The Degree of Value-Based Care Alignment Influences PCP Decision-Making

Part 2 of a study exploring how PCPs are positioned to deliver against a value-based care mandate

THE CHARTIS GROUP

In our first report examining our national survey of primary care physicians (PCPs), we explored the adoption of value-based models and key differences among primary care practices based on the degree of value-based care alignment. We found that 69% of PCPs participate in some value-based care model, and 21% are in a form of capitation. We segmented the PCP landscape into 3 cohorts based on their value-based care alignment: Leaders, Experimenters, and Abstainers. Leaders are more experienced physicians with larger, more productive practices, and they are better positioned for growth. We also discussed our finding that the majority of PCPs (71%) anticipate an increasing focus on financial costs of their patient panel over the next 5 years.

In this report, we hypothesize that the level of value-based payment alignment influences how PCPs make decisions. These decisions directly affect PCPs' performance against value-based care contracts and therefore are of significant value to these physicians. We explore 3 key themes related to PCP decision-making: How compensation is aligned with participation in value-based care contracts, whether PCPs can influence which health insurance products or plans their patients choose, and how referrals are made and managed.

Key Takeaways From This Analysis:

01 **Compensation mechanics differ by degree of value-based care alignment.**
63% of Leaders receive a performance-based bonus, compared to 21% of Abstainers. 15% of the average PCP's compensation is based on the performance of their panel, increasing to 20% for Leaders.

02 **Significant opportunity exists to change specialist referral management practices.**
PCPs believe that enhanced alignment with certain specialists, such as radiologists and oncologists, can significantly influence the cost of care. Only 24% of PCPs know how much the specialists they refer to charge for services. Despite this, 41% of PCPs would shift their referrals for price discounts of up to 20%.

03 **PCPs have significant influence on patients' decision-making on health plan products.**
62% of PCPs recommend specific plans or products for their patients, and approximately half of their patients frequently or always follow their advice.

04 **The impact of value-based care alignment on clinical decision-making is growing.**
69% of PCPs believe value-based care has more of an effect on clinical decision-making than it did 5 years ago, and 72% expect that impact to continue to grow.

01 KEY TAKEAWAY

Compensation Mechanics Differ by Degree of Value-Based Care Alignment

Compensation is an important tool for practices to influence PCP behavior. Specifically, tying individual compensation to panel or practice performance can align incentives for all stakeholders and enable performance against value-based contracts.

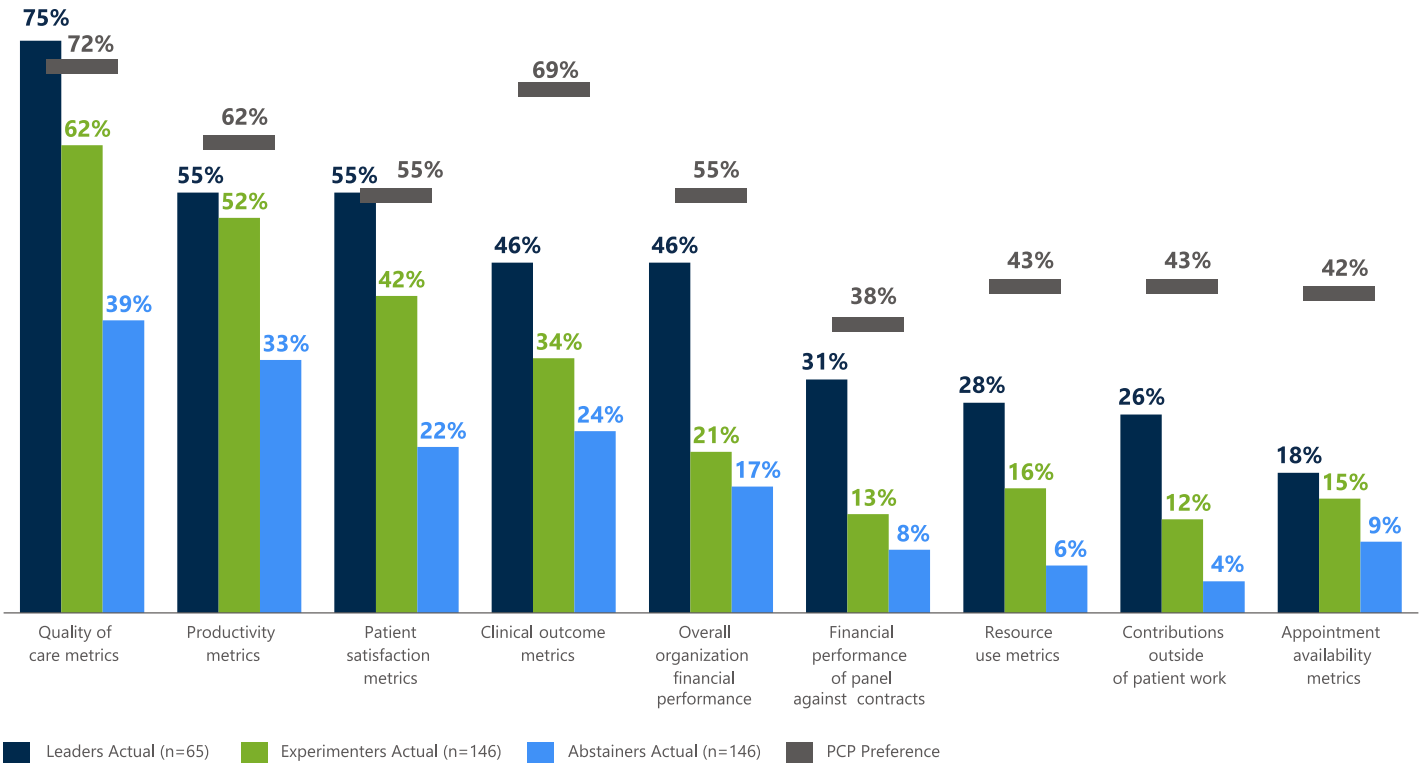
Total compensation can be a combination of many factors. Accordingly, PCPs were allowed to select multiple types of compensation. Salaries are the most prevalent compensation mechanisms, with 57% of PCPs reporting they receive a fixed salary. Interestingly, productivity-based compensation (based on Relative Value Unit [RVU] production) and performance-based bonuses from value-based metrics are similarly prevalent among PCPs, at 42% and 41%, respectively.

COMPENSATION TYPE (% OF COHORT)	LEADERS (N=65)	EXPERIMENTERS (N=146)	ABSTAINERS (N=96)	AVERAGE (N=307)
A fixed salary	46%	55%	68%	57%
Based on productivity	48%	48%	28%	42%
Performance -based bonus (panel, practice or other metrics)	63%	44%	21%	41%
Profit sharing of the business	25%	10%	11%	14%
Other mechanism	2%	3%	3%	3%

Differences in individual compensation mechanisms emerge when comparing PCPs across value-alignment cohorts. Specifically, Leaders are disproportionately more likely to receive bonuses or profit sharing based on practice or panel performance than their peers. 63% report a performance-based bonus, compared with 44% and 21% for Experimenters and Abstainers, respectively. Additionally, Leaders are more likely to participate in the economics of the business, with 25% receiving profit-sharing distributions.

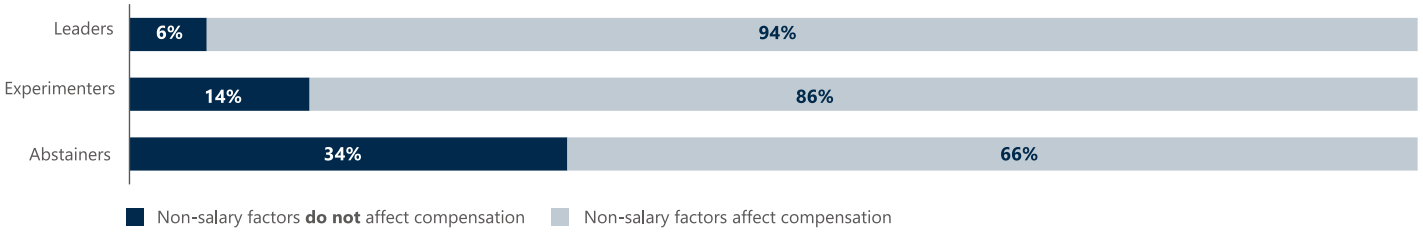
Shown below are the factors that affect PCPs' variable (non-salary) compensation by cohort and the importance PCPs perceive should be ascribed to each, regardless of their use today. The most commonly occurring metric is quality of care, which PCPs agree is the most important factor that should affect compensation. After quality of care, physicians believe clinical outcomes, physician productivity, patient satisfaction, and overall organization financial performance are the top factors that should contribute to variable compensation.

Non-Salary Factors that Affect Compensation (Actual by Cohort vs. PCP Preference)



Particularly noteworthy is the percentage of PCPs by cohort that said none of the factors in the above list affect their compensation. One-third of Abstainers reported this to be the case, compared to only 6% of Leaders.

Non-Salary Factors That Affect Compensation



Finally, the financial performance of PCPs' panels themselves (excluding productivity metrics, such as RVUs) makes up a meaningful share of their overall pay, averaging 15% of total compensation across all PCPs surveyed. The share of total compensation rises to 20% for Leaders and averages 13% for Abstainers. On a median compensation of $287,000 per year for primary care physicians, Leaders could see a total variable compensation of approximately $57,000 per year tied to the financial performance of their patient panel.[1]

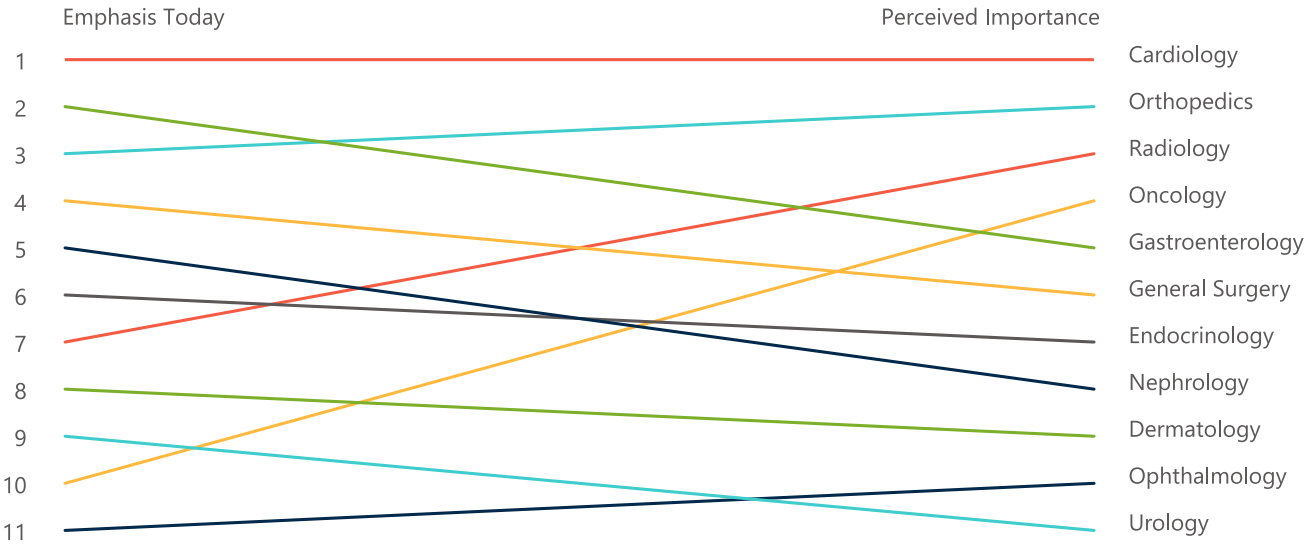
Average Individual Compensation Based on Financial Performance of Panel

02 KEY TAKEAWAY

Significant Opportunity Exists to Change Specialist Referral Management Practices

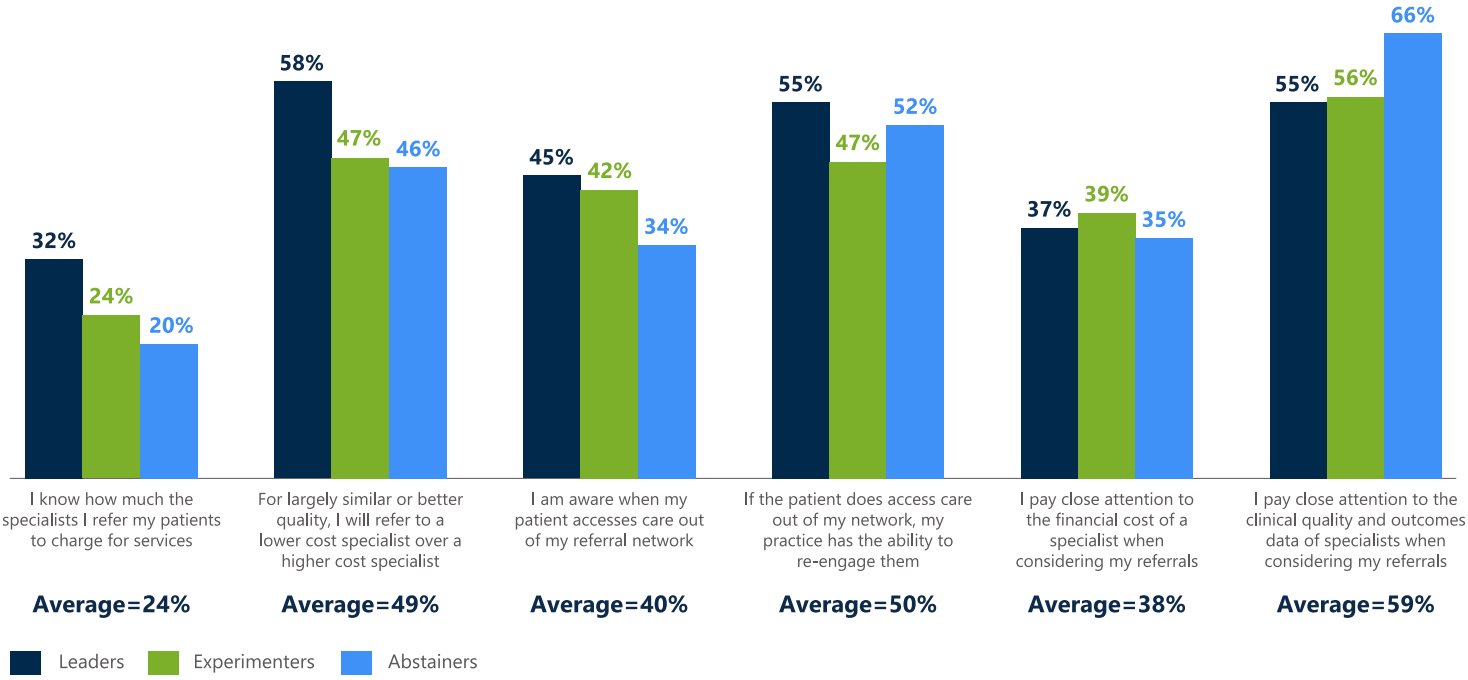
Among primary care physicians, some misalignment exists between which specialists PCPs have strong relationships with today and those who are most impactful to managing against value-based care. The chart below shows the priority of specialist relationships PCPs have today, ranked most to least strong, and compares them to the PCPs' perceptions of those that ideally should be strongest for managing against patient financial outcomes. Cardiology retains its top importance through both scenarios. However, radiology and oncology rise considerably as specialties PCPs should be establishing stronger ties with to manage value-based care contracts. While minor differences exist in the rankings between cohorts, generally they did not differ materially.

Ranked Importance of Specialists in Managing Financial Costs



Looking further into the referral behaviors of PCPs helps to explain the ability of PCPs to create value under these contracts. Our findings show that Leaders more closely manage their referral networks and have a keener understanding of the dynamics at play for specialists they refer to. They are more likely to know how much specialists cost, be willing to refer based on cost, and proactively monitor out-of-network usage. By contrast, Abstainers appear to have a higher focus on clinical quality and outcomes of the specialists they refer to.

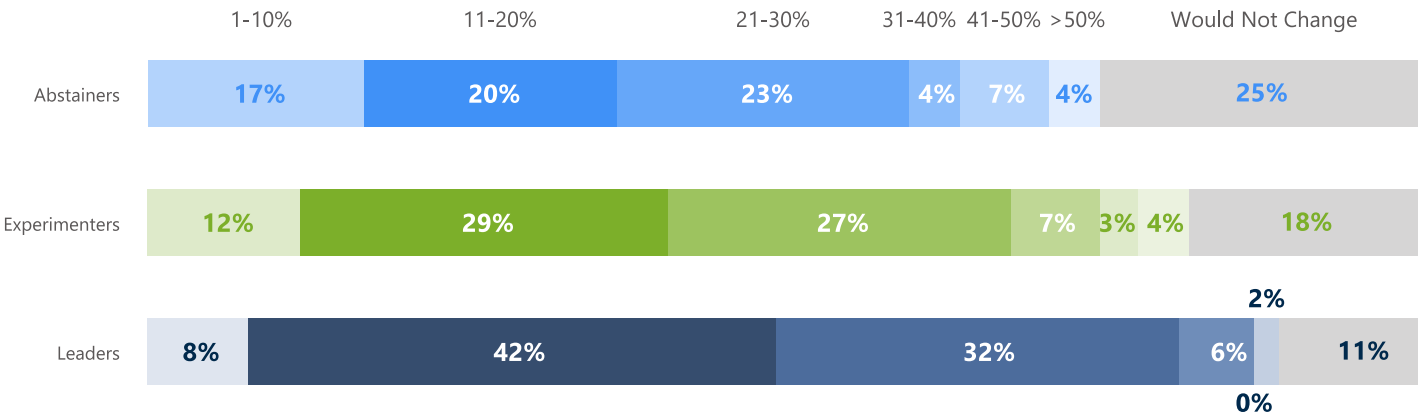
Prevalence of Referral Practices by Cohort



Interestingly, all 3 cohorts score low on their understanding of how much specialists charge for services. On average, only 24% of PCPs agree that they know how much specialists charge for services. While it appears the degree of value-based care alignment is correlated with an understanding of price, only 32% of Leaders report understanding this very important metric.

Finally, when considering referrals based on cost, the cohorts had different tolerances for changing referral patterns. The chart below shows the price differences a PCP would require, by cohort, to change referral patterns for a specialist with demonstrably similar quality and outcomes.

Price Sensitivity Among PCP Referrals



There are 2 important takeaways here:

- First, regardless of cost difference, a greater percentage of Abstainers would not change their referral behavior. When asked if PCPs would consider changing referrals for demonstrably similar quality and outcomes, 25% of Abstainers said they would not consider changing as compared to only 11% for Leaders. That sensitivity is further seen in the level of pricing arbitrage required to affect a referral.
- Secondly, when taking into account price differences of up to 30%, there is greater price sensitivity among Leaders (82%) than Experimenters (68%) or Abstainers (60%). Overall, Leaders were more responsive to price differences when referring patients for care. The sweet spot to affect referrals based on price is somewhere between 11% and 30%. A discount of up to 10%, 20%, and 30% would shift referrals for 12%, 41%, and 68% of all PCPs, respectively.

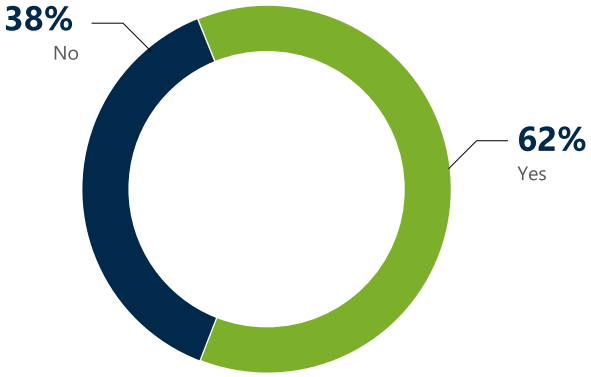
03 KEY TAKEAWAY

PCPs Have Significant Influence on Patients' Decision-Making on Health Plan Products

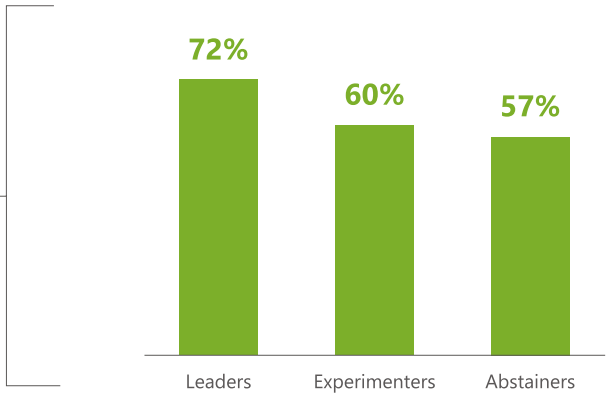
We hypothesize that value-based-care-aligned physicians will influence patients to select certain health plans and products that most closely align to their practice goals and competencies. Focusing panels within select products creates opportunities for the PCPs to capture more value from their efforts across a financially aligned patient population.

Across cohorts, 62% of PCPs reported that they recommend specific health plan products to their patients. This data point shows the influence PCPs have over patient selection of plans. What's more, the difference becomes even more stark when stratified by value alignment. Leaders were far more likely than their Abstainer peers to recommend products, with 72% of Leaders reporting they engage in this activity, as compared to 57% of Abstainers.

% PCPs Who Recommend Specific Health Plans or Products



% Who Recommended by Cohort



Not only are Leaders more likely to recommend specific health plans or products, but they are more convincing. For Leaders, 70% of patients that they recommend specific plans or products to always or frequently follow their advice. This contrasts with only 40% of Abstainers who make recommendations.

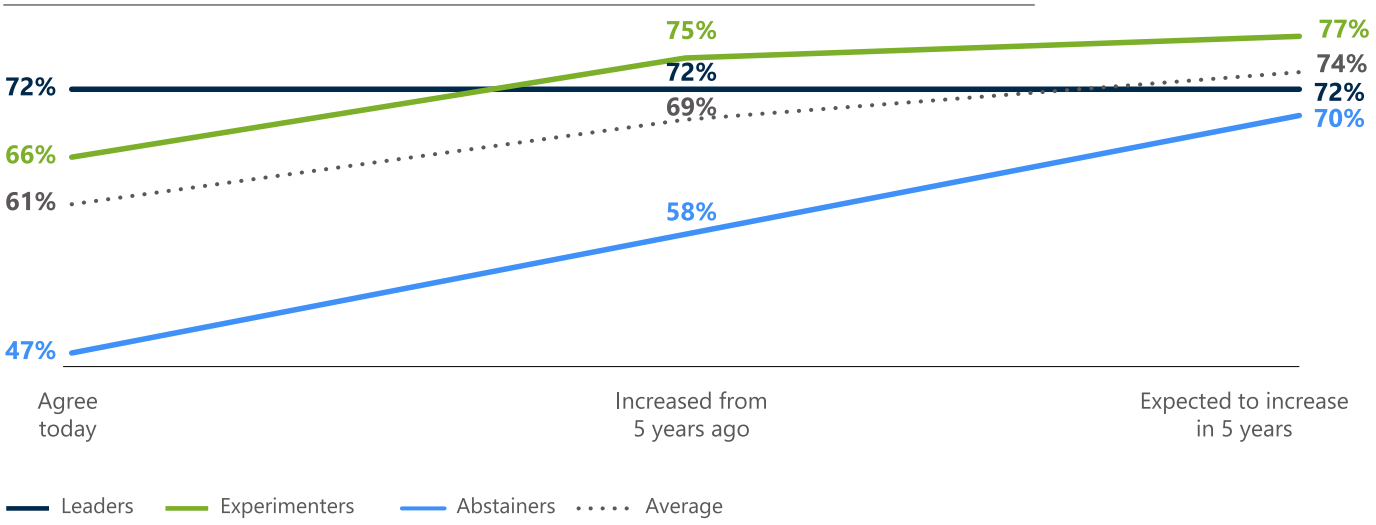
% of Patients Who Follow PCP's Advice on Health Plan Products ("Always" or "Frequently")

The confluence of these data points on the frequency and success rate of influencing health plan product decisions shows the level of influence PCPs have over their patients' decision-making when choosing health plan products. This is an important metric both to health plan marketers and physician practices alike when it comes to driving enrollment outcomes that can align patients with products that provide more affordable care or greater access to services they need to stay healthy.

04 KEY TAKEAWAY

The Impact of Value-Based Care Alignment on Clinical Decision-Making Is Growing

VBC Affects Clinical Decision-Making (% Somewhat or Strongly Agree)



Not surprisingly, 72% of Leaders agree that value-based contracts affect their clinical decision-making today. However, somewhat surprisingly, the estimate of this impact appears to be static over time, with the same percentage agreeing that its effect has increased from 5 years ago and will continue to increase. By contrast, Abstainers believe the trajectory of this impact is far more profound. 58% believe it is more acute than 5 years ago, and 70% believe it will increase over the next 5 years.

Implications and Opportunities

Physician compensation is an important tool for practices to align goals and incentives. Referrals have a significant impact on the cost to deliver care. Health plan product enrollment enables value-oriented PCPs to capture the value of their efforts. Significant differences among these 3 important areas exist, correlating to degree of value-based care alignment.

Across the board, Leaders are more likely to receive compensation for their value-based care efforts and outcomes, engage in referral management activities that can drive better outcomes and lower costs, and proactively drive enrollment into specific health plans and products. Primary care practices looking to advance their participation in value-based care models should consider these 3 areas as ways to drive value and align to common practices among Leaders in the space.

Delivering on a value-based care mandate requires effective practice capabilities and supporting infrastructure. We will focus our upcoming analysis on detailing the PCPs' specific capabilities to deliver on value-based care, how practices approach risk adjustment, the leverage model in which they operate, and how all of these factors translate to PCP workload and satisfaction.

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ACKNOWLEDGMENTS

This survey was informed by leaders from both our Private Equity Advisory and Strategy practices, including Bret Anderson, Todd Fitz, and Roger Ray, MD. Special thanks to Jun Chen, Ben Kelty, and Christopher Lu for supporting the development and evaluation of the survey findings.

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SOURCES

1. 2022 MGMA National Median, 2021 Data, Primary Care Physician median

About the Survey Data

SOURCE

We partnered with our survey administration firm ROI Rocket to field this survey in August 2022 with a target n=300 (n=307 achieved). We surveyed a representative sample of self-identified primary care physicians throughout the United States. Individuals captured in these data must have been a primary care physician who actively practices medicine and whose patient panel is at least 10% seniors. Those not meeting these criteria were not included in the results.

QUALIFICATIONS

Respondents to this survey must have met the following qualifications to be included in the n=307 sample used for our analysis:

QUESTIONS	ACCEPTABLE RESPONSES
What best describes your profession?	• Physician
What is your primary specialty as a physician?	• Primary Care • Family Medicine • Internal Medicine • Geriatric Care
Do you actively practice medicine today?	• Yes
In your estimation, what % of your patient panel is 65 years of age or older?	• 10-25% • 26%-50% • 51-75% • 76-90% • Over 90%

RESPONDENT PROFILE

	TOTAL	LEADERS	EXPERIMENTERS	ABSTAINERS
Total Responses	**307**	**65**	**146**	**96**
Reported Physician Specialty (Question: What is your primary specialty as a physician?)				
Family Medicine	59%	58%	60%	59%
Geriatric Care	2%	2%	2%	1%
Internal Medicine	18%	17%	15%	23%
Primary Care	21%	23%	23%	17%
Years Practicing (Question: How many years have you been practicing in your current specialty?)				
1-5	23%	12%	21%	33%
6-10	16%	17%	18%	11%
11-20	27%	26%	32%	20%
21-30	25%	34%	24%	20%
>30	10%	11%	5%	16%
Geographic Distribution (Question: In what state do you practice?)				
Midwest	26%	31%	25%	23%
Northeast	18%	15%	20%	18%
South	35%	28%	36%	38%
West	21%	26%	19%	22%
Employment Model (Question: What is the best way to describe your physician practice?)				
Employed by a single hospital or a multi-hospital health system	48%	32%	57%	46%
Independent physician practice not employed by a hospital or health system	50%	68%	42%	52%
I don't know	1%	0%	1%	2%
Payer Mix (Question: In your estimation, what is the health insurance mix of your practice?)				
Commercial	41%	39%	44%	36%
Medicaid (including Managed Medicaid)	16%	17%	15%	16%
Medicare (including Medicare Advantage)	33%	37%	32%	32%
Self-Pay, Uninsured, or Other	11%	6%	9%	16%

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