

# Areas of Addressable Friction for the Adoption of Greater Healthcare Affordability: Insights from US Physicians

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## ABSTRACT

**OBJECTIVES:** Despite the rise of new value-based payment models as mechanisms to engage physicians in healthcare reform, there is currently limited physician participation in these new models. Little is known about specific physician perspectives on the direction of US healthcare under the Affordable Care Act (ACA) and the National Quality Strategy. Awareness of these perspectives is crucial for the development of strategies to support physician engagement with healthcare reform.

The aim of this study was to explore physician perceptions about the provisions of the ACA as it pertains to the concepts of value, quality, and cost.

**STUDY DESIGN:** This study synthesized insights from 3 quantitative and qualitative datasets to explore physician perceptions from 2011 to 2014.

**METHODS:** (A) analysis of 5 nationwide, online surveys that were fielded to 90,563 Medscape physician members across 25 specialty areas to assess compensation, number of hours worked, practice changes resulting from healthcare reform, and adaptations to the new healthcare environment; (B) Analysis of key themes in commentary in Medscape articles published online (January 2013 to March 2014) that focused on the implementation of new models of care linked to the ACA; and (C) sentiment analysis of 790 unstructured, free-text, Internet-based comments posted online by physicians who read the 8 most popular articles posted on the Medscape platform from January 2013 to March 2014 that focused on quality improvement in healthcare and value-based reimbursement.

**RESULTS:** We identified, among physicians, 5 areas of friction related to healthcare reform that are associated with the transition to new models of value-based reimbursement and that potentially pose barriers to physician engagement in healthcare reform.

**CONCLUSIONS:** Physician engagement in healthcare reform is largely being incentivized via pay-for-performance models and metrics. There is currently little evidence that health systems have sustainable plans to engage physicians beyond performance incentives. Targeted physician engagement strategies—continuing medical education, for instance—have been shown to be drivers of healthcare transformation. This study identifies key areas for targeted education that can help build skills to drive greater adoption of new models of more affordable healthcare delivery.

## Introduction

The 2010 Affordable Care Act (ACA) makes copious reference to the concept of value,<sup>1</sup> which the Institute for Healthcare Improvement considers a function of the triple aim of quality, satisfaction, and, notably, cost. Indeed, healthcare affordability is 1 of the 6 priorities of the National Quality Strategy (NQS), which the Agency for Healthcare Research and Quality launched in 2011 as a comprehensive framework to guide efforts to improve and measure quality. Hospitals have already been participating in this quality rubric through exposure to value-based purchasing and the CMS Readmission Reductions Program,<sup>2</sup> through which hospitals suffer economic penalties for excess readmissions. Now, the NQS priority of affordability is being extended to physicians via new healthcare delivery models, metrics-driven payment systems, and value-based reimbursement.

Change management leaders suggest that 4 elements are necessary for organizational transformation to occur, including: 1) skills to succeed, 2) role models, 3) compelling reasons for change, and, importantly, 4) reinforcing mechanisms for engagement.<sup>3,4</sup> In the context of healthcare reform, many value-based payment and delivery models serve as reinforcing mechanisms and as recognition by payers of the importance of physician engagement.<sup>5,6</sup> Such delivery and payment models include accountable care organizations (ACOs), Patient Centered Medical Homes, Medicare Advantage, Meaningful Use (MU), and the Physician Quality Reporting System (PQRS) tied to CMS's value-based payment modifier (VBPM). Commercial payers such as Aetna, Cigna, and UnitedHealthcare, as well as many state Medicaid agencies, are launching similar programs, and they are slowly becoming universal. By 2017, for example, some form of value-based payment system will be in place for all physicians taking Medicare reimbursement.<sup>5,7,8</sup>

Despite the function of these new payment models as engagement/reinforcing mechanisms, there is currently limited physician participation in new models of delivery; there is also lower-than-anticipated data reporting for reimbursement pro-



grams.<sup>5,7</sup> Although ACOs have increased in number, currently only approximately a quarter of physicians are in ACOs.<sup>9,10</sup> Similarly, CMS reporting trends show that although participation in PQRS has grown from 17% in 2007 (then known as Physician Quality Reporting Initiative), only one-third of eligible professionals in 2010 reported performance metrics.<sup>11</sup>

The success of new healthcare delivery models is dependent on the active participation of physicians. As such, it is important to examine reasons for low physician engagement.

Although trade surveys and discussion in trade publications suggest unease among physicians about healthcare reform,<sup>10,12-14</sup> little is known about specific physician perspectives on the direction of US healthcare under the ACA and the NQS. Therefore, the aim of this analysis was to explore physician perceptions about the provisions of the ACA as they pertain to the concepts of value, quality, and cost.

**Methods**

Medscape (www.medscape.com) is an open-access online publication that receives more than 1.5 million physician visits per month. Medscape’s readership represents about 60% of total AMA-active physicians, as well as a large proportion of physicians who are not members of the AMA. One section, titled The Business of Medicine, publishes analysis, interviews experts, summarizes commentary, and provides a forum for physicians and providers to discuss the evolving business of medicine landscape. Insights were synthesized from the following 3 datasets:

(A) Between 2011 and 2014, 5 nationwide online surveys were fielded via a third party to Medscape physician members across 25 specialty areas to assess compensation, number of hours

worked, practice changes resulting from healthcare reform, and adaptations to the new healthcare environment. Analysis focused on 90,563 completed surveys, and self-reported survey data were used to rank physician compensation by specialty.

(B) The Medscape editorial team and one of this paper’s authors (Wright) identified key themes in commentary in Medscape articles published online (January 2013 to March 2014) that focused on the implementation of new models of care linked to the ACA.<sup>15-17</sup>

(C) We conducted a sentiment analysis of 790 unstructured, free-text, Internet-based comments posted online by physicians who read the most popular healthcare quality improvement and value-based reimbursement articles posted on the Medscape platform from January 2013 to March 2014. Sentiment analysis extracts and analyzes attitudinal information from sources as varied as articles, blog postings, e-mails, call-center notes, and survey responses. Sentiments refer to private, subjective states that individuals share publicly via social media and other accessible sites, which contain emotive elements and represent moral evaluations that have a bearing on behaviors and norms.<sup>18-20</sup> Two college-educated reviewers with no context for this work independently scored each comment as negative, positive, or neutral with respect to the provider’s attitudes and perceptions on aspects of the ACA. The assessment focused only on the content of the comment as related to the regulations of the ACA, and reviewers considered a comment as “neutral” if it did not specifically comment on the law. Where there was disagreement, it was flagged and reconciled through discussion with the authors of this analysis.

**Table 1. Sentiment Analysis of ACA Related Comments**

Title	US Physician Page Views	Total Page Views	Publication Date	Total Comments	Negative	Neutral	Positive
"4 Top Complaints of Employed Doctors"	316,859	373,563	May 8, 2013	0			
"Are Doctors Being Exploited?"	152,925	185,635	February 13, 2014	428	49.5%	45.1%	5.4%
"8 Ways That the ACA Is Affecting Doctors' Incomes"	154,496	178,357	August 15, 2013	64	43.8%	10.9%	45.3%
"How Insurance Exchanges Will Affect Doctors' Income"	141,058	180,973	July 10, 2013	113	31%	11.5%	57.5%
"How to Keep Your Income Up as RVUs Transition Away"	127,355	261,198	January 3, 2013	0			
"Why 'Cherry-Picking' Patients Is Gaining Ground"	112,899	149,177	December 19, 2013	81	69.1%	22.2%	8.6%
"Will You Be Pressured to Perform 'Cookbook' Medicine?"	126,564	143,667	July 30, 2013	78	34.6%	48.7%	16.7%
"VBMs: Coming Soon to Either Increase or Lower Your Income"	108,433	121,874	February 6, 2014	26	84.6%	15.4%	0%

ACA indicates Affordable Care Act; RVU, TKTKTK; VBM, TKTKTKT.

## Results

Overall, our analysis identified 5 points of friction between surveyed physicians and the adoption of the new healthcare delivery model necessary to accomplish the triple aim.

### 1. Change fatigue

Qualitative examination of both commentary and sentiment analysis of online postings revealed that physicians are exhausted by the significant changes linked to the ACA and especially by the weight of new reporting regulations and performance metrics. For instance, physicians commented nearly 4 times more than average in response to an article titled “Are Doctors Being Exploited?” and our sentiment analysis showed that only 5.4% of these comments were positive.<sup>15</sup> **Table 1** (see Appendix for links to articles) presents an overview of our sentiment analysis. Comments posted in response to articles that helped explain how to be successful working within the framework of the ACA were generally balanced and positive.

### 2. Complex policies

Healthcare is an industry that is highly impacted by policy. These policies are often represented by dozens of acronyms and other complex jargon. The ACA, and its implementation, has significantly increased the number of these policies. Analysis of commentary and comments indicates that these new and changing policies are creating friction for physicians. For instance, as the following quotes illustrate, analysis of physician comments revealed confusion associated with policies intended to promote greater accountability.

*When is Congress going to get paid for performance? Any medical "practitioner" who thinks VBPM is going to offer anything other than reduced reimbursement should definitely pull their head out of the sand!*

*Then of course there is a question of what is "quality of care." Clearly, something that can be measured, like the blood pressure of an anxious patient, is preferable than treating the actual patient and their anxiety. PQRS favors treating a number, not a person.*

*Does this mean we can stop PQRS and MU as we are exempt? Who to contact at CMS for an accurate answer? Will this new incentive to be a group of less than 10 discourage group mergers?*

### 3. Pathways to success are unclear

Physicians seem to be receiving mixed messages on how to succeed under the paradigms of new metrics. Among the employed providers who responded to Medscape online surveys (N = 4600), approximately 59% reported they are still held to volume targets. Analysis of article commentary suggests that physicians view the persistence of volume targets as incongruent with the value-based care paradigms. Physicians also noted confusion associated with incongruent policies such as increasing account-

**Table 2. Comments Illustrating Change Fatigue**

<i>The short answer is yes, doctors are exploited! And doctors know it.</i>
<i>The system is simply crazy!</i>
<i>Although people give lip service to medicine, the system as it is designed does not favor doctors even slightly. The best way one can hope to respond is push their children into something else.</i>
<i>We are being pressured to do more with less pay and less utilization of diagnostic studies, yet we are the ones ultimately responsible if a failure to diagnose occurs.</i>
<i>Dealing with sick people is much different from manufacturing cars and flying planes.</i>
<i>This is the end of great patient care. Not the beginning of it. You can quote me on that....waiting for the 'Train Wreck'... It's coming. The law of unexpected consequences will make itself seen.</i>

ability while still having to manage payer-led utilization and prior authorization rules.<sup>15</sup>

### 4. Concerns over “cookbook” medicine

Physicians are concerned that evidence-based medicine can be reductive, thoughtless “cookbook” medicine. Analysis of the comments on Medscape articles indicates that the opinions expressed about evidence-based medicine are often cautionary, warning of how clinical guidelines are being implemented in the reality of practice.<sup>17</sup> Commentators shared concerns about reducing guidelines into hard-and-fast rules rather than viewing them as guideposts for providing good care. Provider comments pointed to the view that requiring strict adherence to guidelines limits physician ability to recognize the nuances of disparate patient needs.

### 5. Trends in PCP compensation

Despite the critical importance of primary care providers (PCPs) in the performance of value-based models, their overall compensation lags well behind that of other specialties (**Table 3**). Trends in physician compensation summarized from 4 years of provider compensation surveys place PCPs in the bottom quartile for all 4 years (**Table 4**).

## Discussion

This analysis provides insights into physicians’ perspectives on new models of care and payment that are intended to improve overall healthcare impact and affordability. Programs that require collection and reporting of quality and performance measures are likely to proliferate as more public and private payers tie payment to value in healthcare.<sup>21</sup> Regardless of how attractive new models of care delivery and reimbursement might appear at a policy or political level, negative physician perceptions create significant friction for implementation.<sup>22</sup> This study identifies 5 particular points of friction that may pose barriers to physician engagement in healthcare reform. In this discussion, we suggest



**Table 3. Survey Data Used in This Analysis**

Survey Data Analyzed	N	Survey Start	Survey End
Medscape Physician Compensation Report: 2011 Results	15,794	February 2, 2011	March 30, 2011
Medscape Physician Compensation Report: 2012 Results	24,216	February 1, 2012	February 17, 2012
Medscape Physician Compensation Report: 2013 Results	21,878	February 14, 2013	February 28, 2013
Medscape Physician Compensation Report: 2014 Results	24,075	December 11, 2013	January 24, 2014
Employed Doctors Report: Are They Better Off?	4600	January 15, 2014	February 15, 2014
<b>Total data points</b>	90,563		

potential solutions that can help overcome these points of resistance.

**Build Knowledge and Skills to Manage Change Fatigue**

This study suggests that physicians are experiencing change fatigue and that feelings of frustration and exploitation may be driving this sentiment. Although change fatigue is a commonly used concept in reference to organizational change, few studies have actually explored the concept of change fatigue.<sup>23</sup> The organizational change literature considers change fatigue as too many changes taking place within a given organization (and suggests that people’s capacity for change is often much lower than anticipated). When change fatigue occurs, the commitment to change by those affected is lowered, and their attachment to and involvement in (or support for) an organization may be weakened.<sup>24,25</sup> A nationwide survey of patient centered medical home demonstration projects. The pace of change within the last decade in healthcare has been frantic (eg, adoption of electronic health records tied to MU incentives, quality measures endorsed by the National Quality Forum, new standards for Maintenance of Certification, hospital report cards, value-based purchasing and reimbursement, the passage of the ACA). Broader evidence of change fatigue may also be inferred from the number of physicians leaving medicine or not recommending medicine as a career to others, or in the way some physicians view themselves as pawns in the healthcare system.<sup>15,26</sup> Although rewriting policy may not be feasible, educating and building skills to manage new paradigms is a ready way to address change fatigue.

**Clarify Pathways to Quality by Highlighting Best Practices**

This analysis points to a degree of skepticism among physicians about the most appropriate pathways to quality as well as the place of performance incentives along these paths. Similar skepticism that performance incentives really improve quality of care is evident in other studies.<sup>27</sup> Notably, there is currently no “gold standard” for measuring performance in primary care, which involves complex patient management and the sharing of respon-

sibility with hospitals and specialists.<sup>5,28,29</sup> Therefore, it may be necessary to honestly address this lack of clarity and provide both encouragement as well as role models who can provide guidance for how to succeed.

**Educate on Complex Policy**

There was evident frustration in physician comments and online postings about the various complex policies related to changes in care delivery and reimbursement. Not only has the pace of change been frantic, as previously noted, but so too has been the breadth of change, ushering in several reimbursement and delivery models with

different performance measures, players, and standards. The literature notes inconsistent and/or multiple criteria for evaluating healthcare delivery and payment models, as well as uncertainty about how these programs are coordinated and aligned with each other to support patient outcomes.<sup>4,22</sup> For instance, ACOs require providers to be accountable to many federal agencies (including the departments of HHS and Justice, the Federal Trade Commission, and the Internal Revenue Service),<sup>30</sup> and recent studies have found knowledge deficits among primary care and specialist providers about ACOs as models of care delivery and about the implications of healthcare reform.<sup>14,31,32</sup> It is perhaps unsurprising that pay-for-performance and quality programs (eg, PQRS) have proven daunting for physicians to implement.<sup>4</sup> Creating lexicons and providing simple pathways where physicians can define and answer questions on various forms of policies will likely be helpful.

**Have Honest Discussions Addressing the Issues of “Cookbook Medicine”**

Evidence-based guidelines provide the foundation for most validated performance measures and reflect a shift toward standardizing clinical practice broader than any that has taken place since the 1980s.<sup>33</sup> Indeed, many medical homes and payer networks now require the incorporation of tools that drive guideline-concordant care in order to achieve their goals. This shift toward evidence-based clinical practice (or “cookbook medicine”) has pros and cons that are beyond the scope of this paper except to note that there is currently a significant debate in the medical literature about the validity and reliability of what constitutes the evidence underpinning clinical practice guidelines.<sup>34,35</sup> As is reflected in our sentiment analysis, many physicians view “cookbook medicine” as threatening physician autonomy and ignoring the complex clinical scenarios/context in which healthcare is delivered.<sup>4,36</sup> One key point to emphasize is that new models of payment necessarily reward some degree of standardization, which inherently does create some trade-offs with some physician autonomy. Educating providers honestly about these trade-offs would be an

important component of improving adoption—and improving less-resentful adoption—of accountable care.

### Educate and Build Skills to Manage Pay-for-Performance

Primary care physicians' compensation ranks very low in our study. As shown in other studies, physicians are already unhappy about reimbursement changes. A survey of 2556 physicians found that only 7% were happy that the fee-for-service model was shifting toward value-based compensation.<sup>37</sup> Concomitantly, other studies report that providers feel unprepared for pay-for-performance initiatives<sup>38</sup> and that they perceive misalignment between current payment systems and the goals of new delivery models.<sup>22</sup> As found in a Robert Wood Johnson Foundation-funded survey of 2356 physicians participating in Medicare PQRS, a majority are skeptical overall about the impact of PQRS on quality (50.1% believed it had no impact on quality, and 36.1% reported it had a small impact).<sup>27</sup>

This perception of misalignment raises questions about the efficacy of financial incentives as a mechanism to reinforce physician behavior change. Pay-for-performance modules assume that financial incentives alone are sufficient to change behavior (eg, improve performance, metric performance), however the empirical foundations for this assertion are weak.<sup>5,39</sup> For instance, early participants in pay-for-performance were frustrated because of internal CMS contradictions in instructions, and their perception that their efforts outweighed possible returns.<sup>40</sup> With such perceptions in place, the ability of pay-for-performance models such as VBPM to incentivize behavior change may be blunted,<sup>41</sup> and the question of how large an incentive is needed to generate a measurable effect on performance remains unanswered.<sup>5</sup>

### Limitations

This study analyzed 3 distinct data sources to explore physician perspectives on changes in healthcare delivery based on the ACA. There are 4 caveats to our findings. First, the study interpolates key findings from survey data that, in and of itself, could be very limiting; as such, we used textual and survey-based data to explore and expand on the insights we uncovered. Second, our sample may suffer from bias since only Medscape physician members were included in the survey and sentiment analysis. Although Medscape members represent about 60% of AMA active physicians, as well as a large proportion of physicians who

are not members of AMA, it is possible that the Medscape physician sample included in this analysis may differ in some ways from those not included or nonmember physicians. The relatively small sample included in sentiment analysis for instance, reflects those physicians who took the time to comment, which while 4 times higher than average, was still very small. Third, sentiment analysis requires that coders agree on the sentiment expressed in a text, and achieving agreement about whether a sentiment is positive, negative, or neutral is a challenge for sentiment analysis; therefore, many practitioners advocate machine-based coding. Since our sentiment analysis was not machine-based, our assignment of comments may suffer from coding bias; however, we would argue that because people express sentiment in complex ways (using irony, sarcasm, humor, etc), manual, human coding potentially does a better job than machine coding of capturing this complexity. Finally, it may be that questions posed by the writers of the articles solicited negative comments from contributors; it may also be argued that people holding

**Table 4. Physician Compensation Rank by Specialty (2011-2014)**

Specialty	2011	2012	2013	2014
Orthopedic surgery	1	2	1	1
Radiology	2	1	3	5
Anesthesiology	3	4	6	6
Cardiology	4	3	2	113
Urology	5	5	5	0
Gastroenterology	6	6	4	81
General surgery	7	11	9	78
Dermatology	8	8	8	26
Oncology	9	7	10	11
Plastic Surgery	10	9	7	7
Emergency Medicine	11	14	12	13
Ophthalmology	12	10	11	10
Critical care	NA	13	13	12
Pulmonary medicine	13	12	15	14
OB/GYN	14	15	17	15
Pathology	NA	15	16	17
Nephrology	15	17	14	16
Neurology	16	18	18	18
Psychiatry	17	21	20	20
HIV / Infectious disease	18	20	25	24
Rheumatology	19	19	19	19
Diabetes / endocrinology	20	22	22	22
Internal medicine*	21	23	21	21
Family medicine*	22	24	23	23
Pediatrics	23	25	24	25

\*In the 2011 survey, internal medicine and family practice physicians were combined.

HIV indicates human immunodeficiency virus; OB/GYN, obstetrics/gynecology.



negative attitudes are more likely to post comments on Internet sites (ie, responses to articles); however, the tendency to respond when one is being negative is not empirically supported.<sup>20</sup>

## Conclusions

Organizational change theory posits that participants in organizational transformation need to be engaged with the rationale for, and processes of, change.<sup>3</sup> In healthcare reform, physician engagement, especially for those who bill Medicare, is largely being incentivized via pay-for-performance models and metrics. This strategy appears to be an insufficient precondition for behavior change, and, ergo, quality improvement.<sup>7</sup> Physicians may simply lack the skills to succeed in implementing new delivery models and pathways to quality,<sup>3,5</sup> although, notably, there is currently little evidence that health systems have sustainable plans to engage physicians beyond performance incentives.<sup>4</sup> Studies show that education about the science of quality improvement (eg, systems thinking; strategies for practice-based learning and improvement; quality measures; concepts—such as value—and their consequences) can build physician engagement in improvement efforts and prepare the foundations for success.<sup>4,42,43</sup> Targeted education to equip physicians with knowledge and skills concerning the triple aim of quality, satisfaction, and cost, as well as education on topics related to the 5 points of friction we identify in this study, could help mollify feelings, model change, and build skills to drive greater adoption of new models of more affordable healthcare delivery. Such education could address physician concerns that new models of care are intended to “exploit” providers and enhance provider satisfaction with the process, as well as the impact, of strategies to improve healthcare affordability.

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## APPENDIX

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