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Title

Adoption of Alternative Payment Models in Virginia: Low Uptake Despite High Interest

Priority 1 (Research Category)

Healthcare Services, Delivery, and Financing

Presenters

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Abstract

Context: The US healthcare system suffers from high healthcare costs, suboptimal health outcomes, and a fragmented primary care system, at least in part due to a fee-for-service payment model. The National Academies of Sciences, Engineering, and Medicine recommend a transition to alternative payment models (APMs) as a pathway to implementing high-quality primary care. Many suggest that practices need at least 25% APM-attributable revenue (AAR) in order to see change.

Objective: We sought to assess the adoption of APMs among primary care practices in Virginia.

Study Design: Mixed-methods evaluation of practice surveys and semi-structured interviews.

Population studied: All primary care practices in Virginia were surveyed. 40 clinicians from responding practices were interviewed, representing the spectrum of rurality, ownership, and APM penetrance.

Dataset: Surveys were emailed and mailed to practices up to six times between 9/1/21 and 4/22/22. Non-responding practices were called. Surveys followed up a 2018 primary care survey with an emphasis on APM. Interviews further explored findings.

Outcome Measures: Practice characteristics, current APM participation, AAR, and interest in future APM.

Results: 418 of 2119 practices completed the survey (19.7%). Nearly half (49%) of practices have no AAR, 30% have 1-10% AAR, 9% have 11-24% AAR, and 12% practices have 25% or more AAR. For practices with no (0% AAR), medium (11-24% AAR) and high (≥25% AAR), there were only minor differences in: ownership (clinician owned: 59% vs 39% vs 46% / health system owned: 29% vs 50% vs 39%), care of vulnerable populations (81% vs 89% vs 85%), quality measurement (51% vs 67% vs 68%), and social needs screening (29% vs 28% vs 32%). However, for practices with no, medium, and high AAR, practices

with medium payment seemed different from the others in terms of APM perspective including: interest in Medicaid APM (29% vs 65% vs 28%), would make changes if more APM (24% vs 41% vs 17%), reduce turnover with more APM (19% vs 41% vs 35%), and improve access with more APM (35% vs 59% vs 31%). Many clinicians felt APMs would allow them to hire additional support staff and care for more patients, yet there was skepticism on whether APMs would represent a true increase in primary care investment.

Conclusions: While uptake of APM is low, there is general interest in more APM and a belief it can improve care. Practices with a medium amount of AAR may be most open and amenable to change.