Aligning Physician Groups to Maximize Managed Care Performance

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Introduction
Today’s speaker

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Introduction

Today’s agenda

- Introduction
- What is the “X” we are trying to solve for?
- Case Study Reviews:
  - One: Multispecialty Group Practice
  - Two: Integrated Health System Cardiology Group
  - Three: Integrated Health System Cardiology Group
  - Four: Community Hospital
- Questions and Answers

Introduction

Learning objectives

- To understand the symptoms of an aligned physician group that is not integrated (a loose collection of individual groups) in order to correctly diagnose the problem.
- To identify the core components of an integrated physician group that can promote the execution of key managed care strategies.
- To understand how to quantify the benefits of integration (and the costs of the first generation alignment models).
- To understand the cultural differences between independent physician groups and health systems and models for moving toward a common culture over time.
- To apply processes and tools to a real life physician group integration example.
What is the “X” we are trying to solve for?

Provider and Payment Evolution

Payment Methodology

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

Stage of Evolution

- Non-MD Clinicians
- Integrated Delivery System
- Multispecialty Group Practices
- Group Practices
- Solo MD Practices

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


What is the “X” we are trying to solve for?

“Payer Defined” Metric Performance

- How should providers be structured/organized to maximize performance for value-based metrics?
  - Level of Physician-Hospital Alignment? (too many alignment strategies stop here—the work has just begun)
  - Level of Physician-Physician Integration?
  - Level of Specialty-Specialty Integration?

Sample Performance Measures

<table>
<thead>
<tr>
<th>#</th>
<th>Sample Performance Measures</th>
<th>Prim. Care</th>
<th>Cardiovascular</th>
<th>Onc.</th>
<th>Ortho.</th>
<th>Anesth.</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Asthma Management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Back Pain: Lower Acute</td>
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<tr>
<td>3</td>
<td>Breast Cancer Screening</td>
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<tr>
<td>4</td>
<td>Cervical Cancer Screening</td>
<td></td>
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<tr>
<td>5</td>
<td>Colorectal Cancer Screening</td>
<td></td>
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<tr>
<td>6</td>
<td>COPD Management</td>
<td></td>
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<tr>
<td>7</td>
<td>Diabetes Management</td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>Diabetes Management: BP Control</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9</td>
<td>Diabetic Retinopathy: Lower Grade</td>
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<tr>
<td>10</td>
<td>Diabetic Retinopathy: Higher Grade</td>
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<tr>
<td>11</td>
<td>Heart Failure: Management</td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>Hypertension Management</td>
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</tr>
<tr>
<td>13</td>
<td>Hypertension: BP Control</td>
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<tr>
<td>14</td>
<td>Kidney Disease Chronic</td>
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</table>
What is the “X” we are trying to solve for?

After years of health systems adding primary care physicians and more recently key specialists, how do they integrate a high number of previously separate pieces into a provider structure capable of driving strong managed care performance?

CASE STUDY ONE: MULTISPECIALTY GROUP PRACTICE

Integrated Medical Professionals
Integrated Medical Professionals

Overview:
• Located in the New York metro area.
• Formed in 2006 by thirty-one physicians from thirteen different independent practices.
• An independent multi-specialty physician group with over 100 physicians seeing patients in nearly 50 clinical sites.
• A clinical affiliation with The Mount Sinai Hospital focused on:
  o Providing state-of-the-art screening, assessment and treatment for complex urologic conditions.
  o Improving access to cutting-edge radiation oncology services.

Source: Integrated Medical Professionals.

Integrated Medical Professionals

Process:
• A concerted quality management effort to develop/set clinical guidelines.
• Reviews by the IMP Utilization Review processes.
• Monitoring and mentoring of physicians on clinical pathways.

Results after several years of focused work effort:
• Sample utilization and estimated TCOC performance:

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Office Sonograms as Percent of Office Visits</th>
<th>4th Qtr Procedures</th>
<th>Est. Annual TCOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal</td>
<td>7.97%</td>
<td>1.60%</td>
<td>6.37% 3,212</td>
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<tr>
<td>Pelvic</td>
<td>13.25%</td>
<td>1.00%</td>
<td>12.25% 2,521</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td></td>
<td>5,733</td>
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</tbody>
</table>

Source: Integrated Medical Professionals.
CASE STUDY TWO:
INTEGRATED HEALTH SYSTEM

Kettering Health Network and Kettering Physician Network

Kettering Physician Network Profile
Overview

• Kettering Health Network (KHN)
  o Not-for-profit health system located in southwest Ohio.
  o Facilities include 8 hospitals and 120 outpatient facilities.

• Kettering Physician Network (KPN)
  o Physician enterprise for KHN.
  o Employs more than 250 physicians.
  o More than 70 plus locations throughout the service area.
Kettering Health Network Service Area

Kettering Physician Network
Cardiology Profile

- Depending on your point of view…
  - A subspecialized cardiology group with 23 physicians or…
  - A collection of three, relatively small physician groups.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Count</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Interventional</td>
<td>12</td>
<td>52%</td>
</tr>
<tr>
<td>Invasive</td>
<td>9</td>
<td>39%</td>
</tr>
<tr>
<td>Non-invasive</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Electrophysiology</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Group A
5 Physicians
Employment

Group B
11 Physicians
Employment

Group C
7 Physicians
PSA
What is the “X” we are trying to solve for? Key issues

KPN Perspective:
- How to improve quality, patient satisfaction and total cost of care (TCOC) performance?
- How to incent efficient utilization of resources/overhead?

Cardiology Perspective:
- For physicians nearing retirement – is there a transition model that works for both the individual as well as the overall group?
- How can we functionally merge three cardiology groups (that have maintained separate cultures even after aligning with KPN)?
- How do we build a more integrated cardiology group that is better positioned to thrive in the emerging health care environment (versus status quo)?

What is the “X” we are trying to solve for? The Call Conundrum

- Inefficiency issues:
  - On call cardiologists passing each other on the roads between covered hospitals.
- Senior cardiologists seeking alternative models:
  - A significant number of senior cardiologists seeking reduced call or to drop out of call completely.
  - Physician willingness to realize a significant compensation decrease in exchange for reduced call.
- Current physician compensation models did not anticipate a significant number of physicians requesting a decrease in the call schedule.
- Recognition that call compensation is valued very differently within physician groups vs. incremental health system or national compensation survey views.
What is the “X” we are trying to solve for? The Call Conundrum

- An example of significant differences in “valuing” call responsibilities.

### Annual Compensation Breakdown by Estimated Work Effort

<table>
<thead>
<tr>
<th>Work Effort Description</th>
<th>Estimated Annual Compensation</th>
<th>Percent Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internal Method</td>
<td>External Method</td>
</tr>
<tr>
<td>Non-Call related</td>
<td>$440,000</td>
<td>$527,000</td>
</tr>
<tr>
<td>Call related</td>
<td>$160,000</td>
<td>$73,000</td>
</tr>
<tr>
<td>Total</td>
<td>$600,000</td>
<td>$600,000</td>
</tr>
</tbody>
</table>

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**Structural Solutions: A Single Physician-Hospital Alignment Model**

From:
- 3 distinct cardiology groups.
- 2 employed groups.
- 1 group with a PSA.

To:
- A single physician-hospital alignment model (KPN leadership indifferent to which model – pick one).
**Structural Solutions**

**Key Group Practice Decisions**

1. Physician compensation: Health System-Foundation economics  
2. Physician compensation: Allocation methodology  
3. Physician recruitment: Decision to add physicians  
4. Physician recruitment: Decision to extend offer  
5. Terminating physicians  
6. Budget approval: Capital and operating  
7. Expenditure approval over defined threshold  
8. Managed care contracts  
9. Hiring/firing lead administrator  
10. Retirement plan decisions  
11. Physician vacation policy  
12. Participation in IPAs/contracting organizations  
13. Scope of practice issues  
14. Hospital staffing/coverage  
15. Clinical practice standards/guidelines  
16. EMR decisions/platforms  
17. Hiring of staff: Clinical staff  
18. Call responsibilities and schedule decisions


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**Structural Solutions**

**Existing Governance Structure**

- Overview of current KPN governance/decision-making model.
  - All hospital CEOs.
  - 7 Physicians.
  - CEO and President of KHN.
  - Members are appointed by KHN leadership.
  - 9 physicians.
  - 1 Physician administrator.
  - 3 administrative executives.
  - Transition to a dyad leadership model.
  - Physician leaders selected by service line.

The diagram illustrates the governance structure with KPN Board at the top, followed by Physician Leadership Group (PLG) and Service Line Leadership, each detailing their respective roles and memberships.
Structural Solutions
Proposed Decision-Making Structure

Cardiology Group Council
- Comprised of 5 physician members chosen by cardiology group.
- Distinction between original groups disappears.
- Addresses physician human resource issues, geographic service issues and scope of service issues, i.e., aortic valves.
- All decisions are passed on a majority vote unless otherwise specified.

Cardiology Management Committee
- Addresses operational or day-to-day issues related to cardiology.
- Comprised of physician and administrative leadership from defined cardiology service locations.
- Initially consists of members from 3 locations.

Practice Operating Divisions (PODs)
- Administrative and physician leadership that are located at defined practice locations.
- Consists of the outpatient sites where cardiology physician services are provided.

Structural Solutions
Physician Compensation Structure

- Guiding Principles
- All patient care is valued equally regardless of payer.
- Some equal sharing of compensation for a defined set of responsibilities (call/coverage, citizenship, etc.).
- Productivity will continue to be incented.
- A portion of compensation will be tied to quality/patient satisfaction.
- Incentives to utilize overhead/resources efficiently.
**Structural Solutions**
**Physician Compensation Structure**

- A two-part physician compensation design to promote integration.
- Similar in structure to many PSA models.

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**Cardiology Group Compensation Pool**

**Physician Compensation Methodology (Pool Distribution)**

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**Structural Solutions**
**Physician Compensation Structure**

- A cardiology group compensation pool structured to reflect market realities.
- A focus on appropriate pool funding (vs. the mechanics of getting there).

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**Cardiology Group Compensation Pool**

**Key Components**
- Base salary contributions per FTE.
- Quality & patient experience funding.
- Productivity bonus.
- Cost efficiency bonus.
Structural Solutions
Physician Compensation Structure

Key Components
• Excludes new physicians and part-time physicians.
• Base salary: Based on subspecialty (considered equal share income).
• Quality, Patient Experience & Citizenship: A defined percentage of the base salary.
• Production Bonus: wRVU based.
  ✓ Production gateway.
  ✓ Production “credit” for low volume geographies.

Structural Solutions
Unique Characteristics – So what?

1. A defined decision-making structure for key group decisions:
   ✓ Example: Physicians petitioning to be removed from the call and coverage schedule.
2. Defined cap on individual production (at a defined point individual physician bonuses do not increase).
3. The highest producers will earn the least on a per wRVU basis.
4. A defined value for call that was 3+ times greater than the original starting point.
   ✓ The amount a physician’s compensation is decreased if the group recommends that the physician be removed from the call schedule.
   ✓ Compensation savings is re-distributed into the pool for physicians absorbing increased call load.
CASE STUDY THREE: INTEGRATED
HEALTH SYSTEM

Aligned Cardiology Group

Overview

• An integrated health system based in the Midwest with more than 150 locations including 11 hospitals, 27 long-term care and senior living facilities.
• The employed physician group includes over 300 physicians across a broad range of specialties including cardiology.
• Cardiology consists of 13 cardiologists including interventional cardiology, EP and non-interventional cardiology.
• The cardiologists are currently located in 5 separate clinics dispersed throughout the service area.
• The largest site, Cardiology POD A, consists of 5 interventional cardiologists and was formed by the combination of two previously independent groups who integrated with the health system during the same time period.
An interventional cardiologist from an unaligned, independent group practice has an informal (verbal) agreement to take an employed physician’s share of interventional call. (The employed physician is old enough to opt out of call per the medical staff bylaws).

Physician compensation for the employed interventional cardiologist no longer taking call remains similar to the other 4 cardiologists taking a full share of call, i.e., no compensation reduction for no call responsibilities.

The interventional cardiologist from the independent group is on the medical staff of the employed group’s hospital. However, his primary location is at a competing health system and all elective clinical work and patient relationships are shifted to the competing health system.

Structural solution: Develop and implement a revised physician compensation plan that better aligns incentives (both physician-health system and physician-physician).

Aligned Cardiology Group Overview (continued)

Aligned Cardiology Group Structural Solution

- The base salary will be calculated at 80% of FY 2014 compensation.
- Call responsibilities:
  - Call pay will be deducted from the calculated base salary and allocated to a call pool to be distributed based on actual call responsibilities.
  - Physicians are “all in” or “all out” of call schedule (no designer call schedules).
  - Administration will determine a value for the different types of call.
Aligned Cardiology Group Structural Solution

Base Salary (Less Call) +
Call Pool +
Quality/Patient Satisfaction

Productivity Incentive

Total Cash Compensation

- 10% of a physician’s compensation will be based on performance for defined measures:
  - 2.5% Patient Satisfaction
  - 3 distinct quality measures each worth 2.5%. These measures are currently being defined by Physician Group Quality Council.

Aligned Cardiology Group Structural Solution

Base Salary (Less Call) +
Call Pool +
Quality/Patient Satisfaction

Productivity Incentive

Total Cash Compensation

- A physician will need to generate wRVUs that meet or exceed a defined production threshold in order to access the productivity incentive. These incremental wRVUs will be paid at the 50th percentile CF.
CASE STUDY FOUR: COMMUNITY HOSPITAL

Community Hospital case study

Overview:
• Located in New Jersey.
• Approximately 300 licensed beds, more than 350 employed physicians and a clinically integrated network.
• Evaluated bundled payment opportunities in partnership with a large regional payer.

Highlighted outcome:
• Derived co-efficients of variation:
  • Total joint = .32
  • CHF = .76.
• Concluded the Medicare Bundled payment program for total joints was not viable, whereas CHF offered significant clinical improvement opportunities.
LESSONS LEARNED

Lessons Learned...

1. **Health system aligned physician groups should focus on stealing best practices and structures from high performing independent groups.**
   - In some cases, previous best practices were lost in the transition to alignment.
   - Independent groups utilizing loose federation models may be good sources for best practices.

2. **Physician to physician integration is required to achieve managed care results.**
   - Payment evolution is one piece of the puzzle.
   - Health systems cannot skip this process step.
Lessons Learned…

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

4. **Timing is everything.** The ultimate success of an alignment/managed care strategies will hinge on payer contract structures that reward providers based on value-based principles (including significant payments for reducing patient population health care costs).
   - A significant gap between theory and reality in many markets.
   - A proposed approach designed to appropriately tie strategy to market timing.

Q & A
Q and A

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THANK YOU!