

Ready, Risk, Reward:

Optimizing Primary Care Model Design to Improve Performance

Abstract

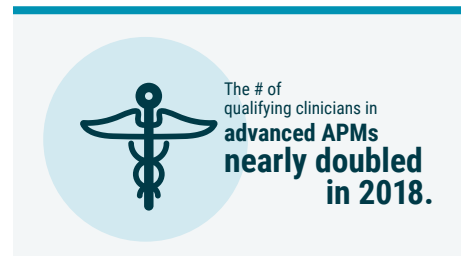
- Primary care is one of the highest priorities for health systems as they move to value-based payment models and take accountability for the health of populations.
- Leveraging its robust database of detailed physician practice information, Premier® analyzed family medicine and primary care clinics to pinpoint variation across staffing models and identify opportunities for improvement. The analysis found wide variation in staffing model composition, performance and costs, as well as opportunities for improvement.
- Premier's analysis found that under fee-for-service payment:
 - + Skill mix is not necessarily a predictor of provider productivity.
 - + Medical assistant-only models may be the most cost-effective option for practices that are fee-for-service revenue based.
 - + The highest performing models have a larger number of support staff per provider.
- As primary care practices transition to value-based models of care, they will need to methodically adjust their staffing models to a richer skill set that can support a more coordinated model of care. A higher skill mix will be a more cost-effective option in the shift to value-based payment.
- Providers need access to more meaningful data, a clear understanding of their patient/payer mix and the ability to network with peers to enhance practice model design and effectiveness.

Introduction

The need to create more efficient and coordinated models of care has become a priority as providers are faced with high costs, low reimbursement and new competitive entrants. This is putting independent, affiliated and employed physicians, as well as the employers and health systems working with them, at a critical juncture in time. These entities are searching for ways to allocate limited capacity and resources to provide more coordinated, higher-quality care at a better price point, and position themselves as the choice provider in their markets.

Increasingly, hospitals and physician practices are partnering and aligning on financial and operational priorities to form high-value networks, patient-centered medical homes (PCMHs), accountable care organizations (ACOs), alternative payment models (APMs) and clinically integrated networks (CINs). These value-based care and payment models align incentives to support coordinated, higher-quality care while managing the healthcare expenditures of defined patient populations. They can also help to lower financial and regulatory risk for independent practices by providing the capital necessary for investments in essential resources, such as technology and staffing, to improve workflows and reduce the burden of everyday operations for physicians.

In fact, more physician practices are partnering with health systems than ever before, which has led to a decline in independent physician practices while the percentage of hospital-owned practices doubled between 2012 and 2018.¹ Moreover, the number of qualifying clinicians in advanced APMs nearly doubled in 2018 as clinicians sought additional reimbursement through value-based payment models.²



Primary care, specifically, is one of the most sought-after specialties in today's value-based payment environment, with employers and health systems looking to invest in partnerships and better align with high-value primary care physicians. There are several factors driving this desire, including the Quality Payment Program, which uses specific patient attribution rules to link patients who receive primary care services to an ACO and/or advanced APM. These models will increasingly be driven by primary care as organizations move to APMs and the applicable patient count/payment thresholds increase over time. The Centers for Medicare & Medicaid Services' (CMS') new Primary Care First Model will reward value and quality by offering an innovative payment structure to support delivery of advanced primary care. Additionally, as more people are covered through Medicaid expansion, more will have access to affordable primary care providers. Meanwhile, most medical groups are still operating under the fee-for-service payment model and need to manage efficiency and productivity to achieve reimbursement through the Quality Payment Program's Merit-based Incentive Payment System (MIPS).

1 Physicians Advocacy Institute, *Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018* (February 2019), <http://www.physiciansadvocacyinstitute.org/PAl-Research/Physician-Employment>

2 CMS.gov, *Quality Payment Program Releases 2017 Physician Compare Data and Sees Increases in Clinician Participation Rates and Success for 2018* (July 2019), <https://www.cms.gov/blog/quality-payment-program-releases-2017-physician-compare-data-and-sees-increases-clinician>

While hospitals and health systems are focused on building the capabilities needed to standardize their operating models and support these new payment models, the emphasis is often placed on acute settings or inpatient operations. This has left medical groups with wide variation in their operating models, as well as sub-optimized resources to support them. This variation often contributes to increased physician frustration and less efficient, uncoordinated care with unsatisfied patients.

In fact, physician burnout was recently determined a public health crisis in a 2019 report from Harvard and Massachusetts medical organizations, finding the problem harms both physicians and patients.³ The report noted that nearly 80 percent of physicians experience feelings of professional burnout at least some of the time.

In a recent panel of more than 100 medical leaders facilitated by Premier, more than two-thirds of medical group executives stated they lack the necessary business intelligence to perform their duties. Business intelligence, including access to timely, actionable and accurate insights, is essential to understanding how to respond to external forces and optimize medical group performance effectively. For example, these insights can help medical groups understand how to improve their operating models as they transition to value-based models of care by pointing out unnecessary variation in staffing, costs and provider performance.

Many hospitals have near real-time measurement systems in place to show how individual clinicians stack up against their peers, however physician practices often lack the necessary reporting systems and rely on surveys based on outdated information with limited sample sizes. Moreover, the accuracy of the data is often questionable due to unclear data definitions and are potentially skewed based on the interpretation of individuals

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completing the survey. New innovations in physician practice technology are challenging the traditional benchmark survey model and creating access to more credible insights from peers.

The continued shift toward value-based care and payment has resulted in a greater need to manage utilization, quality and overall standards of care. However, medical groups still must navigate the pressures relative to productivity and volume considerations under fee-for-service. Increasingly, health system and medical group leaders are realizing the value in leveraging technology and information to better understand how their physician practice operating models affect productivity and costs to improve overall performance and efficiency while transitioning to new models of care.

Premier's analysis studied family practice and primary care staffing models in order to guide providers with new insights into how clinical staffing variation can help physician practices design the most effective model design.

³ Massachusetts Medical Society, Massachusetts Health and Hospital Association, Harvard T.H. Chan School of Public Health, and Harvard Global Health Institute, A Crisis in Health Care: A Call to Action on Physician Burnout (January 2019), <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2019/01/PhysicianBurnoutReport2018FINAL.pdf>

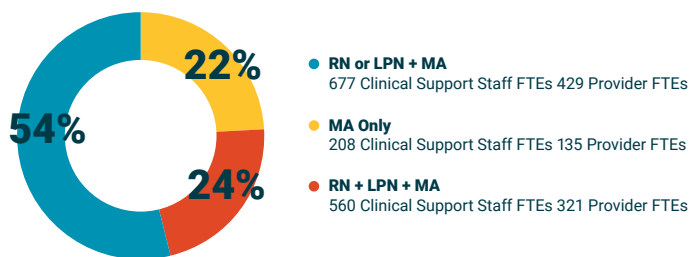
Identifying Variation in Primary Care Staffing Model Skill Mix, Productivity & Costs

Leveraging its robust database of detailed physician practice information, which includes more than 30,000 providers, Premier benchmarked 2018 data and identified wide variation in staffing models across 257 family medicine and primary care practices comprised of more than 885 providers and 1,445 staff. Overall, 22 percent of family medicine clinics used a medical assistant (MA)-only model; 54 percent were staffed with a combination of registered nurses (RNs) or licensed practical nurses (LPNs) along with MAs; and 24 percent were staffed with RNs, MAs and LPNs (Chart 1).

Provider productivity is measured in terms of work relative value units (wRVUs), meaning each medical code has a corresponding RVU value that is set by CMS based on how much effort they believe is required to perform a service. An RVU is comprised of both a technical and professional component – the hospital charge and the physician charge. The wRVU measures how much effort the provider puts into the service that was billed. If coding for the service is accurate, then the wRVU measurement should be a good determinant of the time and effort required by the provider.

The additional charts separate out provider productivity into quartiles per clinical FTE based on Table 1.

Chart 1 : Family Medicine & Primary Care Staffing Models



	Avg Staff per Provider	Avg Staff Cost per Provider	Avg Provider per wRVUs per CFTE
MA Only	1.6	\$53,714	4,763
RN or LPN + MA	1.8	\$74,008	4,536
RN + LPN + MA	1.9	\$81,169	4,786

Table 1 : Family Medicine & Primary Care Staffing Models

	Bottom Quartile	2nd Quartile	3rd Quartile	Top Quartile
wRVUs per Provider	<3,856	3,857 - 4,618	4,619 - 5,506	>5,507

When examining provider performance through the lens of productivity relative to the various staffing models utilized, skill mix was not observed to be a determining factor in overall provider productivity. Clinics with MA-only models and comparable staff to provider clinical full-time equivalent (CFTE) ratios were just as likely to achieve top quartile performance as higher skill mix models inclusive of RNs (Chart 2).

However, the highest performing clinics, in terms of productivity, often had larger

numbers of support staff per provider CFTE than the bottom quartile. In many instances, these clinics have invested in the support staff to enable providers to see more patients (Chart 3).

As provider performance in terms of productivity increases, the analysis also suggests that the overall staff cost per wRVU lowers significantly as practices achieve economies of scale. Furthermore, it is almost half the cost to leverage an MA-only staffing model, compared to a higher skill mix model

Chart 2 : Family Medicine & Primary Care Clinic Total Provider CFTE Distribution Based on Productivity Level

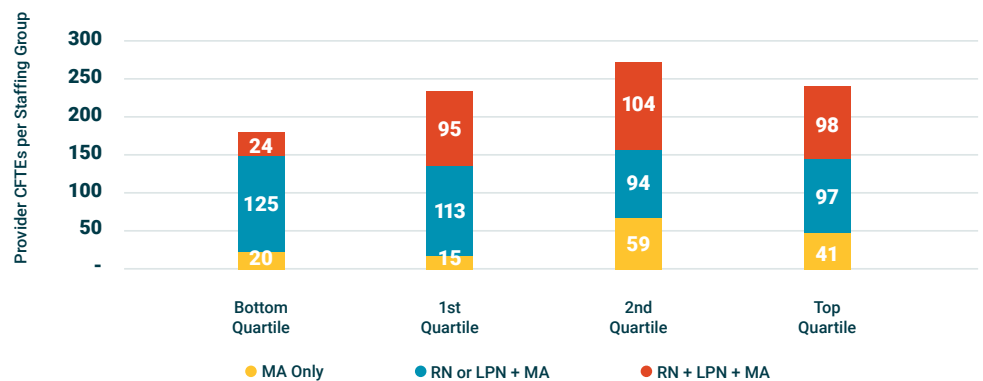
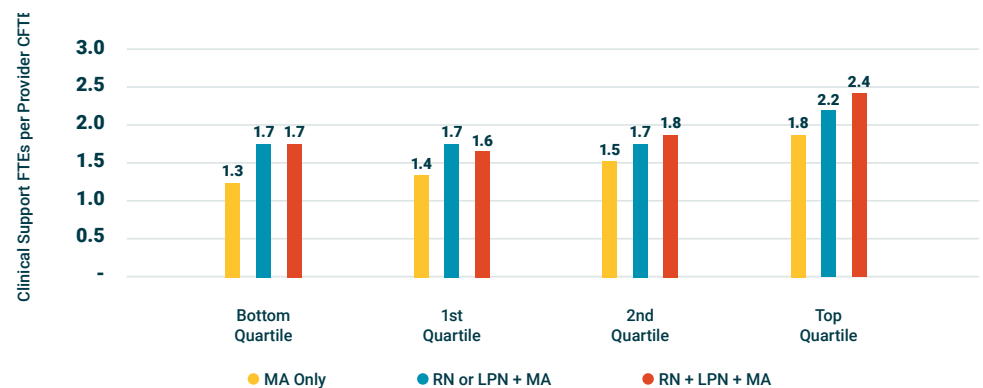


Chart 3 : Family Medicine & Primary Care Clinic Average Clinic Support

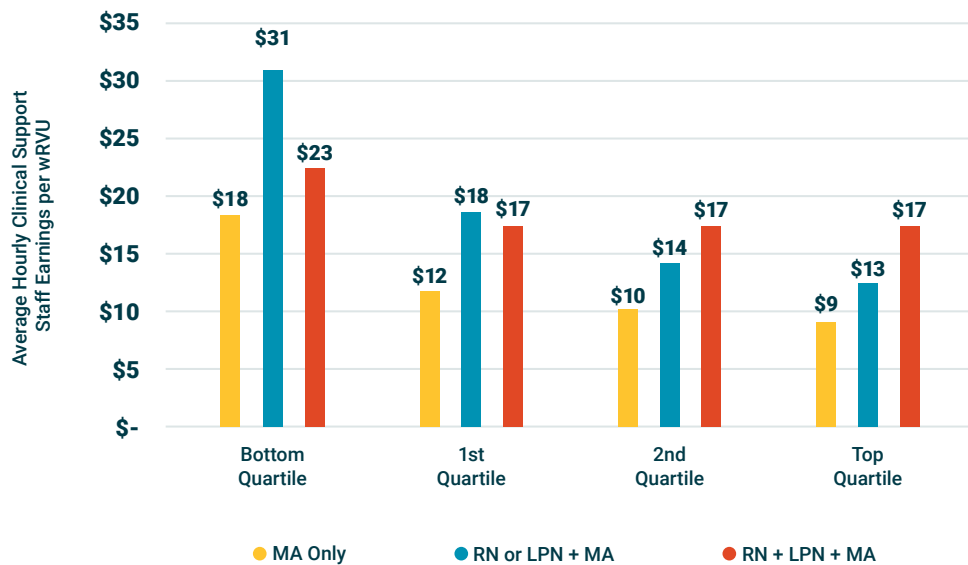


(i.e. RN, LPN and MA) within these practices, with no discernable differences in productivity or output (Chart 4).

While various factors relative to physician practice staffing models can be debated, an important question remains. To what extent are these practices migrating toward new models of care that are designed to address complex health and behavioral health needs of the patient

population? While many of these practices are still largely fee-for-service based from a revenue perspective, it is safe to assume that unless the higher skill mix models are leveraging staff working at the top of their license (i.e. proactively coordinating and managing care), they may be contributing to a higher cost of care.

Chart 4 : Family Medicine & Primary Care Clinic Support Staff Average Hourly Earnings Per wRVU



Designing Intentional Primary Care Staffing Models in the Transition to Value-Based Payment

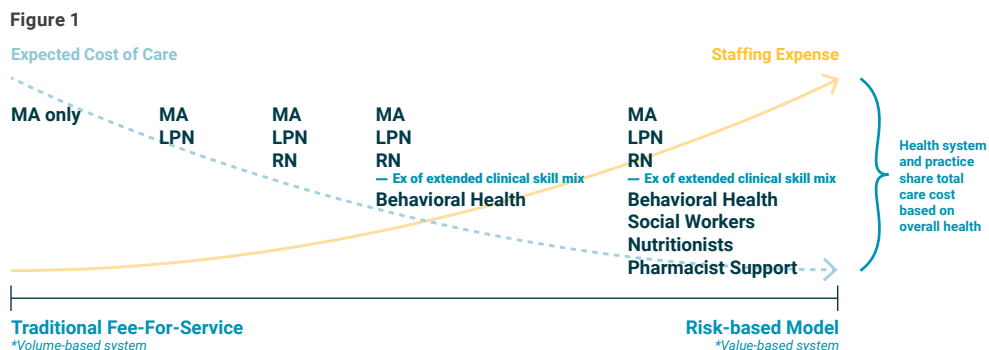
While most medical groups have fee-for-service dominant practices that measure success by productivity level, as the industry moves toward value-based payment, participating in risk-based models will become a more viable option for many to ensure financial success. Ultimately, the decision to stay in fee-for-service or transition to a more coordinated care model should inform the type of staffing model a physician practice pursues.

Physician practices should understand where they are on the journey to value-based care and be intentional about moving toward staffing models that will support that path, such as leveraging staff in relation to volume versus more value-based, coordinated care. Based on Premier’s analysis and experience, Figure 1 represents the appropriate evolution of skill mix as organizations shift toward the management of health for populations.

An MA-only staffing model may be the most practical and cost-effective option for providers still in fee-for-service. However, Premier’s analysis shows wide

variation in skill mix for practices that are in a fee-for-service payment model. Medical groups that are not interested in advanced models of care may want to reconsider their staffing models if they have deployed a richer skill mix since they may only be contributing to higher practice expense and ineffective use of resources relative to licensed staff.

As practices move further along the value chain, they will likely need a higher level of skill mix to support more proactive coordination of care for their patients. Value-based arrangements are more challenging and require very specific clinical, technical and administrative capabilities. For example, pharmacist support, behavioral health providers, nutritionists and social workers are key to supporting community services. Moreover, patient education, care planning and coordination of care for the highly complex or vulnerable populations will further improve efficiency and effectiveness in a value-based payment model. The challenge is determining the readiness for building the right value-based model that can successfully assume and manage greater levels of risk.



Keys to a More Informed Approach to Physician Practice Design

In its work with health systems and physician practices to develop financially successful, high-quality care delivery models, Premier has identified three essential components to enhancing physician practice model effectiveness in alignment with payment model design.

1

Timely, Accurate Data & Analytics on Provider Performance

Premier's analysis points to a common challenge in medical groups as ideal or preferred staffing models have not been well documented or understood through traditional benchmarking practices. This information is becoming increasingly important as health system and physician practice leaders work together to navigate the complexities of the healthcare landscape. With the right insights, healthcare leaders can simplify the conversation and allow data-driven decisions to take place.

Standard data definitions in addition to validated, reconciled and trusted data sources can provide leaders meaningful and actionable information to address common operational medical group challenges, such as the correlation between staffing mix and productivity as addressed in Premier's analysis. This can be achieved by integrating often disparate data sources (e.g., billing, scheduling, payroll, general ledger) into a simple, interactive and easy-to-use management tool.

Business intelligence solutions that can collect timely and accurate information with analytical capabilities that provide peer comparisons on a monthly basis can also help to drive effective provider discussions by enabling more informed decision making. Relevant, accurate, timely and reconciled peer benchmarking comparisons help health system and clinical leaders challenge medical group performance where surveyed benchmarks have traditionally lacked meaningful comparisons and insights.

Lastly, automated data management and reporting processes can help professionals spend more time managing information versus creating it, and therefore more time making the most effective decisions for their patients, providers and staff. Eliminating these burdens can go a long way toward reducing physician burnout, rationalizing the medical group subsidy and achieving a more efficient enterprise-wide operating model.

2

Clear Understanding of Payer & Patient Mix

Providers should be intentional about building a model that is right for their patients' needs and their organization's reimbursement implications. This requires a careful examination of their patient population to understand which patients need additional support/care management, as well as a clear understanding of payer contracts. For example, a health system with a large employer-sponsored health plan may be more likely to develop a wellness clinic with convenient access to care in order to assist in the proactive management in the health of these members.

Higher performing practices ensure their patients receive the right care in the right place and the right time, ultimately helping to reduce unnecessary care. This will enable medical groups to improve patient and provider satisfaction, increase compliance, decrease burnout, and garner optimal quality outcomes.

Moreover, as providers take on downside risk through more sophisticated payment models, they also must factor in the impact of changes in utilization on provider volume and profitability; quality and cost performance targets; and ensuring the technical elements of a contract match patient mix and outcomes.

3

Provider Collaboration & Peer Networking

Networking and collaborating with peers are critical to more effectively share knowledge and develop solutions to address the core issues facing physician practices while managing the required pace for change. When medical group leaders come together to share data, insights and best practices, they can accelerate the discovery of solutions to evolving provider needs.

Participating in forums to share experiences and solutions with peers is essential. Premier collaborative members that share their data and experiences are rethinking the status quo and have been able to implement changes quickly, broadly and consistently. In fact, thousands of providers across the nation are participating in the Premier Physician Enterprise Collaborative. They are currently working together to share data on ambulatory clinical and non-clinical staffing models for family medicine, primary care, urgent care and other subspecialty areas in order to more effectively manage the cost of care and improve practice performance.

Conclusion

The movement toward value-based payment will continue to push providers to pursue alternative care delivery and payment model options as reimbursements are increasingly tied to cost and quality outcomes. Additionally, with CMS' new focus on value-based primary care models, two-sided risk arrangements for primary care providers may become prevalent at a rapid pace. As patient care continues to shift toward the ambulatory environment, taking an evidence-based approach to medical group staffing and reducing practice variation is critical to reducing costs and improving overall provider and patient satisfaction. The key is to have the right information to support a data-driven, intentional approach to staffing models that reduce overall practice expenditures while optimizing care delivery and quality.

LEARN MORE:

For more information about how Premier can help your organization better partner and align with physicians, as well as strategically implement the most cost-effective, patient-centric primary care model over time visit:

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