THE $10,000 QUESTION:
TACKLING THE COMPLEXITIES OF VALUE-BASED PHYSICIAN COMPENSATION

HFMA – First Illinois Chapter
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Agenda

> Background & Context
> Measures & Methods
> Simulating & Transitioning to the New Plan
> Summary & Conclusion
Tackling the Complexities of Value-Based Physician Compensation

BACKGROUND & CONTEXT
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Healthcare Delivery Is Shifting…

- Fragmented care → Coordinated/Integrated care
- Reactive “sick-care” → Proactive “well-care”
- Only treating individuals → Caring for a population
- Payer-driven managed care → Provider-driven accountable care
Physician Compensation Models Typically Emphasize Volume over Value

Typical Compensation Model

- Base: 80%
- Incentive: 20%
- Value: 5%
- Volume: 15%

Value-based compensation models typically affect only 5 – 10 percent of total compensation.

2014 Merritt Hawkins Survey
Why Isn’t Value Emphasized in Current Physician Compensation Models?

**It’s still a volume-based world**
- Government payers (e.g., Medicare and Medicaid) are experimenting with value-based reimbursement, but still primarily pay using a fee-for-service (“FFS”) model.
- The same is true for commercial payers.

**Measuring value is challenging**
- No standard or “best practice” approach to measuring quality exists.
- Total cost of care data has traditionally been unavailable.

**Providers fear the “bleeding edge”**
- Leaders will not test new revenue or compensation models, fearing that change will lead to a near-term decline in revenue.
- Physician compensation models generally lag behind changes in revenue models.
Traditional FFS Reimbursement Misaligns Payer and Provider Financial Goals
New Revenue Models Are Pushing Providers to Focus on Delivering Value
Value-Based Models Reward Providers for Their Collaboration in Delivering Value
Value = \frac{Quality}{Cost}

> Shifting focus from volume to value in health care is a central challenge.
> Measuring value based on results (outcomes), not volume of services delivered, is critical.
> Those who deliver value should be rewarded for it.

What are the drivers of value?

> A) Increased quality and decreased cost.

> B) Increased quality and cost.

> C) Decreased quality and increased cost.

> D) Decreased quality and cost.
Potential Risks in Transition to Value-Based Compensation

> Possible downshifting to focus on higher quality and/or cost management
  - Incentives may encourage activities that reduce revenue

> Possible mixed messages in markets where some revenue is fee-for-service and some is value-based
  - Difficult to reconcile incentives that will encourage behavior in mixed markets

> Physicians can become dissatisfied if:
  - Compensation falls, even in the short term
  - The new plan is perceived as “unfair,” “inequitable,” or “too complex”

> Fair Market Value may be compromised
  - Published benchmarks have not yet incorporated quality and how it should be or is being paid for
Tackling the Complexities of Value-Based Physician Compensation

MEASURES & METHODS
Desired Outcomes Should be Measurable

- Many things to measure
- Many measures can be used
- Select measures based on organizational goals
- Consider data sources
- Do not measure everything!
### MEASURES & METHODS

#### Use Measures Appropriate for Your Goals

<table>
<thead>
<tr>
<th>Patient Satisfaction &amp; Citizenship</th>
<th>Preventive Health</th>
<th>Care Management</th>
<th>Population Health Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction</td>
<td>Process measures:</td>
<td>Availability for</td>
<td>Utilization management:</td>
</tr>
<tr>
<td>Peer review</td>
<td>Vaccination</td>
<td>same day primary</td>
<td>Unplanned 30-day</td>
</tr>
<tr>
<td>Coding accuracy</td>
<td>Screening</td>
<td>care follow-up</td>
<td>readmissions</td>
</tr>
<tr>
<td>Medical record completion</td>
<td></td>
<td>Primary care</td>
<td>Hospital utilization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>follow-up within 3-</td>
<td>SNF utilization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 days after</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>hospitalization</td>
<td>Total cost of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cost of episodes of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usage of lower-cost alternatives as applicable (e.g., urgent care, home health, primary care)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcomes for diabetes, asthma, and heart failure</td>
<td></td>
</tr>
</tbody>
</table>

**Use Measures Appropriate for Your Goals**

**Patient Satisfaction & Citizenship**
- Patient satisfaction
- Peer review
- Coding accuracy
- Medical record completion

**Preventive Health**
- Process measures:
  - Vaccination
  - Screening

**Care Management**
- Availability for same day primary care follow-up
- Primary care follow-up within 3-7 days after hospitalization
- Usage of lower-cost alternatives as applicable (e.g., urgent care, home health, primary care)
- Outcomes for diabetes, asthma, and heart failure

**Population Health Management**
- Utilization management:
  - Unplanned 30-day readmissions
  - Hospital utilization
  - SNF utilization
  - Total cost of care
  - Cost of episodes of care
Measuring Value Evolves from “Quality Lite” to Those Affecting Outcomes and Cost

Value-Based Incentive Metrics by Service Line

How many measures are reasonable? 1 to 5? 6 to 10? More than 10?

Note: Percentages do not add to 100% due to multiple response categories.
## MEASURES & METHODS

### Methods for Rewarding Improved Value

<table>
<thead>
<tr>
<th>Basis for Payment</th>
<th>Description</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| Improvement in Quality Score | Physician is rewarded if his/her own quality score improves from baseline | • Rewards improvement  
• May have most impact on overall population health | • Penalizes those with strong quality at the outset |
| Absolute Quality Scores    | Physician is rewarded if he/she reaches or exceeds a set threshold           | • Easy to describe and understand  
• Dollars available to all | • Difficult to find relevant benchmarks |
| Comparison with Peers      | Physician is rewarded depending on how he/she compares to peers             | • Easy to implement.  
• Realistic and achievable | • Targets vary and are constantly moving based on group performance  
• Can slow progress of change  
• Will produce winners and losers |
Why is it important to initially minimize changes in the new compensation model?

> A) To limit the potential shared savings bonus pool.

> B) To penalize those with strong quality scores at the outset.

> C) To mitigate physician dissatisfaction and FMV concerns.

> D) To eliminate the potential compensation decreases in the early years.
Tackling the Complexities of Value-Based Physician Compensation

SIMULATING & TRANSITIONING TO THE NEW PLAN
Understand the Current Compensation Model

> Understand compensation components and current compensation
> Review productivity and performance metrics
> Assess current revenue streams (i.e., how much are P4P/innovative payments versus FFS?)
> Interview key stakeholders

Value distributions:
- Shared Savings
- Pay for Performance

Incentives:
- Productivity
- Quality
- Total Cost of Care (“TCOC”)

Other Components:
- AS&T
- On-Call

Base Compensation
General Compensation Model Goals

The compensation plan should strive to be a **FEAST**:

> **F**lexible, can evolve over time

> **E**quitable among group physicians

> **A**ccountability and responsibility are promoted

> **S**ustainable financially

> **T**ransparent, objective, and easy to understand and administer
SIMULATING & TRANSITIONING TO THE NEW PLAN

Potential Changes to Compensation Model

Current: $150,000

- Base: $120,000
- Incentive: $30,000
- Productivity: $30,000

Quality Add-On: $154,000

- Base: $120,000
- Incentive: $30,000
- Productivity: $30,000
- Value: $15,000

Productivity Carve-Out: $150,000

- Base: $120,000
- Incentive: $30,000
- Productivity: $30,000
- Value: $15,000

Hybrid: $154,000

- Base: $120,000
- Incentive: $34,000
- Productivity: $30,000
- Value: $19,000

Total Value
- Hybrid: $19,000
- Productivity Carve-Out: $15,000
- Quality Add-On: $19,000
- Current: $15,000
# Potential Changes to Compensation Model

## SIMULATING & TRANSITIONING TO THE NEW PLAN

<table>
<thead>
<tr>
<th>Model</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td>• Aligns physician with practice goals under a FFS world</td>
<td>• Focuses on past or current revenue models, but not future</td>
</tr>
<tr>
<td></td>
<td>• Physicians who produce the most, earn the most</td>
<td>• Does not encourage value</td>
</tr>
<tr>
<td><strong>Productivity Carve-Out</strong></td>
<td>• Encourages both volume and value</td>
<td>• Less incentive for productivity could result in lower productivity, thereby potentially reducing revenues</td>
</tr>
<tr>
<td><strong>Quality Add-On</strong></td>
<td>• Aligns physician with practice goals under a FFS world</td>
<td>• Value incentive may not be enough to align physician behavior</td>
</tr>
<tr>
<td></td>
<td>• Physician compensation increases equivalent to value-based payments</td>
<td></td>
</tr>
<tr>
<td><strong>Hybrid</strong></td>
<td>• Encourages both volume and value</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
Shifting Dollars from Productivity to Quality in a Budget Neutral Compensation Model May Not Be Enough

> Quality should ideally be an add-on (but consider budget and FMV)
  - Aligns physicians with value-based initiatives, while also rewarding for revenue production
  - Maintains compensation satisfaction for providers who struggle with quality

What’s Next?

> It is critical to simulate the model using actual data because:

- It is the only way to know impact on individual physicians
- It is a way to evaluate data coming from EHR
- It informs budget process
- Considers Fair Market Value

> Also important to be sure old model made sense
SIMULATING & TRANSITIONING TO THE NEW PLAN

How to Simulate the Model, Step by Step

> Understand all components of historical compensation
> Determine metrics to be used in new model
> Apply new proposed model to historical performance data to determine compensation that would be earned
> Ensure new model complies with Fair Market Value (at physician and/or group level)
> Compare historical and proposed physician compensation to evaluate whether budget targets have been met
> Determine numbers of winners and losers relative to historical compensation
> Evaluate likelihood that new compensation model will meet other identified goals
> Refine the model to maximize physician buy-in
Case Study: A Large, Urban Academic Medical Center with about 100 PCPs Shifted to a Hybrid Compensation Model

**Historical Model**
- Base $150,000
- Incentive $30,000
- Volume $30,000
- Maximum Total Compensation: $180,000

**Hybrid Model**
- Base $150,000
- Incentive $40,000
- Volume $22,500
- Maximum Total Compensation: $190,000
Case Study: Goals Are Tied to the Strategic Vision and Aligned with New Payment Models

<table>
<thead>
<tr>
<th>Goals</th>
<th>Proposed Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost of Care</td>
<td>15%</td>
</tr>
<tr>
<td>At-Risk Population Health Management</td>
<td>30%</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>20%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>30%</td>
</tr>
<tr>
<td>Citizenship &amp; Engagement</td>
<td>5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
### Case Study: Measures Are Aligned with Goals

<table>
<thead>
<tr>
<th>Imperative</th>
<th>Proposed Weight</th>
<th>Number of Measures</th>
<th>Sample Measures</th>
<th>Method</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost of Care</td>
<td>15%</td>
<td>1</td>
<td>› Reduction in costs across all settings</td>
<td>Comparison to peers</td>
<td>› Top quartile: full 15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>› 2nd quartile: 10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>› Bottom half: 0%</td>
</tr>
<tr>
<td>At-Risk Population Health Management</td>
<td>30%</td>
<td>Composite of 3</td>
<td>› Composite Measure of:</td>
<td>Comparison to peers</td>
<td>› Top quartile: full 10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>› Hemoglobin A1c Poor Control</td>
<td></td>
<td>› 2nd quartile: 8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>› Complete Lipid Panel and LDL Control (100 mg/dL)</td>
<td></td>
<td>› Bottom half: 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>› 1d Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>20%</td>
<td>1</td>
<td>› In-office follow-up 3-7 days after hospital discharge</td>
<td>Self-Improvement</td>
<td>› Greater than 10% improvement in score:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>full 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5% – 10% improvement in score: 10%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>30%</td>
<td>2</td>
<td>› Provider level patient satisfaction scores</td>
<td>Comparison to peers</td>
<td>› If top quartile in overall score, full 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>› Likelihood of recommending practice</td>
<td></td>
<td>› Top quartile for improvement: full 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>› 2nd quartile: 25%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>› Any improvement: 15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>› No improvement: 0%</td>
</tr>
<tr>
<td>Citizenship &amp; Engagement</td>
<td>5%</td>
<td>1</td>
<td>› 2 meetings attended</td>
<td>Absolute</td>
<td>› All or nothing</td>
</tr>
</tbody>
</table>
SIMULATING & TRANSITIONING TO THE NEW PLAN

Case Study: Using Historical Performance Data, Physicians Scored a 58% on Average

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 39%</td>
<td>8</td>
</tr>
<tr>
<td>40 to 59%</td>
<td>40</td>
</tr>
<tr>
<td>60 to 79%</td>
<td>28</td>
</tr>
<tr>
<td>80 to 100%</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
</tr>
</tbody>
</table>

> **Strengths:**
  - Care Coordination
  - Citizenship & Engagement

> **Opportunities:**
  - Patient Satisfaction
  - At-Risk Population Health
  - Total Cost of Care
**Quality Performance Scorecard**

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure</th>
<th>Proposed Weight</th>
<th>Performance</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost of Care</td>
<td>Reduction in costs across all settings</td>
<td>15%</td>
<td>n/a</td>
<td>0%</td>
</tr>
<tr>
<td>At-Risk Population Health Management</td>
<td>Hemoglobin A1c Poor Control</td>
<td>10%</td>
<td>45%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Complete Lipid Panel and LDL Control (100 mg/dL)</td>
<td>10%</td>
<td>70%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>1d Blood Pressure</td>
<td>10%</td>
<td>97%</td>
<td>10%</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>TBD</td>
<td>20%</td>
<td>n/a</td>
<td>20%</td>
</tr>
<tr>
<td>Patient Satisfaction:</td>
<td>Likelihood of recommending practice</td>
<td>30%</td>
<td>96%</td>
<td>30%</td>
</tr>
<tr>
<td>Citizenship &amp; Engagement</td>
<td>Meeting Attendance</td>
<td>5%</td>
<td>n/a</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>100%</td>
<td></td>
<td>73%</td>
</tr>
</tbody>
</table>

**Value Incentive**

- **Earned Incentive**: $12,775
- **Unearned Incentive**: $4,725
- **TCOC**: $2,625
- **At-Risk Pop. Health**: $2,100

Dr. X left unearned incentives on the table because he performed poorly in managing cost and at-risk populations.
Case Study: Volume Focus vs. Value Focus

Those who perform well in a volume world might not do well in a value world.

Dr. X has great quality scores, but is less productive.

Dr. Y is highly productive, but has poor quality scores.

* Each quality score is a composite score based on clinical, patient satisfaction, and engagement indicators.

SIMULATING & TRANSITIONING TO THE NEW PLAN

Case Study: Minimize Change to Mitigate Physician Dissatisfaction and FMV Concerns

### Case Study: Hybrid Model Results

<table>
<thead>
<tr>
<th><strong>Advantages</strong></th>
<th><strong>Disadvantages</strong></th>
<th><strong>Lessons Learned</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Aligns payment from payers with compensation to physicians</td>
<td>- If physician does not meet productivity target, there is no money in the bonus pool for quality</td>
<td>- It is possible to use payer data to design model</td>
</tr>
<tr>
<td>- Resulted in substantial increases in quality scores and related payment levels</td>
<td>- Potential for small differences in quality to result in large differences in quality bonus</td>
<td>- Link metrics to payer programs</td>
</tr>
<tr>
<td>- Incentivizes care management activities (forms) important to population health</td>
<td>- Difficult to implement administratively</td>
<td>- Change can be implemented swiftly so long as communication is clear</td>
</tr>
</tbody>
</table>

> Physicians may not want to see complex patients

- Insurers are paying for quality, but are not expecting providers to achieve results
  - Payers generally set criteria to a level reasonable for provider attainment

> Providing frequent progress scorecards to physicians can improve performance significantly
Once the revised compensation model metrics are determined, what is the crucial next step before transitioning to the new plan?

> A) Misalign organizational goals with the new strategic payment model.

> B) Simulate the model.

> C) Expand the revised metrics to each section of the organization.

> D) Let each physician decide on a transition strategy and begin the new payment model.
There Is No Standard Recipe for Success: Choosing the Right Transition Strategy Is Dependent on Your Starting Point

- √ Start with a single specialty
- > Start with a section of the organization
- > Let each physician decide
- √ Phase in the incentives over two years
- √ Give credit for “effort” in year one
- > Minimize/eliminate potential compensation decreases in first year
- > Run as a “shadow program” for a year
Tackling the Complexities of Value-Based Physician Compensation

SUMMARY & CONCLUSION
Feel Free to Contact Us at Any Time

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