Next Generation Physician Compensation Design in a Schizophrenic Payer Environment

Presented to:

2015 Spring Managed Care Forum

Friday, April 24, 2015

Today’s agenda

- Setting the Stage – Why are we Here?
- The Fundamentals of Value-Based Reimbursement
- The Fundamentals of Physician Compensation
- Defining First, Second and Third Generation Physician Compensation Design
- Case Studies
- Question and Answer
Physician compensation – Why does it matter?

1. A huge bottom line expense for health systems

2. A structure that either supports or fights vision

3. One of the two major components that determine physician group culture (governance is the second)

4. Self proclaimed experts say I need to change my model

5. Significant shifts in payment models are suggesting equally significant shifts in compensation design - but is it the right thing to do?

Provider and payment evolution

Payment Methodology

- Full Capitation
- Subcapitation
- Case Rates
- P4P (Robust)
- P4P (“Lite”)
- Fee for Service

Stage of Evolution

- Solo MD Practices
- Group Practices
- Multispecialty Group Practices
- Integrated Delivery System
- Clinic Model

Notes:
1-P4P = Pay for Performance
2-EMR = Electronic Medical Record

Source: Lee, T. and Mongan, J., Chaos and Organization in Health Care – Cambridge: Massachusetts Institute of Technology, 2009
Provider and payment evolution – What is the market opportunity?

![Bar graph showing Total Medicare Reimbursements per Enrollee 2012](image)

Notes: 1-Adjustment Type: Price, age, sex and race.
Source: The Dartmouth Atlas of Health Care

Payment evolution
Value-based payment design – A three-legged stool

![Three-legged stool diagram](image)

Has our reimbursement model fundamentally changed?

Value – based payment nomenclature

- **Value Based Payment** – a method of reimbursing providers for delivering high-quality, efficient clinical care.
- **Risk Adjustment** – process of adjusting cost to reflect the different illness burden and complexity of the respective patient population.
- **Medical Home** – provides accessible and continuous care managed by a primary care provider. The home is driven by a registry, care coordination fees and outcome incentives and accountable for the costs and quality of its attributed members.
- **Pay-for-Performance Lite** – Insurers reward providers with bonus payments for increasing the reliability of care (e.g. regular eye exams for diabetes patients).
- **Pay-for-Performance Robust** – Providers given direct incentives for improving efficiency and patient outcomes.


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Value – based payment nomenclature

- **Member Attribution** – Methodology for attaching a patient population (and related health care budget) to a primary care physician and health system.
- **PMPM (per member per month) Calculation** - aggregation of all payments for an attributed member, i.e. the total cost of care as a function of price, types and volume of services.
- **Shared Savings** – Money shared by an insurer and a provider if the cost of care for a patient population is lowered over a specific time period.
- **Total Cost of Care** – Total Cost of Care (TCOC) includes total claims costs for a patient population. TCOC includes all health care services, all providers and all places of service.
- **Patient “churn”** – Patients in commercial, value-based payer contracts who change products on an annual basis.

Source: Adapted from Pederson/Praxel MGMA presentation, “Leveraging Marshfield Clinic’s Practice Demonstration Experience in a Value-Based Environment: October 2011.
**Value – based payment nomenclature**

**Patient attribution**
- All patient attribution is retrospective NOT prospective
- Three buckets:

  - **Patients who received the plurality of their care from Physician Group A.**
  - **Patients who touched Physician Group A but not enough for it to be considered plurality of care.**
  - **Patients who never see the inside of a Physician Group A physician’s office.**

*Source: Pederson/Frawel, MD MGMA presentation; “Leveraging Marshfield Clinic’s Practice Demonstration Experience in a “Value-Based” Environment: October 2011.*

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**Which point of view are we using?**

<table>
<thead>
<tr>
<th>Population A: Patients Assigned to Dr. Doe</th>
<th>Population B: Patients Assigned to Another Physician in the Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Population A" /></td>
<td><img src="image2" alt="Population B" /></td>
</tr>
</tbody>
</table>

1. The primary care physician’s?
1. The primary care physician’s health system employed physician group?
1. The health system (the clinical enterprise)?
Total Cost of Care Initiatives – The “Plays”

1. Readmissions
2. Admissions, i.e., priority patients
3. Pharmacy
4. Coding
5. Emergency Department (ED) utilization

- Successful managed care initiatives will incent PCPs to “bear hug” their patients.
  - More primary care office visits.
  - Increased investment in infrastructure/support.
  - Increased primary care production.
  - Increased primary care costs.

1. Readmissions
2. Admissions, i.e., priority patients
3. Pharmacy
4. Coding
5. Emergency Department (ED) utilization
6. Other?
A sample readmissions “play” diagram
More (not less) PCP engagement and productivity

Players

Hospital
- Patient presents at ED (or Unit).
- Patient Admitted (admin/admit)
- Inpatient Stay and Patient Discharge:
  - Discharge summary completion
  - Pharmacy plan completion
  - Patient education

Care Coordination
- Notification (within 1 day)
- Readmission Risk Assessment
- High Risk to Readmit?
- Patients triaged via standard process
- Patients triaged to CC Intensive Plan
- Readmission Reporting Package developed and presented at clinic sites on a regular basis
- Phys Ops works with individual clinics to impact change

Physician Ops
- PCP notification of admission (via EMR)
- Possible PCP notification of ER admit via technology (e.g., Alert MD)
- PCP notification of discharge
- PCP visit scheduled prior to discharge
- Outreach to Inpatient CM:
  - Point of Care
  - Before Discharge
- PCP visit:
  - Pre-PCP Visit
  - Readmission Risk Assessment

Aligned Clinic/PCP
- Inpatient Stay and Patient Discharge:
  - Discharge summary complete
  - Pharmacy plan completion
  - Patient education

Physician Ops works with individual clinics to impact change.

Notes: Sample diagram of a potential readmissions “play”.

What do we already know?

1. Fee for service (FFS) reimbursement structures are here to stay:
   - Underlying reimbursement system within global capitation models.
   - All patient populations will not move to global capitation.
   - One physician’s capitated patient is another physician’s FFS.
   - A bifurcated payer environment for the foreseeable future.

2. Attribution will not work.
   - A baby step toward assignment.
   - Significant TCOC improvements will require patient assignment models.
   - Aggressive managed care strategies are tied to patient assignment and global capitation.
What do we already know?

3. Quality improvement without meaningful improvements in TCOC will result in minimal long term rewards from payers.

Building blocks of physician compensation

- **Productivity**
  - Individual wRVU production
  - Professional charges and net receipts
  - Office visits and new patient visits
  - Other, i.e., patient “touches”

- **Performance: Profit & Loss (P&L)**
  - Some level of P&L risk (health system, physician enterprise, division, specialty, site, individual)
  - Managing the revenue and expense relationship

- **Performance: Quality**
  - Patient and referring physician satisfaction
  - Patient access
  - Defined quality measures

- **Performance: TCOC**
  - Bonuses based on managing medical expense costs for a patient population
  - Managed and Value Based models

- **Citizenship**
  - Recognition for activity that supports the group
  - Leadership, call and coverage activity
  - Group productivity / new physician development
  - The forgotten compensation component in many aligned groups

Source: Adapted from Pederson/Ebers HFMA ANI presentation; “Physician – Health System Alignment, A multispecialty group perspective, June 24, 2014.”
A physician group’s culture acts as the fulcrum

- Transitional strategies – recognize and vs. or
- No one size fits all
- All components needed – don’t burn the boats

Quality

Revenue

Outcomes

Total Cost of Care

Productivity

Operating Overhead

CULTURE – ENVIRONMENT


Physician compensation model characteristics

- Physician compensation models for employed physicians can differ significantly based on the local health care environment and the maturity of the practice.
- Physicians fresh out of training (or recently purchased practices) will typically have a salary guarantee for a minimum of two years.
  - Production upside.
  - No downside.
- Physicians with mature practices that are not in their initial employment contracts/models will typically move into a physician compensation with 1st Generation characteristics.
- Market factors and culture will influence how quickly organizations shift to models with 2nd or 3rd generation characteristics.
Physician compensation design – Key decisions
A short list

1. Individual physician vs. team-based incentives.
   ✓ Productivity, quality, patient satisfaction, citizenship, TCOC, revenues less expenses, etc.
2. Call responsibilities and value.
   ✓ Assign a value for call for core specialties (cardiology, orthopedic surgery) that includes sub-specialties.
   ✓ Not defined by external data/surveys.
3. Define physician compensation floor.
   ✓ What is the minimum amount of compensation a physician can earn?
   ✓ Physicians who perform below compensation floor may trigger decisions regarding their long term fit with the group.
4. Define target compensation position relative to market.
   ✓ Impacted by local/regional environment.
5. Define cash draw mechanics.
   ✓ What is monthly/bi-monthly payment amount (prior to annual or quarterly performance calculations and bonuses)?

Physician compensation design – Key decisions
Positioning relative to market
Next generation physician compensation design

Key issues

- Sample patient distribution for a primary care physician:
  - Different payers.
  - Different product types and structures.
  - Different incentives and performance measures.

<table>
<thead>
<tr>
<th>Payer Contract</th>
<th>Patient Panel Distribution for Sample PCP - Patient Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Medicare</td>
</tr>
<tr>
<td>FFS</td>
<td>360</td>
</tr>
<tr>
<td>Risk</td>
<td>230</td>
</tr>
<tr>
<td>ACO</td>
<td>330</td>
</tr>
<tr>
<td>Totals</td>
<td>920</td>
</tr>
</tbody>
</table>

Sources:

Next generation physician compensation design

Key issues

- How will work effort be measured for different types of contacts and patients?
  - Attributed patient.
  - Patient attributed to other physician in group.
  - Patient attributed to competing health system.

Physician Work Effort

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>BCBS</th>
<th>Aetna</th>
<th>UHC</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee For Service Related Work Effort</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value Based / Global Capitation Work Effort</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources:
Next generation physician compensation design
Key issues

• How will work effort be measured for different types of contacts and patients?

Notes: 1-Assumes value based and capitated patients are risk adjusted using appropriate methodology, e.g., Hierarchical Condition Categories (HCC) and/or Adjusted Clinical Groups (ACG).
2-Spring Managed Care Forum presentation; Next Generation Physician Compensation Design, May 2, 2013.

Physician compensation model characteristics – Mature practice models

<table>
<thead>
<tr>
<th>1st Generation</th>
<th>2nd Generation</th>
<th>3rd Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• FFS model. Productivity measures including: ✓ wRVUs. ✓ Charges. ✓ Receipts less expenses. ✓ Citizenship incentives.</td>
<td>• Quality incentives (including patient satisfaction). ✓ Applies to all patients. ✓ Starting at 5-10% and increases proportional to value based payer contracts. • Patient panel incentives. ✓ Patient panel defined using internal criteria and includes all patients. • FFS model. Productivity measures including: ✓ wRVUs. ✓ Charges. ✓ Receipts less expenses.</td>
<td>• Quality incentives (including patient satisfaction). ✓ Applies to all patients. ✓ Starting at 5-10% and increases proportional to value based payer contracts. • TCOC incentives. ✓ Applies to assigned and possibly attributed patients. • Two distinct compensation models (for 2 patient populations): ✓ FFS patients. ✓ Managed care patients.</td>
</tr>
</tbody>
</table>
Physician compensation model – 2nd generation

2nd generation physician compensation models currently include a FFS methodology with defined quality, patient experience and citizenship incentives.

Physician compensation model – 3rd generation

3rd generation physician compensation models will include FFS and Managed Care Compensation methodologies with incentives common to both.
2nd generation compensation incentives
Case study 1

- An example of incentives that fail to drive desired behaviors and organizational performance.
- Incentives that are less relevant for highly productive physicians.

<table>
<thead>
<tr>
<th>Facility (Team Based)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1: Achieve NCQA recognition as Patient Centered Medical Home</td>
</tr>
<tr>
<td>Level 1 = $500</td>
</tr>
<tr>
<td>Level 2 = $1,000</td>
</tr>
<tr>
<td>Level 3 = $5,000</td>
</tr>
<tr>
<td>Goal 2: Patient Satisfaction (Press Ganey scores)</td>
</tr>
<tr>
<td>Maintain 86th - 88th percentile = $1,000</td>
</tr>
<tr>
<td>Maintain 90th - 94th percentile = $2,500</td>
</tr>
<tr>
<td>Maintain 95th plus = $5,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 3: Improve dashboard performance for 8 CMO ACO preventative measures</td>
</tr>
<tr>
<td>70% - 74.9% = $625</td>
</tr>
<tr>
<td>75% - 84.9% = $1,250</td>
</tr>
<tr>
<td>85% plus = $2,500</td>
</tr>
<tr>
<td>Goal 4: Diabetic composite score. All or nothing measure for each individual reviewed.</td>
</tr>
<tr>
<td>26% - 39.9% = $625</td>
</tr>
<tr>
<td>40% - 59.9% = $1,250</td>
</tr>
<tr>
<td>60% plus = $2,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Scenario</th>
<th>% of Average Comp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Med.</td>
</tr>
<tr>
<td>Goal 1</td>
<td>$500</td>
</tr>
<tr>
<td>Goal 2</td>
<td>$1,000</td>
</tr>
<tr>
<td>Goal 3</td>
<td>$625</td>
</tr>
<tr>
<td>Goal 4</td>
<td>$625</td>
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<tr>
<td>Totals</td>
<td>$2,750</td>
</tr>
</tbody>
</table>

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2nd generation compensation incentives
Case study 2

- 50 percent based on quality and patient experience.
- 72 percent based on team (vs. individual) performance.

<table>
<thead>
<tr>
<th>Compensation Elements</th>
<th>Percent Total Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team</td>
</tr>
<tr>
<td>1ST GENERATION MODEL</td>
<td></td>
</tr>
<tr>
<td>Productivity</td>
<td>0%</td>
</tr>
<tr>
<td>Quality</td>
<td>0%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>0%</td>
</tr>
<tr>
<td>Total Cost of Care</td>
<td>0%</td>
</tr>
<tr>
<td>Totals</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2ND GENERATION MODEL</th>
<th>Percent Total Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team</td>
</tr>
<tr>
<td>Productivity</td>
<td>10%</td>
</tr>
<tr>
<td>Quality</td>
<td>35%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>15%</td>
</tr>
<tr>
<td>Total Cost of Care</td>
<td>12%</td>
</tr>
<tr>
<td>Totals</td>
<td>72%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Metric Description</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>35%</td>
</tr>
<tr>
<td>Cancer Screening</td>
<td>25%</td>
</tr>
<tr>
<td>Disease Measure 3</td>
<td>15%</td>
</tr>
<tr>
<td>Disease Measure 4</td>
<td>15%</td>
</tr>
<tr>
<td>Disease Measure 5</td>
<td>10%</td>
</tr>
<tr>
<td>Totals</td>
<td>100%</td>
</tr>
</tbody>
</table>
2nd generation compensation incentives
Case study 2 (continued)

- Physicians that were historically high producers realized significant compensation decreases with the shift away from individual production incentives.

Assumptions:
- Annual wRVUs: 7,000
- Compensation per wRVU (for productivity based compensation): $42
- Average annual compensation: $200,000
- Incentives Achieved:
  ✓ Quality: 100 percent
  ✓ Patient Satisfaction: 100 percent
  ✓ TCOC: 100 percent

<table>
<thead>
<tr>
<th>Compensation Elements</th>
<th>1st Gen.</th>
<th>2nd Gen.</th>
<th>Change</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>$264,600</td>
<td>$102,320</td>
<td>-$162,280</td>
<td>-61.3%</td>
</tr>
<tr>
<td>Quality</td>
<td>$70,000</td>
<td>$70,000</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>$29,400</td>
<td>$30,000</td>
<td>$600</td>
<td>2.0%</td>
</tr>
<tr>
<td>Total Cost of Care</td>
<td>$24,000</td>
<td>$24,000</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Totals</td>
<td>$294,000</td>
<td>$226,320</td>
<td>-$67,680</td>
<td>-23.0%</td>
</tr>
</tbody>
</table>

2nd generation compensation incentives
Case study 3

A sampling of the the 60+ provider measures utilized by a large ACO.

- Asthma Management
- Back Pain: Lower Acute
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- COPD Management
- Diabetes Management
- Diabetes Management: BP Control
- Diabetic Retinopathy: Lower Grade
- Diabetic Retinopathy: Higher Grade
- Heart Failure: Management
- Hypertension Management
- Hypertension: BP Control
- Kidney Disease Chronic
- Lipid Management CVD
- Macular Degeneration: Monitor
- Melanoma
- Pneumococcal
- Well Child Visit: First 15 Mos.
- Well Child Visits: 3-6 Years
- Well Child Visits: 12-18 Years
- Well Visit Age 65 and older
- Total cost of care (tbd)
- Patient satisfaction metrics
- Clinical Integration engagement metrics
### 3rd generation compensation incentives

**Case study 4**

#### Sample Performance

<table>
<thead>
<tr>
<th>Medicare Risk Contract</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient count</td>
</tr>
<tr>
<td></td>
<td>Member months</td>
</tr>
<tr>
<td></td>
<td>Physicians</td>
</tr>
</tbody>
</table>

#### Independent Group Practice Example

**Overview**
- A 12 physician family practice group with strong financial performance.
- Multiple, long-term managed-care contracts.
- Significant bonus payments to supporting physician groups, i.e., hospitalists.
- Located in a high opportunity market/state.

**Results**
- A group that consistently outperforms the market.
- Strong payer relationships including information support.

**Source:** Adapted from Pedersen/Ebers HFMA ANI presentation, "Physician – Health System Alignment, A multispecialty group perspective, June 24, 2014.

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### The crystal ball questions?

1. Will individual physicians pick a **patient population specialty** or will they continue to see all payer types?
   - FFS or managed care?
   - Contract or payer type specific?

2. What are the rationale for specialization by payer type?
   - Maximize investments in and utilization of practice resources, i.e., patient centered medical home.
   - Individual physician preference and skillset.

3. How will fair market value (FMV) analysis evolve as capitation and non-wRVU related work effort increases?
   - Physician bonuses for TCOC performance may be significant and not supported using traditional FMV methodologies.

4. **Other questions:**
Craig Pederson, Principal

Craig Pederson is a Principal with Insight Health Partners. Craig brings more than 22 years of expertise in the areas of physician compensation design, physician and health system alignment strategy development, business development, joint ventures and fair market value analysis and opinions.

Craig has significant experience working with integrated health systems and physician organizations, including large multispecialty group practices. Prior to joining the Firm, Craig was a Principal with SullivanCotter and a Partner at Health Care Futures, LP where he led the physician services practice. His past experience has included significant work with health system clients that are known as national leaders in the areas of population-based health and value-based contracting models.

More specifically, a sampling of his past projects includes the following:

- Developing compensation and governance structures for three separate, health system employed physician groups in order to form a more integrated and aligned multispecialty group practice.
- Developing performance improvement strategies for a health system aligned physician enterprise.
- Developing next generation physician compensation models.
- Restructuring physician and administrative leadership models.
- Facilitating physician and hospital alignment discussions.
- Developing and implementing professional services agreements.

As an author, Craig’s work has appeared in a multitude of professional journals. In 2015 he co-authored a chapter titled “Physician Compensation Valuation in an ACO” in The ACO Handbook: A Guide to Accountable Care Organizations; 2nd Edition, published by the American Health Lawyers Association. He is a frequent speaker on the topics related to physician strategy and health system alignment.

Craig earned both a Master of Health Administration and a Master of Business Administration with a concentration in finance from the University of Minnesota.