AAFP

Evaluating Value-Based Payment in Reducing Administrative Burden

October 24, 2023

Overview

The AAFP is dedicated to optimizing the family medicine experience for physicians and their care teams, as well as for patients and their families. In keeping with this goal, the Academy supports family physicians in achieving the Quintuple Aim: enhancing care for individuals, improving the health of patient populations, reducing the per-capita cost of care, and ensuring equity while also finding joy in their work. To achieve these aims, family physicians should primarily spend their time caring for their patients, and the payment model must reinforce that care experience, not distract from or distort it. The predominant payment mechanism, fee-for-service (FFS), has greatly eroded the family medicine experience rather than enhanced it. The AAFP believes that transforming payment and eliminating FFS as the chief payment mechanism for primary care is essential to addressing the well-documented challenges associated with FFS and optimizing the family medicine experience. The future of primary care payment must include the widespread availability and adoption of well-designed value-based payment (VBP) models that adequately support the delivery of whole-person care by physician-led teams. These payment models should be accessible to all without imposing unnecessary administrative burdens.

The AAFP set out to study solutions that offer not merely incremental improvement but that truly alleviate the underlying problems in family medicine. Alternative payment models (APMs) focused on quality and value create greater value only when they increase the effectiveness and efficiency of primary care delivery for physicians, their teams, and their patients/families.[1] The value proposition of a given payment model must promise, and then deliver, an effective and adoptable archetype.

Fee-for-Service—A Root Cause of Burden

The dissatisfaction associated with FFS in primary care is based on its historically undervalued payment levels coupled with the excessive and unnecessary administrative requirements it places on family physicians and primary care health professionals. Family physicians loudly reflected the burden of FFS in the 2022 Member Satisfaction Survey. Their No. 1 priority was better payment and payment models. No. 2 was reducing administrative burden, and No. 3 was protecting their scope of practice.

Family physicians often describe practicing under the FFS payment model as “being on a hamster wheel”: always running behind, feeling rushed, and never catching up. They feel tethered to their electronic health records system (EHR) throughout the workday, at home after hours, and on weekends. The amount of time they are able to spend caring for their patients and with their families is “inadequate.” As a root cause of administrative burden and burnout, FFS threatens the health of family physicians, the scope of family medicine practice, and the future of the family medicine specialty.

Value-based Payment—The Promise

VBP has promised primary care physicians a shift from care being reimbursed based on volume to being paid prospectively based on population resource needs and incentivized retrospectively for improving cost and quality outcomes. AAFP members who have elected to work in a direct primary care (DPC) setting report that burden and burnout can be nearly eliminated by shifting to a direct contract with patients or employers in a prospective payment system (PPS) model rather than relying on insurance-based FFS reimbursement. By providing primary care a source of predictable, upfront cash flow, the practice is able to deliver care that is designed around the

needs of the patient. Compared to the FFS model, which emphasizes face-to-face, encounter-based care with a physician, prospective payment ensures consistent revenue to cover the costs of caring for an attributed population regardless of whether that care is delivered face-to-face, via secure message or phone call, by a nurse, or even without directly interacting with the patient—all without excessive documentation or other administrative burdens. This consistent revenue also relieves the pressure to generate an excessive volume of services, opening the door to right-sized patient panels.

Unlike DPC, however, most modern insurance-based PPS programs are tied to performance incentives, bonuses for reducing total costs of care, or both. Additionally, most practices in PPS programs still have a prominent percentage of patients in FFS payment models. Our question is: Can VBP models relieve administrative burden, as has been seen in DPC?

Value Based Payment—The Peril

The current transition to VBP can present perils in getting to the promise.[2] Family medicine practices do not have a path to transition 100% of revenue from FFS to VBP overnight. This means that VBP adoption is a process of migration, during which already fragile practices operating on a thin profit margin and overwhelmed by the consequences of FFS are at risk of collapse due to burden that is out of proportion to incentives offered. The perils of VBP may include:

- Ongoing need for FFS patient visit volume (in essence, creating two product lines—FFS and VBP);
- The addition of new work, complexity, and documentation/reporting burden on top of existing FFS administrative burden;
- Nonstandard quality metric reporting requirements, presented via payer-specific technology platforms that are not integrated into the native workflow; and
- VBP programs that may not cover their costs (e.g., 90% of Merit-based Incentive Payment System [MIPS] participants reported payment adjustments did not cover program costs).[3]

As described in the AAFP Guiding Principles for Value-Based Payment,[4] VBP “done right” is designed to support collaborative partnerships between patients and physicians, improve the quality of care, and reduce health care spending. These principles describe the components of VBP essential for success in primary care. The AAFP believes that implementation of these principles is essential to facilitating the transition away from FFS and toward prospective VBP arrangements to sustainably support the kind of robust primary care essential to a high-performing health care system:

- Pay prospectively to support team-based care and ensure primary care payments reach primary care physicians and practices.
- Actively engage patients in the accountable relationship.
- Risk adjust payment for medical and social complexity.
- Evaluate what matters to patients and physicians.
- Equip primary care teams with timely information.
- Reward year-over-year improvement as well as sustained high performance.

To achieve these aims, VBP for primary care must support the four key functions of primary care (first contact access, comprehensiveness, coordination, and continuity), which are essential to meeting the goals of improved quality and reduced spending.

Our Goal

This initial study aimed to test the following hypotheses and identify the barriers and innovations required for mainstream adoption of VBP to be studied more thoroughly in the future. Our hypotheses are:

- Early-adopter family physicians successfully transform to new VBP models based on a set of essential innovations.
- Mainstream family physicians' transition to VBP may present barriers and burdens hindering the adoption of innovations.
- Small independent family practices are challenged by a lack of resources and infrastructure.
- The set of essential VBP innovations may need to be modified and supplemented for mainstream implementation.
- Some characteristics differentiate physicians/practices that have burnout from those that do not after transitioning to VBP.

Methods

Sara Pastoor, MD, MHA, Senior Director of Primary Care Advancement at Elation Health, assisted us in identifying primary care physicians in different stages of VBP adoption and provided insight from her work with many practices transitioning to APMs.

The lab interviewed 10 primary care physicians (nine FPs and one internal medicine physician) in VBP arrangements. They represented a convenience sample pulled from Elation Health client practices and physicians participating in other innovation labs. The 10 participant practices were primarily small, ranging from one to four physicians, with two from larger practices of 25 to 50 clinicians and one from a corporate VBP-focused organization. Interviews were conducted via teleconference and were based on a structured interview survey guide. The interview guide captured quantitative, qualitative, and verbatim responses addressing the following areas:

<u>Demographics</u>
- staff-to-physician ratios
- VBP-to-FFS revenue ratios

<u>Primary Care Vital Signs</u>
- one-item burnout scale[5]
- physician satisfaction
- typical visit time
- patient care time rating
- panel size

<u>Level of Administrative Burdens</u>
- overall
- the FFS hamster wheel
- the EHR
- documentation
- chart review
- prior authorization
- inbox

<u>Level of VBP Burden</u>
- quality measures capture and reporting
- multiple payers and reporting requirements
- managing population health and patient panels
- annual hierarchical category coding (HCC): condition reassessment and suspected condition identification

- managing shared savings

Innovations Adopted

- What innovations have you implemented to address these burdens?

Wish List

- If you could have three things tomorrow to help you be successful in value-based contracts, what would those three things be?

For the Primary Care Vital Signs, Level of Administrative Burdens, and Level of VBP Burden areas, responses were scored on a 5-point Likert scale, and we asked each individual to rate themselves or their practice both before adopting VBP and after adopting VBP. We then asked follow-up questions to determine why they provided the answers they did.

Results

Below are quantitative results and interview findings for the 10 lab participants before and after adopting various VBP models. The participants were broken into two groups based on their level of burnout using a validated one-item burnout measure. This measure consists of a question about the individual's feelings of stress, burden, and burnout, with five potential answers ranging from no stress (i.e., 1) to considering the need to seek help for burnout (i.e., 5). A score of 3 or greater indicates burnout is likely to exist.

For the results, we have segmented the group into two cohorts based on their burnout score after adopting VBP. Those who reported burnout or increased stress (at least one level higher on the burnout scale) after adopting VBP comprised our Burnout cohort (n=5). Those who reported no burnout or increased stress after VBP adoption comprised the No Burnout cohort (n=5). Both cohorts averaged 2.5 out of 5 on the burnout scale before adopting VBP. The No Burnout cohort's average score after adopting VBP was 1.6, and the Burnout cohort's average post-VBP score was 3.1. *(Figure 1)*

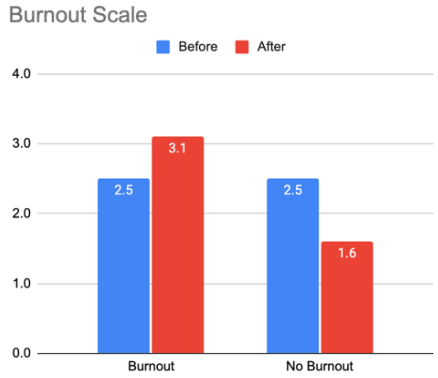

Figure 1 – One-item Burnout Scale Before & After VBP

Before VBP adoption, participants' overall practice satisfaction scores were 2.9 and 3.5 out of 5, respectively, for the Burnout and No Burnout cohorts. Both groups had improved practice satisfaction scores after adopting VBP—a 21% increase in the Burnout cohort and 24% in the No Burnout cohort.

The largest differences between the two cohorts were seen in response to questions regarding where their revenue came from (FFS vs. VBP) and how their practices' staffing ratios compared. Overall, the Burnout cohort had more revenue from FFS and lower staffing ratios. *(Figures 2 and 3, respectively)*

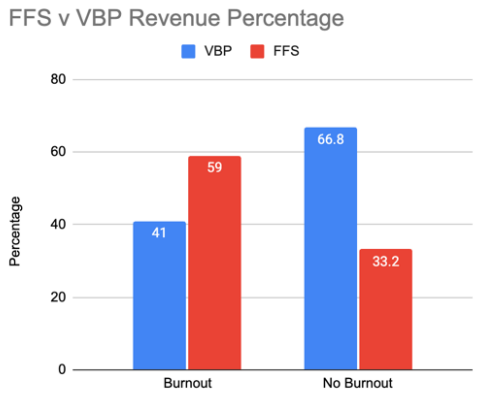

Figure 2 - Source of Practice Revenue

VBP vs. FFS Revenue Percentages
Comparing the two cohorts on their respective percentages of VBP to FFS revenues, the Burnout cohort still had a majority—59%—of its revenue from FFS, while the No Burnout cohort had 75% from VBP arrangements. This measures a practice's relative transition from the burdensome FFS model to VBP.

Staff-to-Physician Ratio
Comparing the two cohorts on their staff-to-physician ratios, the Burnout cohort had 2.7 staff per physician, whereas the No Burnout cohort had more than twice that, or 5.9 staff per physician. This is a measure of the practices' adoption of team-based care.

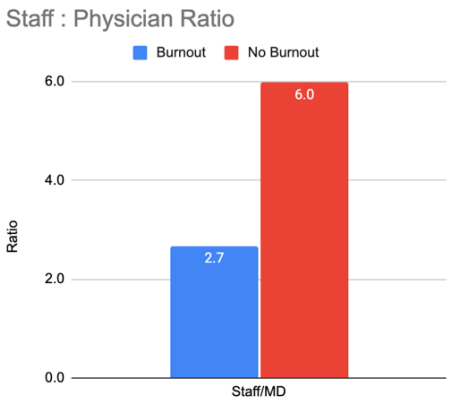

Figure 3 - Staff-to-Physician Ratio

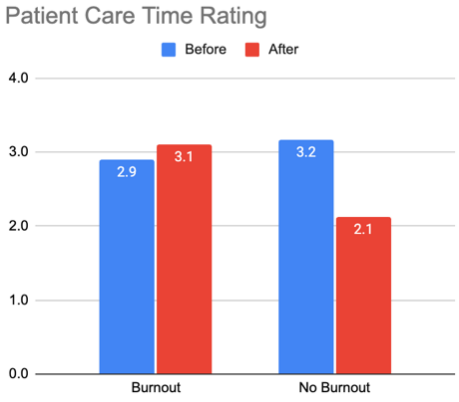

Figure 4 - Time Available for Patients

Patient Care Time Rating
In a follow-up to the question about visit length, participants were asked:

How would you rate your time on direct patient care?
1. Ample
2. Adequate
3. Constrained
4. Inadequate

The Burnout cohort rated their time as "Constrained," slightly worse than before VBP. The No Burnout cohort reported an improvement, moving from "Constrained" before to "Adequate" after VBP transformation. *(Figure 4)*

Patient Panel Size
The Burnout cohort reported an increase in panel size (from 1,475 to 1,775) after VBP adoption, while the No Burnout cohort reported panel sizes decreased after VBP adoption (from 1,467 to 1,331). *(Figure 5)*

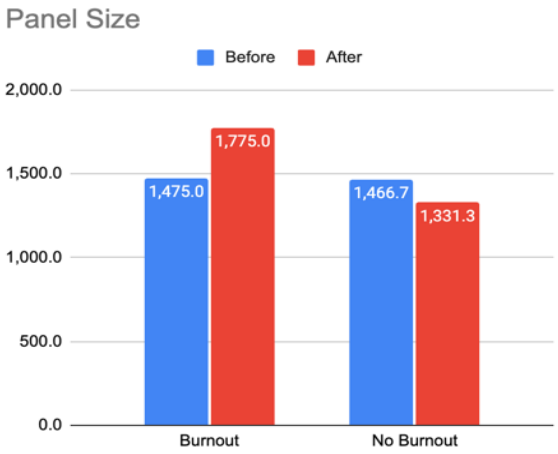

Figure 5 - Panel Size

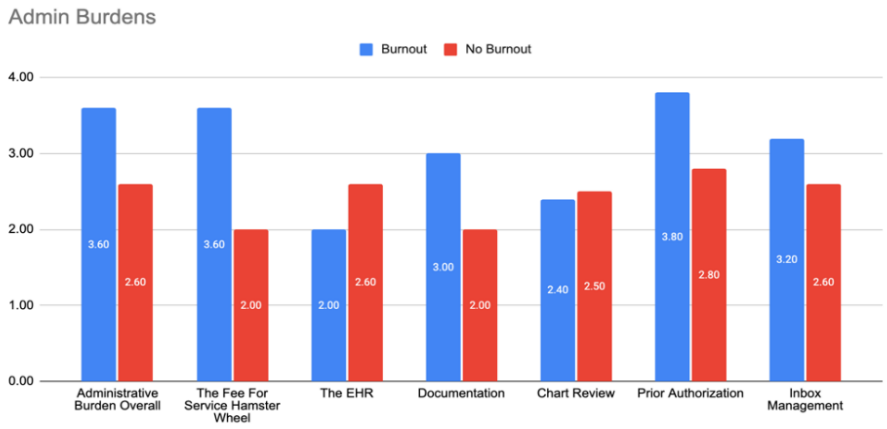

Figure 6 - Administrative Burdens

Administrative Burdens
Compared with the No Burnout cohort, the Burnout cohort reported 1 point higher Administrative Burden Overall (3.6 vs. 2.6). The Burnout cohort also reported higher burden for the FFS Hamster Wheel (3.6 vs. 2.0), Documentation (3.0 vs. 2.0), Prior Authorization (3.8 vs. 2.8), and Inbox Management 3.2 vs. 2.6). The No Burnout cohort reported slightly higher burden for the EHR (2.0 vs. 2.6) and for Chart Review (2.4 vs. 2.5).

Burdens Associated With VBP

The Burnout cohort reported either the same or slightly higher burden levels after VBP adoption than the No Burnout cohort except for the Annual HCC Condition Reassessment (3.20 to 3.50) and Managing Shared Savings (2.33 to 2.63).

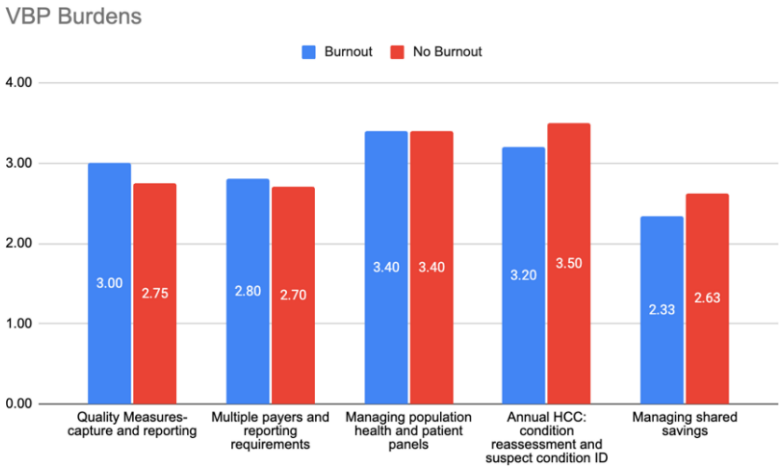

Figure 7 - Value Based Payment Burdens

Discussion

The results of these interviews illustrate both the promise and the peril of VBP. Several common themes were identified that appear to influence a practice's experience of burnout and the ability to realize VBP success.

Infrastructure

A significant factor in burnout is the amount of work to be done divided by the resources available to do the work. As such, there seems to be a threshold of financial investment needed to support infrastructure that is sufficient to enable success in VBP and reduce the associated risk of burnout. In practices with a team, whether integral to the practice or affiliated through a network organization, the additional work of VBP was more manageable, and burnout was lower. The adoption of specific technical solutions introduced additional efficiencies, which helped contain operating expenses and enable both clinical and financial success.

Capitation Factors

It should also be noted that, in general, practices with capitated models experienced less burnout than those with payment models designed around retrospective bonus payments. However, even in capitated models, some specific factors key to success were identified, and these factors support the findings of a 2017 research study published in *Health Affairs*,[6] which modeled (in simulation) the impact of both capitation rate and percentage of total revenue from capitation on financial outcomes in a primary care practice. Our findings indicate that both the capitation rate and the amount of total revenue from capitation are crucial factors in relieving burden/burnout and achieving ongoing financial success in VBP models.

Quality Measures

The effort required to identify, deliver, report, and get paid for a set of payer-driven quality measures is not insignificant.[7,8,9] In our study, we noted that practices with fewer payer contracts had less burnout, likely due to simpler workflows to achieve success. This confirms what is already widely known: Lack of alignment across payer programs in specific quality metrics,

reporting mechanisms, and performance management platforms introduces additional burden into primary care practices and contributes to burnout.

Contract Quality and Innovation

The most successful practices in our cohort benefited from innovative and savvy contract design between the practice and the payer, sometimes involving partner health systems. Practice leaders who worked closely with their payer organizations to design contracts that recognized the power of primary care to influence downstream utilization patterns and costs of care of an attributed population realized better financial outcomes for the practice, reported a better experience of delivering care, and enjoyed the least amount of burnout.

Innovations Needed

Our research has identified innovations that appear essential for more effective and efficient success in VBP. We asked participants for their wish list innovations, and their answers provide insight into the categories of innovation sorely needed, including:

Coding and reimbursement:

- Automated coding of gap-closure for CPT-2 codes
- Higher capitation rates
- Better reimbursement for behavioral health care

Risk and Risk Adjustment:

- Including social drivers of health in risk-adjustment scoring
- Risk-adjustment paneling and resource planning
- Risk prediction and intervention

Data and transparency

- Honest, actionable data and transparency
- Standardizing all quality measures across all payers
- Making data about community and government-based services transparent to practices/physicians to help address social drivers of health

Practice management:

- Streamlined management of attribution
- Capturing external data into the EHR
- Direct connection to an assigned representative of each VBP arrangement
- Practice mentorship program that provides access to practices with experience in VBP
- Practice support services to make it easier for small practices to adopt VBP

Conclusion

This research is limited due to its small sample size, but our findings are consistent with other industry-led work.[2] Therefore, the conclusions are directional in nature, and more validation is needed.

VBP must be well-designed and thoughtfully implemented to empower primary care to be successful relative to the Quintuple Aim. Unfortunately, many VBP arrangements do not provide

the level of prospective payment needed as a percentage of total practice revenue to allow practices to acquire some of the key capabilities necessary for success. Those practices reporting less burnout tend to have a higher percentage of prospective payment. These payments support investments in various innovations—from people to technology—that allow them to be more efficient. Many of those innovations assist the clinician in offloading tasks to technology or teams.

Unfortunately, many practices still have high volumes of FFS patient visits, many of which are tied to so-called VBP payment models, which means that rather than creating efficiencies, VBP adds another layer of complexity. Additionally, payers do not take a homogenous approach to VBP. The good news is that there are many innovations that practices can leverage to be successful in VBP. The challenge lies in proliferating adoption across most practices. One thing is clear: A dramatic reduction in the variance and complexity across VBP arrangements is needed to center efforts on the best arrangements for practices and patients/families, not payers.

More research is needed to understand the most efficient paths to successful VBP transformation and the required essential innovations. Research should focus on these questions:

- What is the PPS-to-FFS ratio tipping point that relieves burden and optimizes care?
- What are the key characteristics of a readily adoptable PPS program?
- What administrative burdens associated with VBP must advocacy push to reform?
- What innovations are essential for mainstream adoption of VBP?
- What are the key characteristics and features of those innovations?
- What are the best practices for adopting the innovations?
- What are the physician and practice prerequisites needed for successful VBP transformation?

References

1. Park B, Gold SB, Bazemore A, Liaw W. How Evolving United States Payment Models Influence Primary Care and Its Impact on the Quadruple Aim. *J Am Board Fam Med*. 2018;31(4):588-604. Accessed October 17, 2023. https://www.jabfm.org/content/31/4/588.long
2. Chartis. Positioned for Growth: The Anatomy of Value-Based Primary Care. Accessed October 20, 2023. https://www.chartis.com/insights/positioned-growth-anatomy-value-based-primary-care
3. Medical Group Management Association. MGMA Annual Regulatory Burden Report – 2022. Accessed October 20, 2023.https://www.mgma.com/practice-resources/government-programs/mgma-annual-regulatory-burden-report-2022
4. AAFP. AAFP Guiding Principles for Value-Based Payment. September 2022. Accessed October 23, 2023. https://www.aafp.org/about/policies/all/value-basedpayment.html
5. Dolan ED, Mohr D, Lempa M, et al. Using a single item to measure burnout in primary care staff: a psychometric evaluation. *J Gen Intern Med*. 2015;30(5):582-587. Accessed October 23, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4395610/
6. Basu S, Phillips RS, Song Z, et al. High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care. *Health Aff (Millwood).* 2017;36(9):1599-1605. Accessed October 23, 2023. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0367

7. Halladay JR, Stearns SC, Wroth T, et al. Cost to primary care practices of responding to payer requests for quality and performance data. *Ann Fam Med*. 2009;7(6):495-503. Accessed October 23, 2023. https://www.annfammed.org/content/7/6/495
8. Knierim KE, Hall TL, Dickinson LM, et al. Primary Care Practices' Ability to Report Electronic Clinical Quality Measures in the EvidenceNOW Southwest Initiative to Improve Heart Health. *JAMA Netw Open*. 2019;2(8):e198569. Accessed October 23, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6687038/
9. National Academies of Sciences, Engineering, and Medicine; National Academy of Medicine; Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being.* National Academies Press (US); 2019. 6, The Influence of the External Environment on Clinician Burnout and Professional Well-Being. Accessed October 23, 2023. https://www.ncbi.nlm.nih.gov/books/NBK552611/

Appendix A – Survey Instrument

VBP Case Study Survey Instrument

Location (city, state)	
Practice / Organization	
A little about your practice and your role: **(see snapshot below)**	
How many days per week do you see patients?	
Please describe how it was on FFS before VBC?	
Please describe your adoption of VBC? **Why did you adopt?** **When did you start?** **What arrangements?** **How are you doing financially?**	

SNAPSHOT OF PRACTICE

BEFORE – when on FFS And AFTER in VBC
Family Medicine Vital Signs (Before and after adopting VBC)

Which of the items below describes you best: 1. "I enjoy my work. I have no symptoms of burnout." 2. "I am under stress, but I don't feel burned out." 3. "I am definitely burning out." 4. "I think about work frustrations a lot. It won't go away." 5. "I feel completely burned out. I may need to seek help."	Before	After
How satisfied are you with your overall practice? **Scale of 1 to 5 with 5 being most satisfied** 1. Extremely dissatisfied ("Can't be much worse than this.") 2. Very dissatisfied 3. Satisfied 4. Very satisfied 5. Extremely satisfied ("Can't be much better than this.")	Before	After
What is your typical visit length in minutes with an established patient?	Before	After

How would you rate your time with your patients? 1. Ample 2. Adequate 3. Constrained 4. Inadequate	Before	After
What is the size of your patient panel?	Before	After

What percentage of your practice is paid as:	
FFS	
DPC	
VBC	
Quality Measures (Pay for Performance)	
Shared Savings/Downside Risk	
Capitation	
ACO	

How many payers do you submit claims with?	

How many FTEs would you estimate you have as:	
FPs	
Other Physicians	
Mid-levels	
Clinical Support Staff	
Non-clinical Support Staff	

Burdens

What is the biggest burden for you in your practice?	Before VBC	After VBC

Please rate your level of burden related to the following:
1. None
2. Mild
3. Moderate
4. Excessive
5. Extreme

	1	2	3	4	5	N/A
Administrative Burden before VBC						
Administrative Burden on VBC						
The Fee-for-Service Hamster Wheel						
The EHR						
Documentation						
Chart Review						
Prior Authorization						
Inbox Management/Phone Calls						
Other …						

What innovations have you implemented to address these burdens? Rate their impact on a scale of 1 to 5 (with 5 being highest):	

Please rate your level of burden related to managing value-based care:
1. None
2. Slight
3. Moderate
4. Very
5. Extreme

	1	2	3	4	5	N/A
Quality Measures - capture and reporting						
Multiple payers and reporting requirements						

Managing population health and patient panels						

Annual HCC: condition reassessment and suspect condition ID						
Managing shared savings						
Managing risk arrangements						
Other …						

What innovations have you implemented to address these burdens? **Rate their impact on a scale of 1 to 5 (with 5 being the highest):**	

Quality Measures: Capture and Reporting

How many payers do you submit quality measures with? **What QMs and how many do you report on?**	
Can you describe the process you go through to capture and report quality today? What is most burdensome?	
Review any innovation impact before and after:	
Do you think quality measures drive better value in your practice? **If so, what is that value?**	

Shared Savings/Shared Risk

How many payers do you share financial risk with or give you access to shared savings?	
Can you describe your processes? What are the most burdensome steps?	
Review any innovation impact before and after:	

Capitation through Risk Stratification

How many payers do you submit HCC codes with?	

Review any innovation impact before and after:	
Beyond informing capitation rates, does HCC coding/RAF Scoring provide value for you, clinically or financially? How so?	

How has VBC affected your scope of practice?

If you could have three things tomorrow to help you be successful in value-based contracts, what would those three things be?	