Aligning Physician Compensation: The Final Mile for Value-Based Care

BY ANDREW SNYDER, MD, AND YOMI AJAO

Physician engagement is not physician alignment. This distinction is the key weakness in many organizations' efforts to move to population health management and risk contracting.

Specifically, the failure to appropriately compensate primary care physicians for managing populations and total cost of care is deterring them from performing as the star quarterbacks they are asked to be. It's also the major reason that large-scale, value-based enterprises that have invested in population health staffing, resources, and services aren't truly transforming their care, costs, or revenues.

The key to substantial progress is truly aligning physician compensation with new care and payment models. An aligned physician is organically engaged. What's more, aligning physician compensation would lead to reduced need for the expense of wraparound services, follow-up, outreach, and other secondary interventions.

EARLY CAPITATION HURT RELATIONS

The problem with compensation began decades ago. The early 1990s saw the first foray into capitation. Capitation inherently alters the operating widget of healthcare from visits and volume to patients and panel size. It thus fundamentally changed health systems' revenue streams toward capturing patient attribution, leading to a major buying spree of primary care practices.

This capitation attempt collapsed by the end of that decade. Providers and payers lacked reliable data and analytics for effective risk stratification. The methodology's other structural flaws led to cherry picking and further systemic problems. Insurers also became less willing to share any gains without transfer of risk, so capitation across most of the country disappeared as a contracting vehicle.

Most health systems reverted to fee-for-service, where they were not beholden to any specific attribution. As a result, many hospitals and health systems divested their physician practices or did not run them efficiently or profitably. This period tore at the fabric of physician-hospital relations, eroding trust that physicians had in what had been their parent system.

SHIFTING RISK TO PROVIDERS

Despite this uneasy history, systems and physicians need each other more than ever to succeed at value-based care and payments. Regulatory and reporting burdens have convinced growing numbers of physicians to join independent practice associations, clinically integrated networks, Medicare accountable care organizations (ACOs) or the new direct contracting entities (DCEs)—and/or to become employed by health systems.

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With health plans realizing they cannot manage actual clinical delivery based on cold rules and dispassionate medical management, they are seeking to transfer the risk to the providers, who will then have to figure out how to manage it themselves. Fortunately, there is significantly better data, clinical analytics, risk stratifications, and other tools that (should) allow for success in population health management.

Risk arrangements remain widely disparate, increasing the burdens on medical practices. Yet it is hard to argue that value is not the right direction, as physicians have been functionally removed from operating their own businesses.

JEOPARDIZING VALUE-BASED SUCCESS

A major sticking point to successfully managing risk, however, is physician-system relationships—especially

> "Value-based care will remain out of reach until true compensation alignment occurs."

as they play out in physician compensation.

In the push for population health management and risk contracting, many health systems have touted physician engagement. But they have largely not followed through with action. To provide population health, their strategies center on care management and other broad-based wraparound services for the highest-risk patients—mostly working around, not with, primary care providers.

Systems are treating their affiliated and employed physicians as their assets, not their partners. As such, they are pre-defining their worth and not treating them as equals at the table.

Consciously or not, this approach is a continuation of one started decades ago by payers when health maintenance organizations (HMOs) first emerged. Since then, for all intents and purposes, physicians have been told their worth. Systems have not learned from the plans' mistakes.

PHYSICIANS SEE LITTLE UPSIDE

As a result, most compensation programs remain transactional and volume-driven, and the physicians remain less than engaged. Some systems have added value-based incentives, such as quality bonuses. But thus far, these are insufficient to change behavior and move any care or cost needles at scale.

Shared savings are similarly proving to be inadequate. The math does not work for providers or hospitals; it only works for the insurers mitigating their risk. The fraction of a fraction that providers *may* take home is not a good enough risk to endure true practice transformation.

Primary care physicians are asked to be accountable and be the "quarterbacks," yet they are paid at the bottom of the physician ladder, with hard-wired ceilings. Further, the tools to document care and perform population health management either are lacking, or those workflows do not succeed when thrown into a transactional process.

At the same time, ACOs are stalled, showing savings for modest changes that fall far short of transformation. Most ACOs seem to have hit an asymptote: They are treading water, reluctant to make further investments because the infrastructure cost versus the returned fraction of shared savings has topped out.

UN-STALLING PROGRESS

The point of service is the true inflection point for best addressing utilization patterns, referral patterns, quality, and efficiency. To drive new efficiencies, we need to change the fundamental building block of delivery.

The way to change care delivery is to change physician compensation. If physicians are properly aligned and appropriately valued, they will be self-engaged and will problem-solve at the root of any issue.

What does fully aligned physician compensation look like?

- Set compensation based on full capitation, risk-adjusted panel size.
- Do not fractionate physicians' populations. Change compensation *as if* all patients are risk-adjusted and capitated.
- Start early. Changing practice and referral patterns takes time.
- Create incentives based on new value creation of quality and efficiency.

Instead of relying on an episodic and transactional compensation methodology, adopting one that is relational and longitudinal would fundamentally change how physicians manage their patients. It would organically foster team-based care, alternative communications, and virtual care adoption. Most importantly, it would prioritize increasing their panel size—not visit volume.

Yet the sensitivities in changing compensation methodologies are difficult for many health systems to want to navigate. They fear losing their network of referrals.

Still, there are many physician compensation attempts and variations that are directionally correct. But sparingly few are fully aligned compensation programs that break through all that noise.

Value-based care will remain out of reach until true compensation alignment—along with necessary physician tools, documentation waivers, and other aspects enabling a new operating model at the point of service—occurs. In truth, the current system is delivering exactly what it is designed to do. ○

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