Market Drivers for Value-Based Primary Care Physician Compensation Models

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The US health care system is among the most expensive in the world, yet health outcomes are lagging behind those of countries spending far less on health care services[1]. Historically, the dominant reimbursement methodology for health care services has been based on the volume of services provided. To address the growing economic burden of health care and to improve outcomes and patient experience, the Institute for Healthcare Improvement (IHI) identified a framework for optimizing health care system performance described as the Triple Aim[2]; specifically:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and
3. Reducing the per capita cost of health care.

A fourth aim, reduction in physician burnout, has also been added to the goals above. To support the achievement of the Triple Aim goals, The Centers for Medicare and Medicaid Services (CMS) set forth a plan to shift Medicare's reimbursement methodology from a volume-based system to a value-based system.

Care delivery frameworks such as Patient-Centered Medical Homes, organizational structures such as Accountable Care Organizations and Clinically Integrated Networks, and alternative payment models (APMs) such as the Medicare Shared Savings Program, Medicare Advantage Plans, and other CMS programs have been developed over time to support the Triple Aim. Legislative and regulatory actions have been signaling the federal government's intent for more than ten years. The list includes the Affordable Care Act of 2010, the establishment of the Centers for Medicare and Medicaid Innovation Center (CMMI), the Medicare Shared Savings Program (2012), Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Merit-Based Incentive Payment System of 2019 (MIPS), and more recently, the 2020 Primary Care First and 2022 ACO REACH programs. All have been established to further encourage the adoption of value-based activities in pursuit of the Triple Aim.

CMS' stated strategic objectives include driving accountable care and the agency has committed to having all Medicare, and the vast majority of Medicaid beneficiaries, in an accountable provider relationship by 2030. According to the CMMI website, "Accountable care reduces fragmentation in patient care and cost by giving providers the incentives and tools to deliver high-quality, coordinated, team-based care. Models should increase the number of beneficiaries in accountable care relationships with providers, such as advanced primary care providers and ACOs. Quality of care and outcome measures should be measures that matter and include patient values and perspective."[3]

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Aetna has described value-based care (VBC) as a health care delivery model under which providers, hospitals, labs, doctors, nurses, and others are paid based on the health outcomes of their patients and the quality of services rendered. Aetna has also indicated that VBC differs from traditional fee-for-service in how providers are paid and how care is managed, which provides an opportunity for health improvements and savings[4].

Given evolving CMS reimbursement methodologies and innovation programs, along with the growing adoption of Medicare Advantage plans and local market opportunities for commercial payer APMs, it is not a surprise that health care organizations are increasingly implementing provider compensation plans that support the behaviors needed to perform well under value-based reimbursement methodologies. This trend has first manifested in primary care settings. Incorporating team-based methodologies and consideration of panel management is a growing trend, particularly for those organizations that can avail themselves to more financially rewarding CMS reimbursement programs and commercial APMs.

DEFINING THE TEAM IN TEAM-BASED CARE

There are many market definitions of the health care team in the context of team-based care. The Institute of Medicine (IOM) defines team-based care as "the provision of health services to individuals, families, and/or communities by at least two health care providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care."[5]

A health care team may also involve a wider range of team members in various settings. The AMA has identified a broader concept of team-based care, identifying it as a "collaborative system in which team members share responsibilities to achieve high-quality and efficient patient care."[6] According to the AMA, team members include:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurses
- Medical assistants
- Front desk staff
- Other practice-specific team members such as pharmacists, behavioral health specialists, social workers, physical therapists, or care coordinators

Other professional societies have established their own definitions, but most are consistent with the examples provided.

From a compensation perspective, plan designs that reward team-based care are increasingly common. SullivanCotter's 2022 *Physician Compensation and Productivity Survey* reported that 27% of responding organizations utilized a team-based component in their physician compensation plans, and nearly half of those organizations included advanced practice providers (APPs) as part of the health care team. For primary care plans the median amount of physician compensation tied to team-based performance has doubled from 5% in the 2019 SullivanCotter survey report to 10% in the 2022 SullivanCotter survey report.

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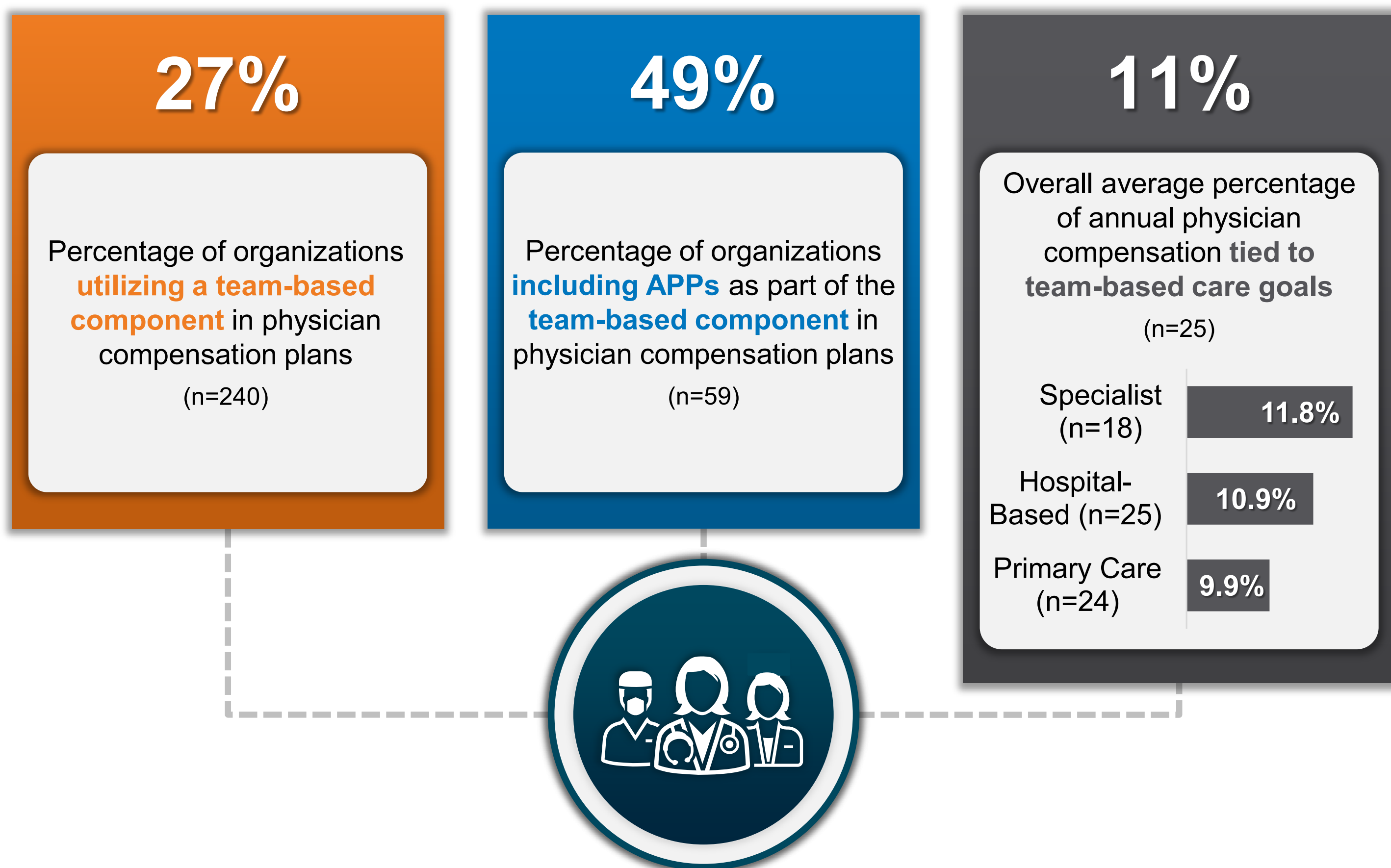

For the purposes of this article, we will consider the “team” in a team-based primary care compensation model as consisting of a physician and one or more APPs.

PRIMARY CARE TEAM-BASED DESIGN CASE STUDY

Background

A large community-based health care system with a significant commercial payer relationship anticipated the conversion of that relationship from fee-for-service to risk-based (including the cost of care) for its primary care services within the next year. In preparation for that relationship change, this health system approached SullivanCotter to redesign its primary care physician (PCP) compensation plan to reward PCP behavior change consistent with its revised payer relationship. Specifically, the health system wanted to reward team-based care through the deployment of more APPs working in conjunction with physicians to reduce the overall cost of its primary care network. Part of this work included a fair market value (FMV) opinion on the new plan design.

New Plan Design

The new PCP compensation plan design rewarded physicians for team-based panel size and for managing that patient panel well as defined by the system’s organizational goals. A high-level depiction of the new plan design is shown on the following page.

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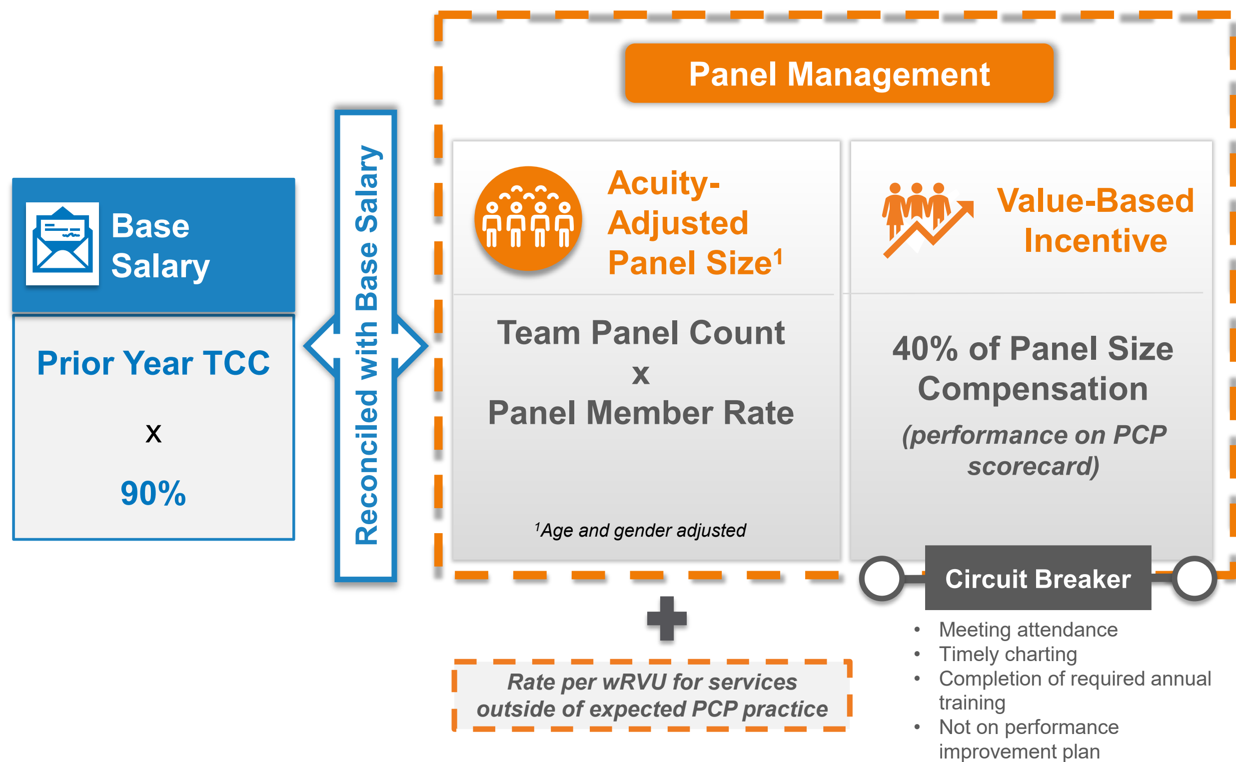

The basis of the new plan design is the team panel count, defined as unique patients seen by the PCP within a 24-month lookback period, and 50% of the additional unique patients seen by an APP supervised by the physician within that same 24-month lookback period. In addition, a significant portion of compensation under the new plan (up to 40% of panel size compensation) was awarded on the basis of managing that patient panel using a balanced scorecard approach consistent with the health system's goals of improving clinical quality, reducing cost and improving patient experience. The first-year PCP value-based incentive scorecard is shown below:

Value-Based Care Scorecard

Category	Weight	Metric	Individual / Group Measurement
Clinical Quality (Process)	15%	*Medicare Advantage Stars Score*	Group
	10%	*Pediatric & Adult All-Payor Composite Quality Score*	Group
	15%	*All Payor Annual Wellness Visit Completion %*	Individual
Coding Accuracy	20%	*HCC Accuracy for Commercial and MSSP Plans*	Individual
Cost	30%	*PMPM Composite Costs, ED Utilization, Readmissions*	Group
Patient Experience	10%	*CG CAHPS (2 questions)*	Individual
Education/Research	TBD	*Optional at Chair discretion*	Individual

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Regulatory Requirements

The updated 2020 Stark Law regulations provide some additional latitude for value-based arrangements. The complexity of complying with the revised regulations and the requirement for physicians to take downside risk has left most organizations relying on the Stark Law employment exception for employed physician compensation arrangements[7]. The employment exception requires that physician compensation be both fair market value and commercially reasonable. Physician compensation must be based on personally performed services.

In the context of predominantly fee-for-service reimbursement environments, valuators have traditionally considered compensation relative to work Relative Value Unit (wRVU) productivity, professional collections, time spent in the supervision of other providers, and time spent in the achievement of quality program objectives.

However, in a value-based reimbursement environment, valuators may also consider additional physician personally performed services. These services include care coordination, access requirements, chronic disease management, and management of a care panel, including direct patient interactions, virtual visits, preventative care measures as well as leading a team of other providers and health care delivery team members.

FMV Assessment Approach

SullivanCotter's approach to FMV assessment relied upon the total cash compensation (TCC) per patient data collected in our surveys. This data has been collected for several years for primary care physicians. The patient panel size data collected for survey purposes is based on the definition as originally published by Murray, et. al. in 2007[8]. The primary care specialty market data averages from the SullivanCotter 2022 survey edition are shown in the table below. Depending on facts and circumstances, specialty-specific market data may be applicable.

2022 Survey Editions	Primary Care Specialty Average				
	n	25th %ile	50th %ile	75th %ile	90th %ile
SullivanCotter – Physician	1,657	$107.15	$137.97	$168.73	$201.57
SullivanCotter – Medical Group	1,446	$105.83	$128.59	$161.33	$189.73
Average	**3,103**	**$106.49**	**$133.28**	**$165.03**	**$195.65**

Before considering APP-attributed panel size in physician compensation for FMV testing purposes, valuators should consider several criteria:

1. The amount of revenue at risk based on value-based care outcomes.
2. How direct costs of the APPs are accounted for in determining APP supervision compensation for physicians. This consideration drove the organization's decision to credit only 50% of the APP-attributed panel to the supervising physician; the other 50% of the compensation derived from the APP-attributed panel was retained by the organization to cover a proportionate share of APP direct costs (salaries, benefits, and employment costs).

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3. Inclusion of both physician and APP-attributed panel members in determining the supervising physician's value-based performance success.
4. The supervising physician's personally performed wRVU productivity level (i.e., the number of patients personally cared for by the physician).
5. Limiting the number of supervised APPs to ensure reasonable supervision is provided by the physician.

Reviewing a range of potential team-based panel sizes (25th to 90th percentile), SullivanCotter tested the resulting maximum physician compensation on a per-patient basis to ensure TCC per patient remained within our quantitative FMV guidelines.

Conclusion

The FMV assessment approach and metrics often require a review of situation-specific facts and circumstances. This case study illustrates how compensation plans are evolving in response to CMS programs and other market forces. A significant shift from fee-for-service reimbursement to risk-based reimbursement necessitated a change in the primary care delivery model from a physician-centric approach to a team-based approach to achieve organizational value-based care delivery goals. The health care organization sought to align its physician compensation model with the new drivers of organizational success. Traditional approaches to measuring personally performed services in a fee-for-service reimbursement environment were no longer applicable to this value-based environment. Primary care panel size, in combination with team-based care outcomes accountability, was used to evaluate FMV for primary care physicians in the new compensation model. As the transition from volume to value continues to evolve and has reached a tipping point for some markets in the country, organizations need to ensure that their physician compensation plans are aligned and subsequently that FMV assessments are reflective of the full complement of physician services.

Sources:

[1]*https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly accessed 06.06.23*

[2]*https://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx accessed 05.23.23*

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[5]*Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. Accessed 06.02.23*

[6]*https://edhub.ama-assn.org/steps-forward/module/2702513 accessed 05.24.23*

[7]*42 CFR 411.357(c)*

[8]*Murray, M., Davies, M., Boushon, B., Family Practice Management, April 2007.*

SullivanCotter offers advisory support and solutions to help your organization implement effective compensation models for primary care physicians.

To learn more, contact us at 888.739.7039 or info@sullivancotter.com

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