

Accountable to Whom?

**PHYSICIANS WEIGH IN
ON VALUE-BASED CARE**

By Shane Jackson, President, LocumTenens.com

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Foreword

BY CHARLES R. EVANS, FACHE

LocumTenens.com's accountable care survey, which garnered responses from over 1200 physicians, produces a number of important findings for hospital executives in developing their value-based care strategy. Perhaps most evident is the need for continuing education of physicians that is systematic and balanced in presenting important perspectives. The success of this education will depend on the degree to which it is targeted at the physicians' need to ensure that patient safety and quality is at the forefront of the strategy.

Physicians indicate clearly that they are willing to share risk but do not want to be held accountable for the variables beyond their control, such as patient responsibilities, hospital care, etc. They also reflect a concern that these accountable care models are first steps in what will ultimately result in their losing control of the care of the patient.

Understandably, there are differences in the readiness of physicians to adapt to these value-based care models based on their own business model. Those who are operating private practices feel considerably more risk than those in some form of employment model. Interestingly, a majority of those surveyed do indicate a willingness to participate in an accountable care arrangement under "the right" conditions.

The underlying message of the respondents is the lack of trust that these models are anything more than the government's or hospitals' continuing efforts at cost-cutting. Therefore, physician engagement is more likely to occur where the commitment to quality care is at least as apparent in the model as the cost-cutting objective. Systems that are able to pilot

these new models and demonstrate their impact in real terms will probably be most successful in rolling them out system-wide over time. Based on the physicians' responses and on lessons learned in working with them in other initiatives, they will be more likely to engage with hospitals in accountable care structures if there is a meaningful role that physicians play in the governance and control of these models.

The biggest surprise of the survey for me was the selection by respondents of Medicare as the payer they would be most willing to participate with in an accountable care arrangement. This may reflect the growing control of their practice exercised by commercial payers versus Medicare.

And indeed, fear of relinquishing control is a recurring theme throughout the responses. Any accountable care program that successfully engages physicians will need to address these trust and control issues.

ABOUT CHARLES R. EVANS

Charles R. Evans is a seasoned hospital executive, having served in key leadership roles including as president of HCA's Eastern Group. He has also served on the faculty of Emory University School of Medicine. He is founder and president of International Health Services Group, which supports healthcare charities around the world. A fellow, past chairman and past governor of the ACHE, he serves on the boards of several healthcare organizations, including Jackson Healthcare.

Introduction

As the Centers for Medicare and Medicaid Services (CMS) continue their rollout of value-based-purchasing (also called pay-for-performance) with its carrot and stick incentives, pushing hospitals around the country to improve processes of care and patient satisfaction, there is a certain amount of inevitability in the advancement of accountable care. The parallel rollout of shared savings arrangements and other value-based payment models is happening both inside and out of the Medicare/Medicaid context. In fact, the Federal government is pushing for value-based payment arrangements with commercial insurers in its Pioneer ACO program, requiring participants to reach a minimum percentage of ACO beneficiaries within its covered population within its three-year ramp up timeframe. Proponents argue that the government is using its considerable healthcare buying power to push for lower healthcare costs across the market. Detractors fear a massive and complex healthcare bureaucracy that will take autonomy away from physicians, lead to denial of care and won't actually achieve savings or quality outcomes.

In that context, we felt that physicians should have an opportunity to have a voice in the conversation and for their concerns and sentiments to be heard. Toward that end, we designed a survey around two questions: do physicians know a lot about value-based care and how do they feel about it? We discovered that, with the exception of pay-for-performance, physicians were surprisingly unfamiliar with the details of value-based care arrangements. Not surprisingly, their comfort level with various new payment models was low, averaging

to three or lower on a five-point scale. More physicians were comfortable with Medicare as a payer in an accountable care arrangement than Medicaid or commercial insurers, with several write-in comments expressing concerns about commercial insurers not treating physicians fairly. Overall there was concern over future payment cuts and scenarios where patients would face denial of care.

In light of these perceptions, the healthcare industry has a steep PR hill to climb to improve physician engagement if it's to move forward with value-based care. Their efforts will have to lean toward educating and actively seeking physician input in design and execution of new payment models. Without physician buy-in, no wholesale reform of healthcare can work.

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Definitions

Value-based or accountable care: A healthcare delivery arrangement in which payment incentives are based not on volume but on incenting savings while improving outcomes and patient satisfaction. This is the umbrella term that encompasses all the new payment models described below.

Bundled payments: A payment model in which a payer and a provider negotiate a discounted fee for an episode of care, which can include three days pre-operation to 30 days post-op. There has been some indication in the healthcare industry that hospitals and healthcare systems may be willing to absorb all of the risk and protect physicians from any cost overruns that exceed the payment bundle; in this risk-protected model, the hospital or health system would keep any cost savings achieved by implementing efficiency measures.

Pay-for-performance or value-based purchasing: A Medicare program beginning in 2011 that rewards hospitals for achievement and improvement in pre-defined process of care protocols, readmission reductions and patient satisfaction scores. Starting in 2014, mortality and outcomes measures will also be evaluated. Hospitals are subject to a one percent withholding on Medicare payments, which they can earn back and more beyond if they meet or exceed pre-defined benchmarks. Hospitals are most incented to improve the patient experience, for a large portion (30 percent) of the total performance score (TPS) awarded by Medicare will come from patient satisfaction ratings.

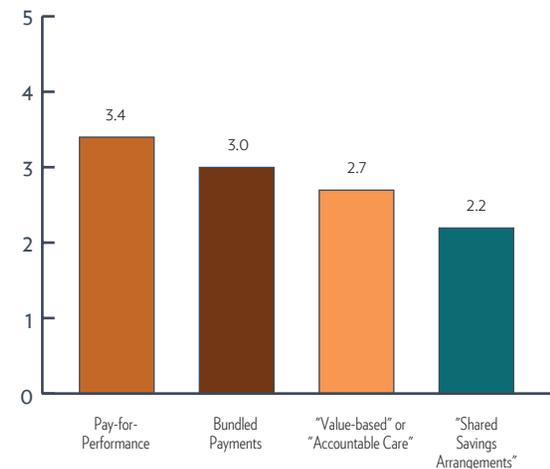
Shared savings or Accountable Care Organizations (ACO): Any value-based payment model whereby a payer and hospital, health system or physician group share in savings generated by implementing a variety of cost-saving and efficiency measures, such as shifting care delivery to the most cost-effective venue, outpatient chronic disease management, reducing hospital readmissions, increasing care coordination, etc. The payer shares a percentage of the savings with the ACO, resulting in a net savings to the payer overall. The payment method used can vary depending on the program; some models offer a pre-payment based on an estimate generated by an evaluation period while others make a retrospective payment based on actual performance. Medicare has established both a shared savings program, which makes retrospective payments, and a Pioneer ACO program which makes pre-payments based on a three-year evaluation period. The Pioneer ACO program requires ACOs to enter into a value-based payment arrangement with a minimum percentage of commercial payers as well. The largest commercial ACO to date was established by Advocate Health Care and Blue Cross Blue Shield of Illinois.

Familiarity & Comfort Level

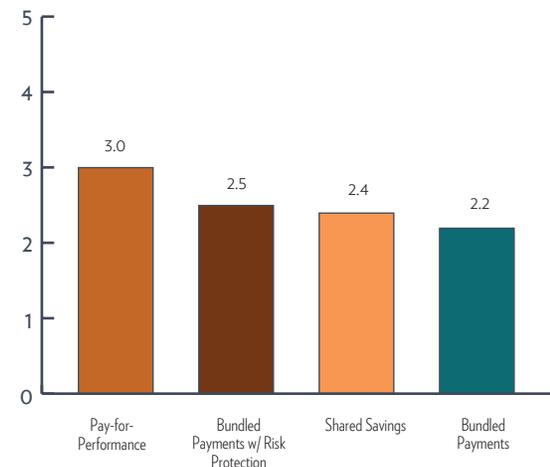
In the first part of the survey, physicians were asked to rate their familiarity with accountable or value-based care terminology on a scale from 1 (low) to 5 (high). They were then asked to rate their comfort level with a variety of value-based payment models on the same scale, with definitions of each payment model provided in call-out boxes for those who needed more information. Pay-for-performance ranked highest on both the familiarity and comfort-level scales, belying the cliché that familiarity breeds contempt. In contrast, bundled payments, which were second on the familiarity scale, ranked last on the comfort-level scale. Arguably more punitive in its incentive structure, pay-for-performance beat out shared savings on the comfort level scale. Shared savings arrangements had, by a significant margin, the lowest familiarity scale score.

As part of our survey methodology, we kept the terms' definitions invisible to respondents until they reached the comfort level question. This allowed them to rate their current familiarity without being affected by new information that the survey provided. However, in order to view the definitions, respondents had to proactively click on a help button, which some respondents chose not to do. This suggests that, with the exception of bundled payments, being less familiar with a payment model directly affected physicians' comfort level with it.

PHYSICIAN "FAMILIARITY" WITH ACCOUNTABLE OR VALUE-BASED CARE TERMINOLOGY



PHYSICIAN "COMFORT LEVEL" WITH ACCOUNTABLE OR VALUE-BASED CARE PAYMENT MODELS

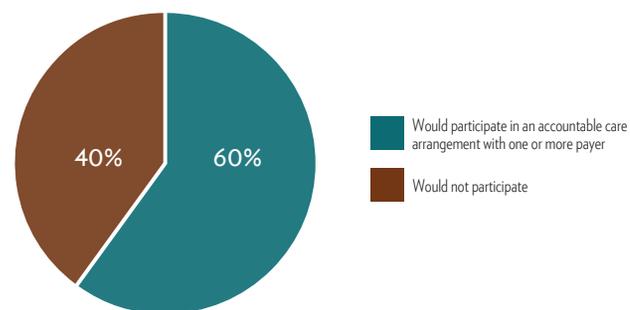


Willingness to Participate

After ranking their familiarity and comfort level with terminology and new payment models, physicians were asked to choose their preferred payment model (choose one of many) and payer arrangements (choose any) with the option to choose that they would rather not participate in an accountable care arrangement with *any* payer. Sixty percent of physicians said they would participate in an accountable care arrangement with at least one payer. Pay-for-performance was the preferred payment model of 39 percent of physician respondents, followed by bundled payments with some type of risk protection. A quarter of respondents chose not to answer the preference question, implying an extreme level of dislike for the models or a sense that they did not know enough to make a choice.

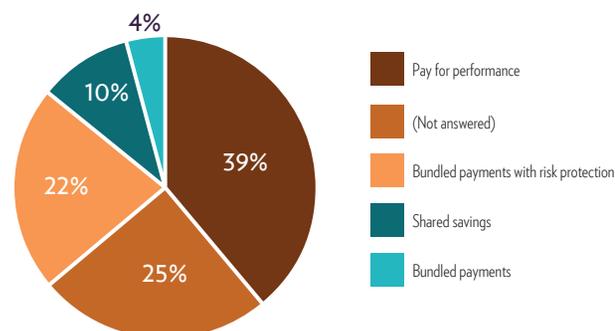
Some physicians were cautiously positive about the possibility of an accountable care arrangement, saying in their write-in comments that they would be willing to give accountable care a try for a period of time or that under certain conditions they would be willing to try it. None of the comments expressed unbridled enthusiasm about value-based care although several physicians said they were confident in their own ability to deliver quality outcomes.

PHYSICIANS' WILLINGNESS TO PARTICIPATE IN AN ACCOUNTABLE CARE ARRANGEMENT



“Until patients are also made accountable for themselves and their lifestyle decisions, physicians cannot be made accountable for care.”
–Emergency Medicine Specialist

PHYSICIANS' PREFERRED NEW PAYMENT MODELS



Willingness to Participate by Profile

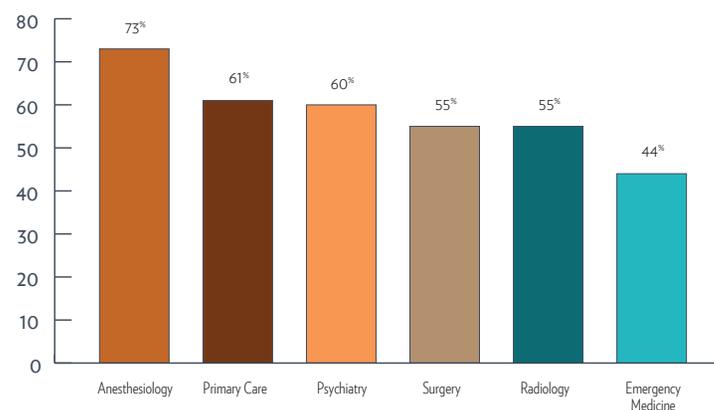
We heard from several respondents across a variety of specialties that they didn't think that their particular specialty was suited to an accountable care arrangement. In the quantitative answers, emergency medicine specialists were the least willing to participate. One emergency medicine specialist said, "Not really very applicable to my situation. In an ED, [it is] very hard to determine risk reduction and appropriate care, with hospitals asking for admissions."

Residents presented an interesting case. They were the most comfortable with shared savings arrangements, compared to salaried physicians and private practice owners/partners, suggesting that residents may constitute an easily-recruitable contingent for newly forming ACOs. They also had the highest comfort level regarding pay-for-performance of any group.

The group most comfortable with bundled payments was salaried employees, and those who were owners or partners in a private practice were least comfortable. This difference is understandable, since bundled payments present a risk of cost overrun, which would typically be invisible to salaried physicians.

“I still do not understand 'accountable care,' but as a radiologist I have little control over patient care costs since the referring doctors send the patients to me. (I am strictly a consultant.)”

PERCENT OF PHYSICIANS WILLING TO PARTICIPATE IN AN ACCOUNTABLE CARE ARRANGEMENT WITH AT LEAST ONE PAYER



COMFORT LEVEL: 1 (LOW)–5 (HIGH)

	Pay-for-performance	Shared Savings	Bundled Pmts w/ Risk Protection	Bundled Payments
Resident or Fellow	3.2	2.8	2.5	2.3
Salaried Employee	3.2	2.5	2.6	2.3
Private Practice Owner or Partner	2.8	2.2	2.3	2.0

Physician Payer Preferences

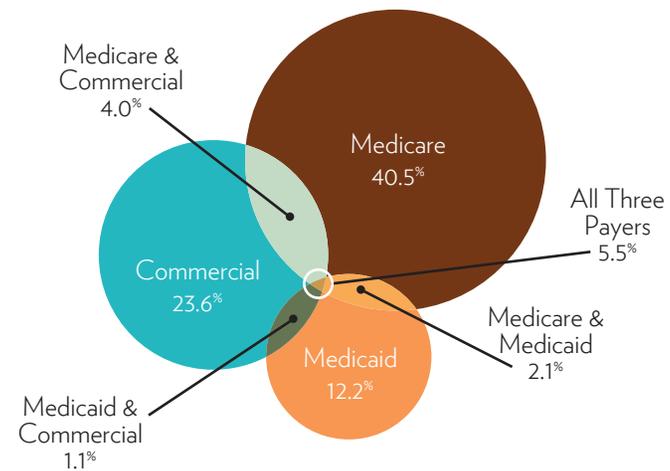
Respondents were asked to choose the payers that they would be most willing to participate in an accountable care arrangement with. They were allowed to choose any or all payers listed or add a write-in category under “other.” By far the most popular choice was fee-for-service Medicare, chosen exclusively by over 40 percent of respondents. Medicaid was the least popular payer, with only 12.2 percent selecting it. Just under a quarter of respondents said they would be willing to engage in an accountable care arrangement with commercial insurers only. Popular combinations included: all three payer types, chosen by 5.5 percent, and Medicare and commercial payers, chosen by 4 percent.

A breast care surgeon we spoke with, who is an expert in health policy, said she believed the reason Medicare was the most popular choice was that “it’s easiest. It pays the fastest, and it’s the least encumbered. They don’t ask questions. You don’t need preauthorization. Medicare patients can go anywhere. You can do anything with them that you want.”

“If I were to go back to private practice, I would not contract with any insurance company. I would have a cash only practice and let patients deal with their own insurance companies.

–Surgeon

PHYSICIAN PAYER PREFERENCES



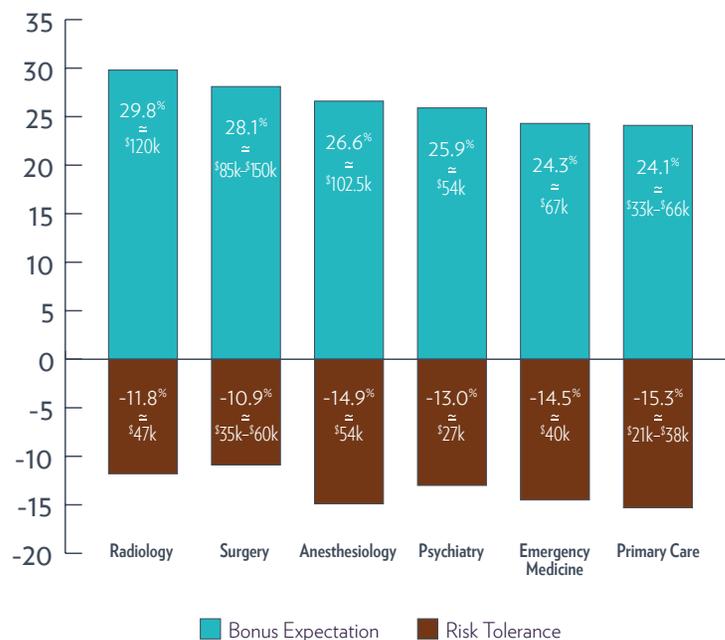
Risk versus Reward

The methodology behind shared savings is that the payer and the provider share both the risk of losses and the savings realized by implementing measures to improve care coordination, disease management, reducing readmissions and hospital-acquired infections.

As ACOs consider ways in which to engage physicians and other healthcare stakeholders, we thought it would be instructive to ask physicians: what would you like to get out of the arrangement? Toward that effort, we asked survey respondents, if they were to engage in an accountable care arrangement, what their bonus expectations would be if they achieved savings targets and what percent of their income they would be willing to risk in exchange for the potential for that bonus. The average bonus percentage preferred by physicians was just over 27 percent. The average percentage of income they were willing to risk was just over 13 percent. The range among specialties was fairly narrow with primary care physicians stating their preference for a 24.1 percent bonus and, on the high end of the range, radiologists wanting a 29.8 percent bonus.

The specialties with the highest bonus expectations did not have correspondingly high risk tolerance. In fact, just the opposite was true; the two specialties with the highest bonus expectations, radiology and surgery, had the lowest risk tolerance. We've included in the chart below, an approximate dollar figure (based on our compensation survey averages) that the bonus and loss percentages would equate to by specialty.

PHYSICIANS' BONUS EXPECTATIONS/RISK TOLERANCE IN AN ACCOUNTABLE CARE SCENARIO



“It is impossible to gamble with the income from each illness a patient has. That is not our job nor is it good for patient care. I know of no other business where you have to gamble to see if you will get paid for your services. This will be the end of good care in the U.S. if it is implemented.

-OB/GYN

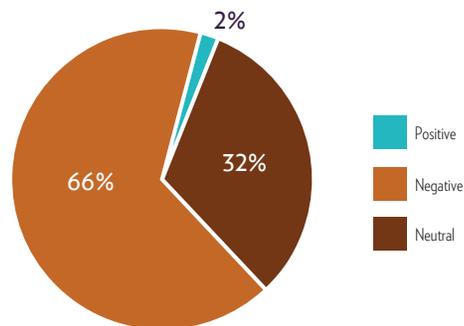
Physician Sentiment

In surveys, comments sections tend to attract responses from people with the strongest feelings about a topic, on both extremes. We categorized the responses according to the tone of the response—negative, neutral or positive. We classified almost two thirds of the comments as being negative in tone toward accountable or value-based care, 32 percent as neutral and only two percent of comments as positive.

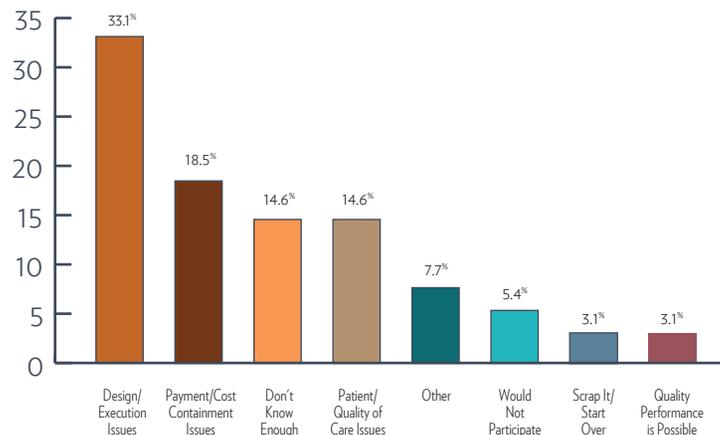
A third of commenters had concerns about the design or execution of accountable care schemes, including concerns about complexity, lack of physician input and incompatibility with their particular specialty. Respondents concerned with payment or cost containment issues said that they were worried that accountable care would result in lower payments for physicians, that it was too much like capitation and that it would put a greater burden of risk on physicians.

Just under 15 percent of physicians had concerns about patient care, including that accountable care would result in denial of care, that there wasn't enough patient accountability in the system and that it wouldn't work for certain populations, like Medicaid patients. Responses that were categorized as neutral mostly included statements by physicians who felt that they just didn't know enough about accountable care. A few of the neutral comments took a wait-and-see stance, saying that their willingness to engage in an accountable care arrangement would depend on how it was executed. A small group said they were confident in their ability to execute on quality measures although not all felt that it would result in a financial benefit to them.

WRITE-IN COMMENTS



WRITE-IN COMMENTS



A Closer Look: PHYSICIAN-BASED ACOs

In order to get an in-depth read on physician perceptions of ACOs, we spoke with a breast surgeon based out of New Jersey who, in addition to running a successful practice, is an expert in health policy, having received a Master's of Health Leadership from McGill University. She told us that, although there is a huge scramble underway to set up hospital-based ACOs, she believes that a more efficient model would involve physician-based ACOs, specifically specialist-based physician ACOs. "The majority of the cost associated with healthcare is spent on the periphery with specialists in patients who are really desperately ill and dying," she explained.

She feels the flaw in the current system is that it is a volume-driven, fee-for-service system. "My thinking is that if specialists were the centerpiece of the ACO, and specialists were incentivized by being given a handsome salary, they would no longer be volume-driven. They would then have as their prime focus how to most cost-effectively take care of the patients, and then the specialists would be able to basically control the most expensive aspect of the budget," she said.

She believes that hospitals will continue to be incented to route as many patients through the hospital as possible as opposed to directing them to lower cost-of-care venues. But she feels that a model in which a physician ACO directs patient care will be much more cost-effective. "I could show very quickly that my ability to take care of breast cancer patients is a third of what it costs the hospital down the street that has its own hospital-based ACO. I'm spending one third taking care of my patients with good outcomes as that hospital is charging," she said.

Currently in the United States, there are 154 ACOs, triple the number of ACOs that were in place in 2011; 10 medical group ACOs formed this year in Florida alone. And the American Medical Association has even issued a how-to guide for physicians wishing to establish an ACO. With the option of establishing an advanced payment ACO, whereby Medicare pre-pays the ACO for projected savings, medical groups, with a smaller financial footprint than competing hospital-based ACOs, can potentially raise the funds needed for the capital and technology investments that will make an ACO viable.

If hospital ACOs want to develop symbiotic relationships with physician groups, they will need to be mindful of negative perceptions among physicians and create partnerships that leverage the specific strengths and efficiencies of physician groups.

“My ability to take care of breast cancer patients is a third of what it costs the hospital down the street that has its own hospital-based ACO.”

Methodology

Through our Employment and Compensation Survey, LocumTenens.com surveyed 1,416 healthcare providers around the United States in a wide range of specialties. For purposes of this ebook, we excluded respondents who were not either MDs or DOs.

For the ACO portion of the survey, we asked physicians to rate themselves on a five-point scale with regards to their familiarity with accountable or value-based care terminology as well as their comfort level with four different new payment models. We then asked them to select their preferred new payment model (choose only one). In order to assist in this process, we provided detailed explanations of the new payment models, which respondents could view by clicking on a link to a call-out box. We then asked them to select the payers they would be willing to have an accountable care payment arrangement with (choose one, none or many). Finally, we asked physicians to tell us, as a percentage of their income, what their bonus expectation would be in an accountable care arrangement if they met savings and quality goals, and what percentage of their income they would be willing to risk in exchange for the potential for a bonus.

In the write-in comments section, physicians were given the opportunity to share their thoughts and concerns about accountable or value-based care. We classified the open-ended comments in two ways, according to tone (negative, neutral or positive) and according to the general category of their comment.

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