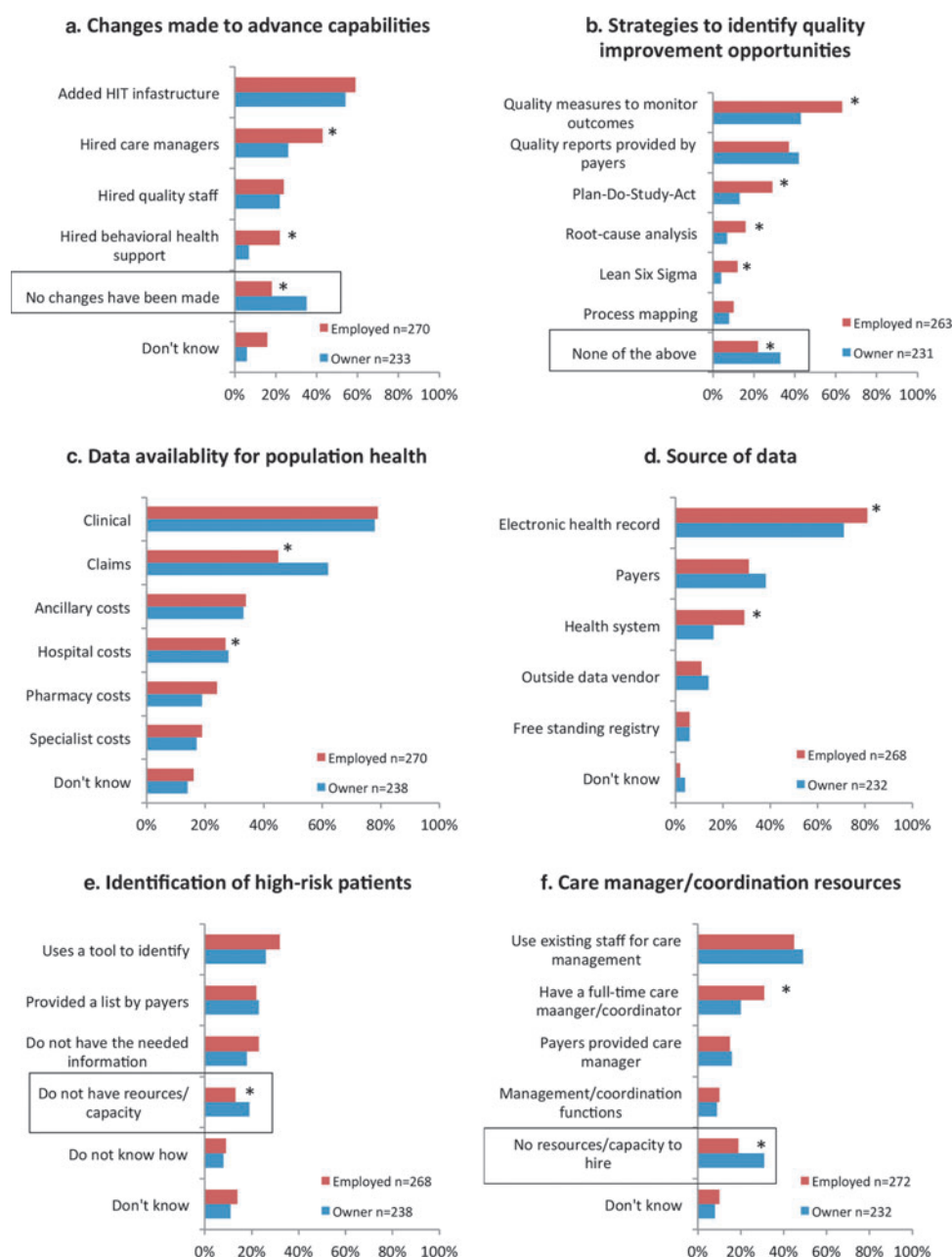
Discussion

This study identified 3 key areas in which physician owners' value-based practice capabilities were not as advanced as the employed physician group: (1) quality improvement strategies, (2) human capital investment, and (3) resources/capacity to identify high-risk patients. First, owners were less likely to report using recognized strategies to identify quality improvement opportunities within their practices. Prior research has shown that participating in external quality improvement initiatives is associated with higher performance.⁵ Owners could benefit from working with their peers in learning collaboratives, quality improvement initiatives, or even integrating at some level to combine resources to support efforts related to value-based care delivery. The Transforming Clinical Practices Initiative, a program offered by CMS to help transform primary care in a collaborative peer-based learning initiative, may serve as a helpful resource on practice transformation for family physician owners.⁶

Owners were significantly less likely to have hired or report having the capacity to hire care managers and related staff. Having adequate human resources has been shown to positively impact performance,⁴ yet hiring can be financially prohibitive when a practice is in transition from fee-for-service to value-based payments. Further, owners reported that they were less likely to have the resources or capacity to identify high-risk patients than their employed counterparts. Such identification requires data access, analytics capabilities, and human capital. For many practices that are engaged in value-based arrangements with insurers, the insurer provides care management support as well as current data on high-risk patients. These partnerships leverage the rich data from the insurer to empower the physician to facilitate care to especially vulnerable populations.

Such physician-insurer collaborations can prove successful; however this study revealed that more than half of physician owners are working with 10 or more different payers. Multiple payers equates to incremental and fragmented quality reporting. Recently, the amount of time and financial burden has been documented as being prohibitive, especially for those physicians in practice with little resources or staffing.⁷ Primary care doctors spend nearly \$50,500 annually tracking and reporting quality measures. Additionally, staff are spending 7.8 hours a week and physicians 3.9 to input, track, and report quality measures. One way to assist with this issue is through the measure alignment efforts under way by CMS, payers, and America's Health Insurance Plans.⁸ If multiple payers adopt these aligned measure sets, the burden of quality reporting by physician practices would be reduced.

This study was subject to limitations. The study sample was derived from members of the AAFP and may not be representative of all family physicians. Ownership status was self-reported from AAFP membership files, which may not be current for all respondents and could be defined differently by members, potentially resulting in misclassification bias.



*Statistically significant vs. owner at $p < 0.05$; the n indicates the number of valid responses for each item

FIG. 2. Practice capabilities for value-based payments. HIT, health information technology.

The survey was administered by AAFP, which could have influenced the way respondents answered; however, owners and employed physicians should have been affected by this bias equally. Because this was primary research and did not use a validated survey instrument, the survey itself was subject to bias; particularly because the questions analyzed in this study were all closed ended. As with all surveys, this study is subject to nonresponder bias; however, the 15.6% response rate and weighting of the data reduces that concern.

As the health care system shifts toward value-based payments, advancing practice functions and capabilities will become increasingly important, particularly for physicians

who own their own practices. Although acceleration of capabilities is imperative for physician owners, stakeholders within the system should collaborate and identify productive synergies for creating shared success in value-based payment arrangements. Public and private payers should consider the ownership status of family physicians and the different supports and resources that may be necessary to adopt key functions and capabilities to be successful in these arrangements. Resources in the form of enhanced payment to support practice functions and capabilities and learning and quality collaborative opportunities have potential to support the adoption and implementation of value-based care delivery for family physicians who own their practice.

Author Disclosure Statement

Other than their employment, Ms. Robertson-Cooper, and Drs. Nesderhiser, Happe, and Beveridge declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. Ms. Robertson-Cooper was an employee at AAFP the time of the study, and is currently employed by Missouri Health Plus, Kansas City, MO.

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