

TAFP MEMBER ASSEMBLY WITH COUNCIL FORUMS

Friday, April 12, 2024

6:30 – 8 p.m.

Ballroom

Renaissance Austin Hotel

AGENDA

1. Call to order by Terrance Hines, MD, President
2. Welcome and introductions
3. Report on quorum – Adrian Billings, MD, PhD
4. Family Medicine Career Benchmark Dashboard – Emily Briggs, MD, MPH
5. Council updates
 - a. Council on Health of the Public – A. Peter Catinella, MD
 - b. Council on Workforce and Member Engagement – Laura Nietfeld, MD
 - c. Council on Medical Practice – Tina Philip, DO
6. Medical Practice in 2024 and beyond: TAFP President-Elect Dr. Lindsay Botsford will facilitate a panel with Norman Chenven, MD, Austin Regional Clinic; Clare Hawkins, MD, Main Street Health; and Stephen Bekanich, MD, Aledade. Topics include:
 - a. Transitioning to value-based care – change at a snail’s pace
 - b. Challenges with patient attribution
 - c. How can we rein in administrative burdens
7. Other business
8. Adjourn

2023 AAFP Career Benchmark Dashboard

National Data Brief

Texas Academy of Family Physicians Meeting



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Using the Dashboard

The dashboard's salary and other data can help you establish a realistic perspective and develop a fair salary range for evaluating your compensation package. You can use the data as a benchmark to evaluate an employer's offer or to make a counteroffer based on your value and expectations. You can also use the data to demonstrate your credibility and marketability by showing that you have done your research and that you are aware of industry standards and trends.

While the salary and other data in the dashboard can be a powerful tool for your negotiation, you should not rely on it alone. You should also consider other factors, such as the employer's budget and needs, the demand for and supply of your skills, the total package of benefits and perks offered, and the work environment and culture.

Finally, please note that information provided by the AAFP is not a suggestion, invitation, direction, or recommendation as to what you should ask for or what you should be paid. You must make that determination based on your own and the employer's needs, your skills and experience, regional and/or practice-specific circumstances, the total benefits package and the other terms and conditions of employment offered, your business judgment, and other factors within your discretion. The dashboard is intended to increase the quality and availability of relevant information in the field of family medicine as a means to enhance, not suppress, competition for the services and care for patients that family physicians provide.

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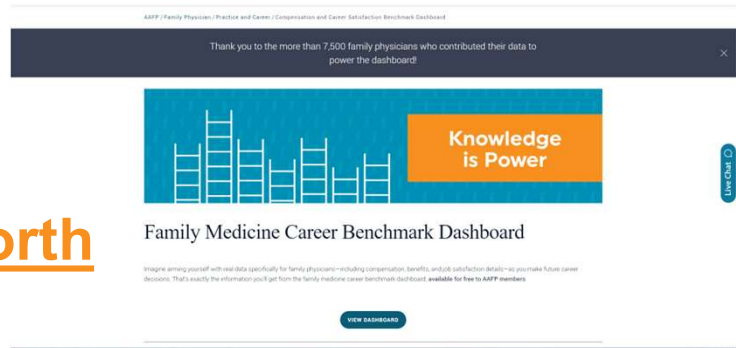
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Career Benchmark Dashboard

Access the dashboard at:

www.aafp.org/worth

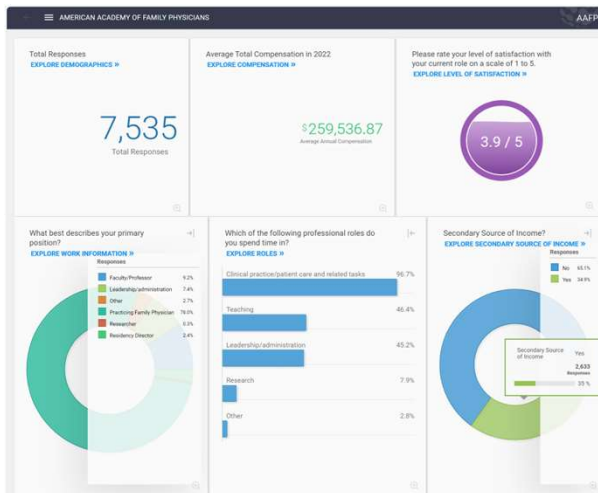


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Overview



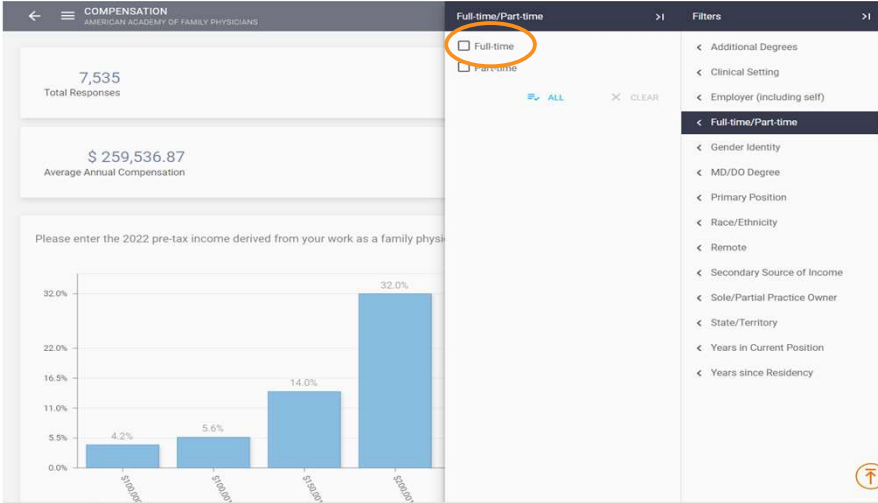
- Includes 7535 responses
- Data collected in 2023 about 2022 compensation
- Compensation shown is the average of full-time and part-time responses
 - 16.8% are part-time
- Click “EXPLORE...” to find much more information for each of the six sections

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Tips for using filters

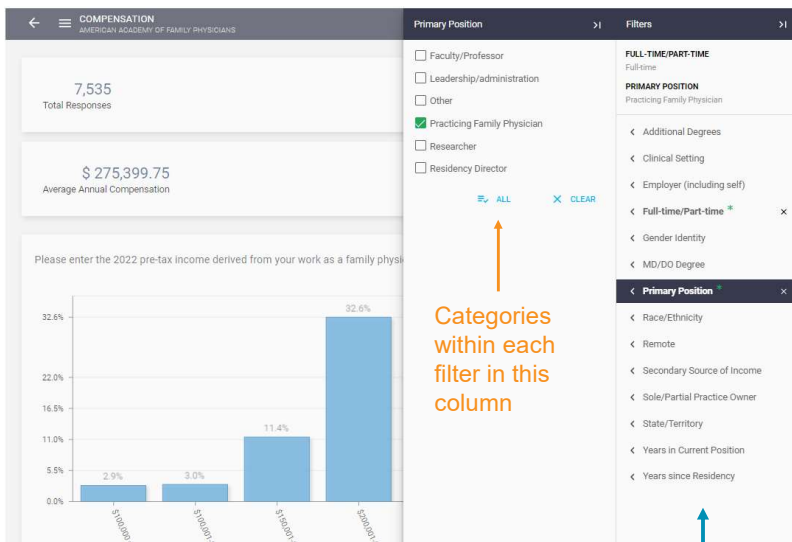


Always add the “Full-time” filter unless you are specifically interested in seeing part-time data

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Categories within each filter in this column

Use filters to narrow down data to compare similar positions or demographics

Click on a filter of interest and then categories within that filter will show

Filters in this column

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The screenshot shows a dashboard for 'SATISFACTION' with 'AMERICAN ACADEMY OF FAMILY PHYSICIANS' branding. It features three main data points: '7,535 Total Responses', '\$ 299,201.54 Average Annual Compensation', and a satisfaction score of '4.3 / 5'. A 'Filters' sidebar is open on the right, listing categories like 'FULL-TIME/PART-TIME', 'PRIMARY POSITION', and 'STATE/TERRITORY'. The 'FULL-TIME/PART-TIME' filter is highlighted with an orange circle. Below the filters, there are two horizontal bar charts showing satisfaction levels on a scale of 1 to 5. A blue bar at the bottom contains the number '7' and the text 'AMERICAN ACADEMY OF FAMILY PHYSICIANS'.

Filters do not transfer between categories

Filters in use show up at the top of the list

Click ">|" to collapse or expand filter list

Collapse filter list before scrolling down to view data

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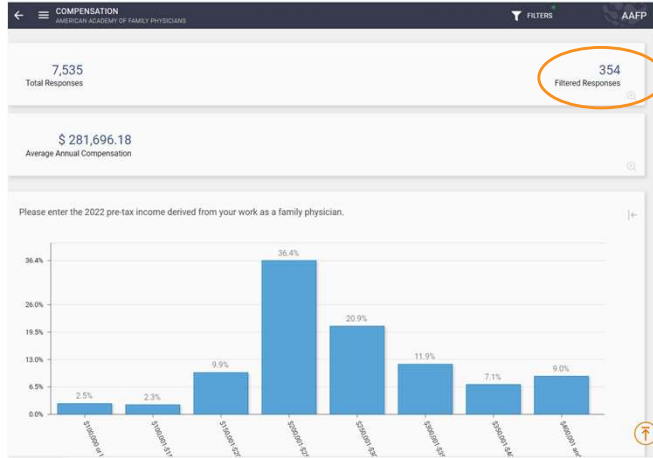
The screenshot shows the same dashboard as slide 7, but with a 'PRIVACY GUARD' overlay. The text 'NO DATA WITH CURRENT FILTERS' is displayed in blue. The 'Filters' sidebar is collapsed, indicated by a '>|' icon. The satisfaction score and compensation data are still visible. A blue bar at the bottom contains the number '8' and the text 'AMERICAN ACADEMY OF FAMILY PHYSICIANS'.

A privacy guard appears when there are fewer than 11 responses to protect the respondents' privacy.

If this happens, remove filters or select more categories in a filter to access data.

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Exploring Data



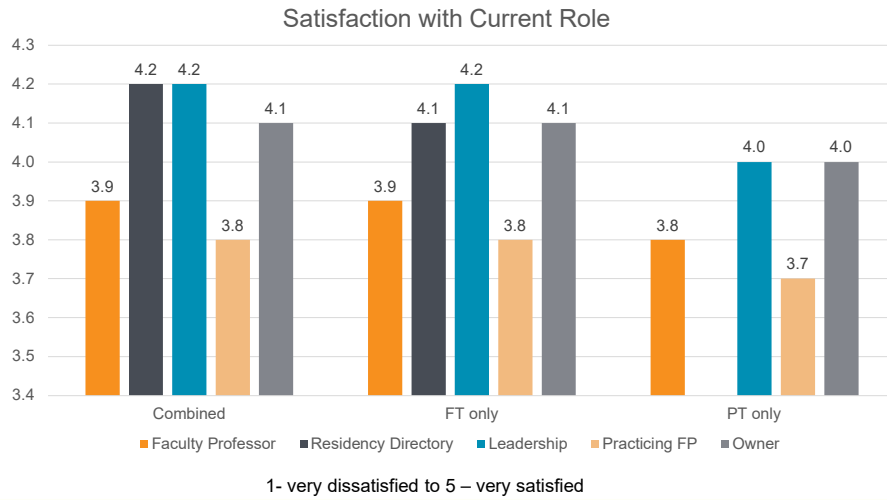
- Use state filter (TX shown here)
- The number of responses included with filter is shown in top right
- Average Annual Compensation is shown at top of every category
- Try using Primary Position filter

← salary distribution in TX

Data Snapshots

National Level

Exploring Primary Position – National Data

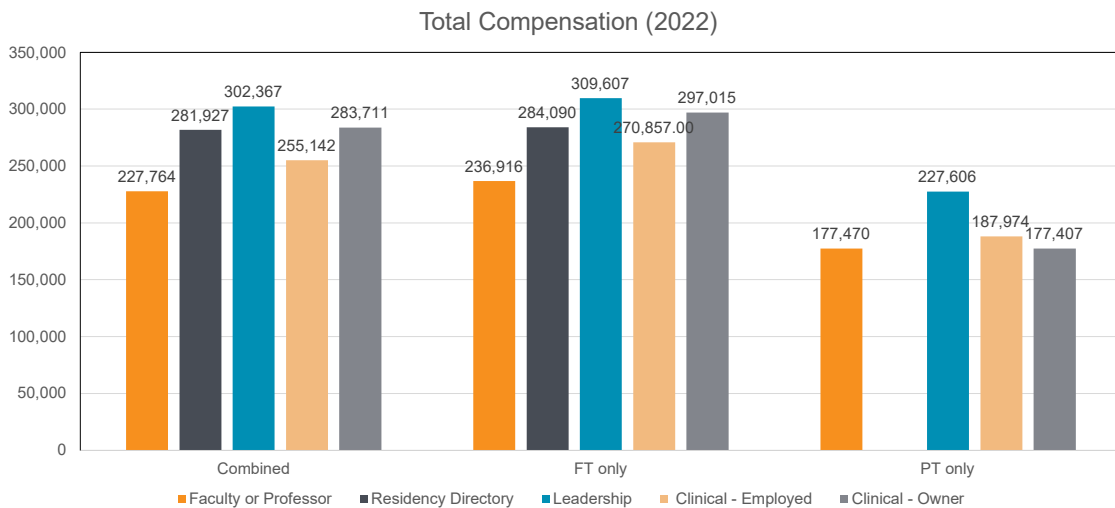


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Compensation by Primary Position

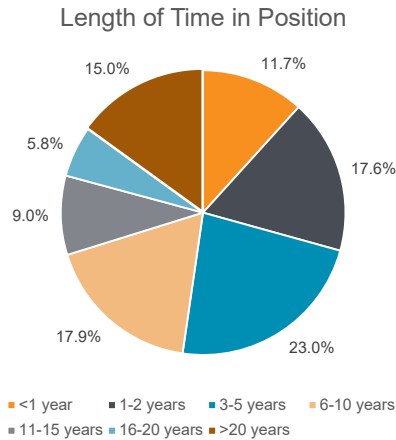


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Current Position



Reported Primary Role	% of Responses
Practicing Family Physician	78.0%
Faculty/Professor	9.2%
Leadership or administration	7.4%
Other	2.7%
Residency Director	2.4%
Researcher	0.3%

Top 5 Family Physician Employer Types

1. Hospital or health system (50.8%)
2. Physician-owned group (11.7%)
3. FQHC/Community health center (9.8%)
4. Self-employed/Practice owner (9.2%)
5. University/Academic Appointment (6.2%)

Top 5 Settings Where Family Physicians See Patients

1. Ambulatory clinical practice (79.0%)
2. Hospital inpatient (25.3%)
3. Academic health center (18.3%)
4. Nursing home/assisted living/hospice (11.5%)
5. Telemedicine/virtual care (10.4%)

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Compensation Structure and Benefits

Top 3 Elements of Compensation Structure

- Base salary (70.5%)
- Incentives or bonus (37.6%)
- Productivity-based salary (RVUs) (34.8%)



Most Common Benefits

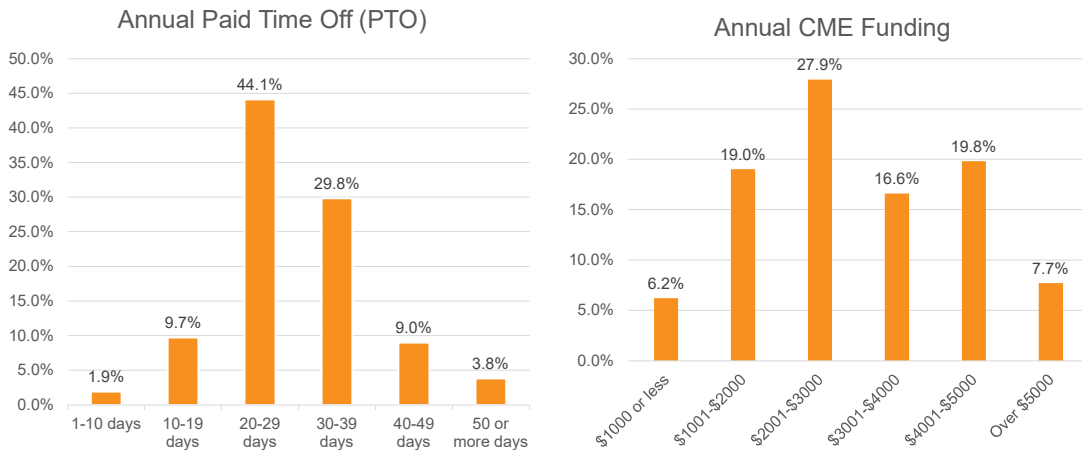
- Malpractice insurance (90.1%)
- Health insurance (86.6%)
- Retirement plan (84.2%)
- CME allowance (81.1%)
- Dental insurance (79.1%)

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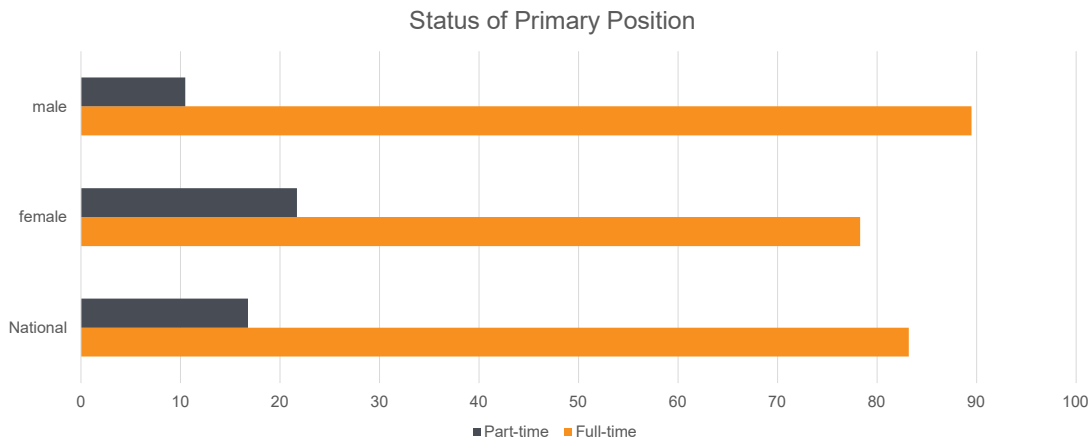
Selected Benefits (Full-time Only)



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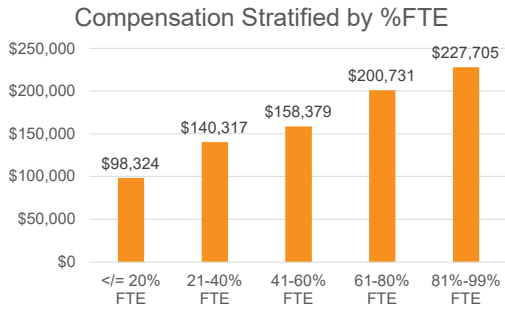
Full-time vs Part-time Work



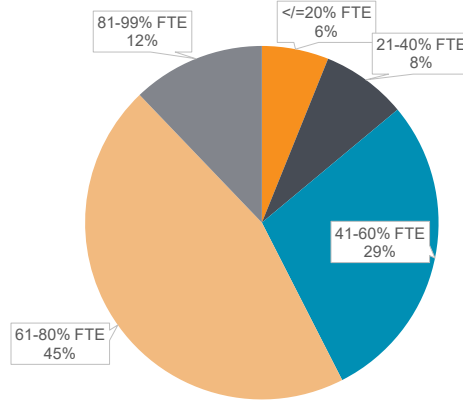
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Compensation – Part-time Physicians



Number of Physicians by %FTE



Additional Career Resources

Career & Employment Resources

[Five Signs of a Good Employer](#)

[AAFP Careerlink \(Job Board\)](#)

[Physician Employer Checklist](#)

[Find a Job Resources](#)

[Non-Physician Clinician Supervision Resources](#)

[Employment Contracting](#)

[Non-Physician Clinician Supervision On-demand CME](#)

[Negotiation Skills Video Series](#)

[Career Coaching](#)

[Physician CV Templates](#)

[Member Advantage Partner - Resolve](#)

BEST PRACTICES FOR

Health Care Organizations Employing Family Physicians

The American Academy of Family Physicians (AAFP) has developed a set of principles for health care organizations that value and prioritize family medicine and primary care to optimize the employment of family physicians. For health care organizations that plan to employ family physicians and want to better understand what matters to them, the AAFP has created a set of recommended practices within each principle that employers can use to help promote continuity in the patient-physician relationship—which, in turn, leads to better health outcomes—and to improve professional satisfaction and retention of family physicians, advance the performance objectives of health care organizations, and support equity.



Practice Resources

AAFP CME **Family Physician** Med Student & Resident Events Membership Advocacy News


AAFP / Family Physician / Practice and Career

Practice & Career

Advance your practice and career with trusted tools, resources, and information.

- Administrative Simplification
- Getting Paid
- Managing your Practice
- Value-Based Payment and Delivery

www.aafp.org/family-physician/practice-and-career.html



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Recognizing the Value of Primary Care: Increasing Payment Resources

Get paid for the care you deliver.

Find comprehensive tools and resources to help you code accurately and optimize documentation and payment.

- [Billing & Coding Resources](#)

Decoding G2211: Myths *Versus* Facts

- [G2211](#)



AAFP Primary Care Investment Toolkit

- [Primary Care Investment Toolkit](#)
- [Primary Care Investment Matrix](#)




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Recognizing the Value of Primary Care: Value-Based Payment Resources


How to Succeed in Value-Based Care





Hierarchical Condition Categories

Learn how using team-based strategies can optimize risk adjustment in your practice with this [Family Medicine Practice Hack video](#).



Risk Stratification Tools

Need help getting started? Download the free [BSCM rubric](#) and [scoring algorithm](#) to identify patients who may benefit from ongoing care management.




A Guide to Easing into Value-based Payment

There are [many reasons](#) family physician who have been successful with value-based care and payment recommend trying it. If you're interested in getting started, these initial steps—with advice from peers—can set you on the right path:

- [Optimize fee-for-service](#)
- [Empower your team](#)
- [Improve diagnosis coding to reflect patient acuity](#)

Reduce Administrative Complexity

[Administrative Simplification Resource Library](#)

 <p>Documentation Burden</p> <p>Continuous process improvements such as these can help you spend more time with patients and less time with paperwork.</p> <p>REDUCE DOCUMENTATION BURDEN ></p>	 <p>Prior Authorization</p> <p>Complementing the AAFP's advocacy for prior authorization reform, guidance to help your practice streamline the PA process.</p> <p>REDUCE PRIOR AUTHORIZATION BURDEN ></p>	 <p>EHR Inbox</p> <p>Ahead of essential systemic changes the Academy is pushing to realize, key ways to reduce time spent on inbox management.</p> <p>REDUCE EHR INBOX BURDEN ></p>
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Techniques



Technologies



Transformations

[Advocating to Reduce Payer Burden](#)

FPM **BEYOND THE BELTWAY: IMPROVING PAYMENT & REDUCING BURDEN** 

Understanding and adopting technology

[Telehealth Resource Library](#)

[Free CME on ways AI Transforms Practice](#)



Comparing Telehealth Services

Learn about your options and how to choose the right technology and vendors.



Telehealth and the End of the Public Health Emergency

Get answers to common questions about telehealth.



Legal Requirements for Telemedicine

Learn more about the telehealth legal requirements.



Setting up Professional Continuous Glucose Monitoring

Get a quick overview of the process of getting your professional CGM program set up.



NEW

AI in FM: Transforming Your Practice



Telehealth Optimization Tips

A family physician gives her tips for refining your telehealth workflows and shares steps to improve your practice.



CME: Telemedicine and Simplification

As part of a CME package on reducing administrative burdens, learn how to make your practice more efficient.

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TAFP calls on insurers to provide payment for G2211 complexity add-on code

By Jonathan Nelson

February 29, 2024

The Centers for Medicare and Medicaid Services introduced a set of new codes to the Healthcare Common Procedure Coding System in the 2024 Medicare Physician Fee Schedule that are designed to compensate physicians for care coordination and other services necessary to provide comprehensive, longitudinal care to complex patients. However, many health insurance companies have not begun paying for the codes, the most important of which is the G2211 add-on code for visit complexity.

This week, TAFP and the Texas Pediatric Association [sent letters to the chief medical officers](#) of the five largest health insurance companies in Texas – Blue Cross Blue Shield of Texas, Aetna, United Healthcare, Cigna, and Humana – asking them to provide payment for the codes across all lines of business.

“Primary care is comprehensive, continuous, and coordinated team-based care that is not adequately described by the revised office/outpatient E/M visit code set and includes resources not reflected in the current relative values assigned to that code set,” the associations said in the letter. “Payment for G2211 more appropriately values family medicine and pediatrics and will help stabilize the primary care workforce, especially community-based primary care practices patients rely on for their care. In turn, this will help prevent practice closures and consolidation, which can negatively impact patient access, care quality, and affordability.”

Along with G2211, the associations advocated payment for the G0019 and G0022 Community Health Integration Services codes, the G00223 and G0024 Principal Illness Navigation Services codes, and G0136, which pays for the administration of a standardized, evidence-based social determinants of health risk assessment tool. Medicare pays \$16.05 for G2211.

“AAFP and TAFP worked for years to get CMS to implement these codes to more appropriately compensate family doctors and other primary care physicians for the crucial work they do improving the health and the lives of their patients,” TAFP CEO Tom Banning said. “Now we need to make sure the payers know that these codes aren’t only for traditional Medicare, but they should be paying these codes in their Medicare Advantage plans, their Medicaid plans, and their fully insured and self-funded commercial plans as well.”

For more information about how and when to use G2211, check out a recent article in Family Practice Management, [“G2211: Simply Getting Paid for Complexity.”](#)

Month XX, 2024

Contact Name
 Contact Title
 Payer name
 Payer address
 City, State, Zip

Dear [Payer Contact]:

The Centers for Medicare & Medicaid Services (CMS) recently finalized new Healthcare Common Procedure Coding System (HCPCS) codes for implementation and payment in the 2024 Medicare Physician Fee Schedule (MPFS) final rule. The AAFP [recommended](#) and [supported](#) these codes to more appropriately pay family physicians as they provide comprehensive, longitudinal care and work to address patients’ health-related needs. The **chapter** regularly communicates with its members regarding important changes to payment policies. As such, we are writing this letter to understand [payer’s] payment policies for your commercial (fully insured and self-funded), Medicare Advantage, and Medicaid plans for each of these codes. We urge [payer] to provide payment for these codes in all lines of business. Below we highlight the new codes and our rationale for support.

G2211 Add-on Code for Visit Complexity

- [Evidence](#) demonstrates that continuous primary care is more complex, comprehensive, and impactful. G2211 is needed to better account for the unique costs of providing this important longitudinal care relationship.
- Implementation and payment of G2211 aligns with the importance of increasing investment in primary care to improve health outcomes and reduce costs by reducing hospitalizations, improving chronic disease management, and enhancing patient satisfaction.
- G2211 recognizes the additional complexity inherent in the delivery of continuous, comprehensive, [coordinated](#) primary care, which includes managing multiple conditions, considering diverse social factors, and coordinating care pathways over time.
- Primary care is comprehensive, continuous, and coordinated team-based care that is not adequately described by the revised office/outpatient E/M visit code set and includes resources not reflected in the current relative values assigned to that code set. The **Chapter** believes these points are consistent with observations CMS itself made when it originally finalized G2211 in the 2021 MPFS [final rule](#).
- Payment for G2211 more appropriately values family medicine and will help stabilize the primary care workforce, especially community-based primary care practices patients rely on for their care. In turn, this will help prevent practice closures and consolidation, which can negatively impact patient access, care quality, and affordability.

G0019 and G0022 Community Health Integration (CHI) Services

- CHI services enable physicians to better address a patient’s identified social needs within a community context and in coordination with a patient’s usual source of primary care.

STRONG MEDICINE FOR AMERICA

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Speaker Russell Kohl, MD <i>Stilwell, KS</i>	Vice Speaker Daron Gersch, MD <i>Avon, MN</i>	Executive Vice President R. Shawn Martin <i>Leawood, KS</i>		

- There is growing evidence that community health workers are uniquely equipped to build relationships with underserved patients by helping them address health-related social needs and navigate the health care system more effectively which leads to better outcomes for individuals as well as reductions in the use of emergency department visits and inpatient hospital admissions.

G0023 and G0024 Principal Illness Navigation (PIN) Services

- PIN services provide patient education, support, and reminders, which can improve medication adherence and overall engagement with treatment plans. This can lead to better disease control and lower complication rates, which saves money while improving outcomes.
- Effective navigation can help patients access appropriate healthcare services and resources, potentially reducing unnecessary emergency room visits and hospital admissions.
- Navigators can bridge the communication gap between patients and physicians, facilitating clear understanding of treatment plans and addressing patient concerns.

G0136 Administration of a standardized, evidence-based social determinants of health (SDOH) risk assessment tool

- SDOH assessments can identify patients at risk for complications or poor adherence due to factors like food insecurity, transportation issues, or housing instability. Addressing these factors early can prevent worse health outcomes down the line, leading to decreased medical costs for insurers.
- Integrating SDOH assessments into routine care allows for a more comprehensive understanding of the patient's situation and tailoring treatment plans accordingly. This can lead to better disease management and higher treatment success rates.
- While there is value to assessing SDOH risk, there is also practice expense associated with doing so, expense that G0136 is intended to address.

In addition, we would like to know if physicians participating in value-based contracts (e.g., partial or full risk agreements) in your networks will be able to bill for these codes. If [payer] has determined to pay for these codes only in certain business lines or has decided not to pay for these codes at all, please provide context for this approach, so we may gain insight into your decision-making process.

For additional information or to schedule a follow-up call, ***please contact...***

Sincerely,