Practicing Physicians and Healthcare Reform: Population Health vs. Compensation Wealth

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In her August 14th 2016 interview with the LA Times regarding the ACA and value-based reimbursement, HHS Secretary Sylvia Burwell stated, ..."and medical providers want this.[1]" After reading this article, I wondered for a moment if I am working in the same healthcare system as the Secretary. Having spent a significant part of my 36-year career negotiating financial transactions with and/or on behalf of practicing physicians, I can unequivocally state that, unlike healthcare thought -leaders and policy wonks, a scant few practicing physicians are on board with population health management, value-based care and the "triple aim."

It is essential to significantly improve the value of healthcare and it will require a lot of work by all. Given the disconnect between the policy makers/'thought-leaders' and the nation's practicing physicians, I am pretty sure we are not going to get very far. Most practicing physicians consider the current movement to value based care/population health to be ineffective, expensive, bureaucratic interference with the practice of medicine.

The results of a recent survey conducted by The Deloitte Center for Health Solutions support this view:

- Eight in ten physicians say they prefer traditional fee-for-service or salary-based compensation as opposed to value-based models.
- 74% of the surveyed physicians believe that performance reporting is burdensome and 79 percent do not support tying compensation to quality[2].

Note: The consolidation of physicians into large hospital-affiliated groups and oligopolistic private practices has afforded many practicing physicians the ability to organize an effective "resistance movement" against local or federal initiatives that threaten their compensation.

Policy advocates frequently cite a handful of health systems that have successfully integrated with their physicians (e.g., Mayo, Cleveland Clinic, Geisinger, etc.) In most cases, these highly touted health systems have used their prestige to negotiate exceptionally high fee-for-service rates with the commercial payers. These premium rates are essential, for they enable a health system to afford the expensive resources and on-going investments necessary for successful integration, a fact that is frequently omitted from the literature. And only a few of these exemplars have successfully taken actuarial risk. Upon closer look, the few successful integrated risk takers possess unique characteristics and market conditions that would be difficult to duplicate elsewhere. Note: caution should be used when evaluating the reported success of a provider-sponsored health plan. In many cases these plans are their own hospital's worst payer which artificially improves the health plan's financial performance.

It is common to hear health system CEOs say that ***'we'*** are committed to the triple aim, population health management and value-based care but it is doubtful that this **'we'** includes the majority of their affiliated practicing physicians (both employed and independent.) Is the typical orthopedic surgical group that refuses to take call unless their call pay compensation exceeds $1,500 per day concerned about the "triple aim?" What about the many ED physician groups that are out of network with a commercial payer and are demanding that patients pay inflated out-of-network rates?

A fundamental principle of payment reform is that financial incentives are the prime motivating factor that determine physician behavior. Yet, the hypothesis

that most physicians will change how they practice if their incentives change is unproven and, in fact, there is some evidence to the contrary. When physician incomes are threatened due to a change in reimbursement methodology, physicians know there are ways to protect their income that will not require changing their clinical practice and they are availing themselves of these opportunities. First, physicians can go out of network with the plan. According to the Deloitte Survey, when asked what they expect the impact of MACRA will be on the practice of medicine, 70% of the physicians stated that it will "cause physicians to stop accepting Medicare.[3]" Or the physicians can limit certain patients from their crowded practices as they have done with Medicaid. Note: today there would be a more severe physician access problem for Medicaid patients if not for the willingness of health systems to compensate their employed physicians at the MGMA median rate per wRVU regardless of the patients' payer status. Also, as they have done over the past decades, physicians who perceive a threat to their income will demand that their health system increase their call pay, stipends, salary and/or medical directorships to offset any reduction in compensation, regardless of its impact on the overall cost of care.

For the many health systems that have prematurely overcommitted to payment and delivery system reform, it's not too late to re-evaluate your strategy. Mid-course corrections are the mark of a good strategy. Health systems that are contemplating taking actuarial risk in the near term are likely to be getting ahead of their competencies (and that of their practicing physicians) and thus will be in store for significant financial losses. This advice is supported by the National Association of ACOs that stated "the overwhelming evidence shows that the current Medicare two-sided ACO risk models are not viable for most ACOs and set the bar much too high in terms of financial risk.[4]"

The vast majority of health systems should avoid any form of actuarial risk until they can empirically demonstrate that they possess the infrastructure and physician support necessary to be successful. This will take years. Stick with the

upside-only MSSP model for now. For most, the cost of not qualifying as an APM is far less than the downside risk exposure of the Track 2 and Track 3 ACOs. Under the Track 1 ACO, key MIPS performance metrics will be measured and reported to the physicians. Providing this data to the physicians will help with their MIPS performance and the practicing physicians will begin to develop competencies necessary to successfully operate a clinically integrated network. Give the physicians the time necessary to develop a hierarchy and collective culture for clinical integration. It took one of my clients, MHMD-the exceptionally successful Memorial Hermann ACO, over 8 years to fully develop this physician culture but it was worth the wait.

Health systems that aggressively pursue a strategy with underdeveloped competencies and physicians support will fail. Incrementally, build trust, demonstrate the financial benefits of alignment and show the physicians that their patients will be better off under this new delivery model. Let being the "Uber for healthcare" take a backseat to the fundamental, essential hard work of standing up a truly integrated, high-performing, delivery network that is driven by the hearts and minds of practicing physicians.

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Foot notes

[1] Obama's health secretary wants to make patients healthier by transforming how doctors and hospitals get paid, LA Times, August 14, 2016

[2] Are Physicians Ready for MACRA and its Changes, Perspectives from the Deloitte Center for Health Solutions 2016 Survey of US Physicians, Page 1

[3] IBID, Page 13

[4] ACOs at a Crossr Allison Brennan, Vice-President of Policy, National Association of ACOs, Page 7