Tackling the Complexities of Value-Based Physician Compensation

Rudd Kierstead, MBA, MPP
Principal, Veralon

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Introduction

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*Principal*

Rudd brings 25 years of experience in a range of provider settings to his work on physician initiatives. He has focused on enterprise performance improvement, medical staff planning, financial analysis, physician alignment, compensation planning, acquisition and employment analysis, and FMV projects.

In addition to his consulting experience with health system, community hospital, and academic center clients, Rudd has worked extensively with physician leadership in New York medical centers, managing physician networks, practices, and departments in several academic medical centers and in different specialties.
Session Learning Objectives

- Understand the environment driving value-based compensation
- Explore new questions about compensation directed at value-based change
- Learn approaches to measuring “value”
- Identify priorities affecting compensation design in a value-based world
- How to successfully engage and transition providers to a new compensation model
Drivers for Change
Physician Enterprise Alternatives

Rehab your existing home or move into new construction?

How health systems usually align

Recruitment into developed infrastructure → Acquisition and Employment → MSO/VBC aggregator → Coalition (CIN/ACO/IPA) → Service Partner (MSO)

Brands and logos:
- Cityblock
- Oak Street Health
- Cano Health
- CenterWell Humana
- VillageMD
- evolent health
- PRIVIA Health
- UpStream
- Carelon Elevance Health
- Carbon Health
- agilon health
- Aledade
- CARAVAN HEALTH PART OF SAGAMORE HEALTH
- Vytalize
- Caravan Health
- Accolade
- Lumeris
- 98point6
- Included Health
- Forward
- Crossover
- Vera Whole Health
- 1one medical
- ioRA Health

Logos include:
- OPTUM
- UnitedHealthcare
### Chutes and Ladders

#### Public (in order of total enterprise value, Yahoo Finance)

<table>
<thead>
<tr>
<th>Value</th>
<th>Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1B</td>
<td>Accolade</td>
</tr>
<tr>
<td>$2B</td>
<td>Cano Health</td>
</tr>
<tr>
<td>$3B</td>
<td>evolent Health</td>
</tr>
<tr>
<td>$4B</td>
<td>one medical</td>
</tr>
<tr>
<td>$5B</td>
<td>iora health</td>
</tr>
<tr>
<td>$6B</td>
<td>PRIVIA Health</td>
</tr>
<tr>
<td>$7B</td>
<td>Oak St. Health</td>
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<tr>
<td>$8B</td>
<td>agilon health</td>
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<tr>
<td>$9B</td>
<td>7.4B</td>
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<tr>
<td>$10B</td>
<td>9.21B</td>
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#### Private (In order of total funding to date)

<table>
<thead>
<tr>
<th>Funding</th>
<th>Company</th>
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</thead>
<tbody>
<tr>
<td>$250M</td>
<td>UpStream</td>
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<td>$500M</td>
<td>crossover</td>
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<td>$1B</td>
<td>Vytalize</td>
</tr>
<tr>
<td>$2B</td>
<td>Included Health</td>
</tr>
<tr>
<td>$3B</td>
<td>vera</td>
</tr>
<tr>
<td>$4B</td>
<td>FORWARD</td>
</tr>
<tr>
<td>$5B</td>
<td>Aledade</td>
</tr>
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<td>$6B</td>
<td>VillageMD</td>
</tr>
<tr>
<td>$7</td>
<td>522M</td>
</tr>
<tr>
<td>$900M</td>
<td>900M</td>
</tr>
<tr>
<td>$1B</td>
<td>6.3B</td>
</tr>
</tbody>
</table>

#### Insurance-backed

- CenterWell
- Humana
- OPTUM
- UnitedHealthcare
- carelon
- Elevance Health
- altai
- blue california

#### Private (little information)

- ChenMed
- Lumeris

#### Purchased by another

- CARAVAN HEALTH.
Volume to Value

A focus on value, changes the business model

Value = \frac{Quality}{Cost}

- High value does not necessarily mean high quality
- Cost, sometimes driven by quality precepts (such as evidence-based medicine), may be easier to affect
  - Lower cost typically does not mean marginal changes like practice efficiency, but relies on rationalized and reduced services
  - Improved care coordination, preventive care, evidence-based referrals
  - Measurable value may only surface quite distant from those providing the value
  - Successfully keeping people out of the hospital has downsides in this largely FFS environment putting hospitals at a significant disadvantage
- Market share, specifically measured in lives, is important
The Challenge: Engaging Physicians with Very Different Perspectives

<table>
<thead>
<tr>
<th>Employed</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR – Robust and Integrated</td>
<td>Many different EMRs</td>
</tr>
<tr>
<td>Care management support provided</td>
<td>Care management at extra cost</td>
</tr>
<tr>
<td>Quality measurement support</td>
<td>Bootstrap on quality measurement</td>
</tr>
<tr>
<td>Compensation model focused on productivity or salary</td>
<td>Compensation focused on total revenue</td>
</tr>
<tr>
<td>Compensated for meeting time</td>
<td>Not compensated for meeting time</td>
</tr>
<tr>
<td>Shared savings used to off-set hospital losses</td>
<td>Shared savings boosts compensation</td>
</tr>
<tr>
<td>Protected from risk-contract losses</td>
<td>At-risk for risk-contract losses</td>
</tr>
</tbody>
</table>
Aligning providers: Compensation is a Gateway Concern

- **Employed physician performance may lag behind independent physicians**
- Independent physicians may **blame** employed physicians for poor overall contract performance
- **Transparency** around performance creates both **accountability and friction**

**Employed**
Not engaged with contract performance

**Independent**
Infrastructure shortcomings (EMR, quality reporting, care management)
Physician recruitment and retention

47% of physicians suffered from burnout in 2019

What Have You Done at Work to Try to Alleviate Burnout?

- 29% Meditation or other thought-stress reduction
- 29% Reduced work hours
- 19% Changed work settings
- 17% Made workflow changes
- 16% Spoke with hospital/group administration
- 6% Hired additional staff

New Compensation Questions
Key Compensation Model Design Considerations

- What are the organizational objectives?
- Is productivity still important?
- How much is enough?
- What are the metrics? Organizational metrics or payer metrics?
- Is performance measurable? How should incentives be paid?
- What is the impact on our physicians?
- Is compensation consistent with FMV?
Why isn’t value more prevalent in current physician compensation models?

- It’s still a volume-based world
  - Fee-for-service encourages productivity
  - Costs to the payer are seen as revenues to the provider

- Measuring quality and cost is challenging
  - No standard or “best practice” approach to measuring quality exists
  - Cost data is typically unavailable and debatable

- Required change vs self-motivated change
  - Management will not test new revenue or compensation models, fearing that change will lead to a near-term decline in revenue

- Physicians might not support the shift
  - The most highly compensated physicians are typically those who are productive
  - Physicians are being asked to do more for the same compensation
It’s the long game that counts

- Have to simultaneously review **payer contract opportunities** AND **operationalize the metrics** that will maximize the intended payer incentive
  - Have to decide, project, and commit to initiatives that will actually “move the needle”
  - Will moving to greater value in the comp plan conflict with existing contracts?

- Do you incent providers at the point operations begin under a new payer contract?
  - “Real time” using performance with metrics as a proxy for anticipated payer contract performance,
  - **or**
  - Payout when contracts payout

- For real time payout using specific metrics, need to decide how, exactly, to pay out. This is less of a problem if payout is based on contract payout.
Scaling Measured Value
What Are Value Based Incentives

● Shift of emphasis to ensure that preferred care is provided
  o “Preferred” by whom?
  o Who is supposed to change their behavior?

● A parallel plan is needed for volume shifts (increase covered lives)

● These reimbursement models require an organizational infrastructure

● Compensation plans can help with the cultural shift to incent adaptation

● Organizations must establish an objective scoring mechanism regardless of metric

● Must work for both employed and independents
  o Transparency, simplicity, frequency, fairness, aligned with payers
What Are Value Based Incentives
High-value measures are increasingly being used

- Patient satisfaction
- Peer review
- Coding accuracy
- Medical record completion

- Process measures:
  - Vaccination
  - Screening

- 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

<table>
<thead>
<tr>
<th>Value Measures</th>
<th>Frequently used</th>
<th>Sometimes used</th>
<th>Rarely used</th>
</tr>
</thead>
</table>

- Utilization management:
  - Unplanned 30-day readmissions
  - Hospital utilization

- SNF utilization
- Total cost of care
- Cost of episodes of care
- SDOHs
## Performance Metrics: Substantive Content?

<table>
<thead>
<tr>
<th>Category</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td>- Patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>- Access to care and information</td>
</tr>
<tr>
<td></td>
<td>- Practitioner communication</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td>- Use of clinical pathway</td>
</tr>
<tr>
<td></td>
<td>- Safe procedure checklist utilization</td>
</tr>
<tr>
<td></td>
<td>- Clinical disease care indicators</td>
</tr>
<tr>
<td><strong>Operational Efficiency</strong></td>
<td>- Utilization of block time</td>
</tr>
<tr>
<td></td>
<td>- Schedule utilization measures</td>
</tr>
<tr>
<td></td>
<td>- Timely completion of revenue cycle</td>
</tr>
<tr>
<td><strong>Practitioner/Employee Engagement</strong></td>
<td>- Citizenship and leadership</td>
</tr>
<tr>
<td></td>
<td>- Employee engagement scores and retention</td>
</tr>
<tr>
<td></td>
<td>- Meeting attendance (practice management)</td>
</tr>
<tr>
<td></td>
<td>- Medical record completion and coding accuracy</td>
</tr>
<tr>
<td><strong>Care Management</strong></td>
<td>- Care plans</td>
</tr>
<tr>
<td></td>
<td>- Receipt of specialist report</td>
</tr>
<tr>
<td></td>
<td>- Potentially preventable ED visits</td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
<td>- PCMH indicators</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>- Admissions/24-hour post procedure holds</td>
</tr>
<tr>
<td></td>
<td>- Unplanned 30-day readmission rates</td>
</tr>
<tr>
<td><strong>Financial Performance</strong></td>
<td>- Performance against operating expenses</td>
</tr>
<tr>
<td></td>
<td>- Cost per case</td>
</tr>
</tbody>
</table>
Performance: Incentive Method
May need to create an overall score for each practitioner

<table>
<thead>
<tr>
<th>Cascading Goals</th>
<th>Department Metric</th>
<th>Baseline</th>
<th>Weight %</th>
<th>Threshold (Weight * .8)</th>
<th>Target (Weight * .9)</th>
<th>High Performance (Weight * 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Commercial Quality Composite Aggregate Score - Ambulatory Process &amp; Outcome</td>
<td></td>
<td>5%</td>
<td>2.5</td>
<td>3.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Quality</td>
<td>Hierarchical Condition Category (HCC) Gap Closure - Risk Assessment Factor (RAF) Capture Rate</td>
<td></td>
<td>5%</td>
<td>70%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Strategy</td>
<td>Growth in Total Panel Size</td>
<td>122,236</td>
<td>5%</td>
<td>2.5%</td>
<td>5.0%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Strategy</td>
<td>Patient Experience</td>
<td></td>
<td>5%</td>
<td>40th Percentile</td>
<td>70th Percentile</td>
<td>80th Percentile</td>
</tr>
</tbody>
</table>
## Performance: Meaningful Structure?

<table>
<thead>
<tr>
<th>Basis for Payment</th>
<th>Example</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| Individual Improvement                   | Readmission rates: 100% if any reduction occurs; 0% if there is no change. | • Rewards improvement  
• May have most impact on overall population health | • Penalizes those with strong quality at the outset                  |
| Absolute Threshold Performance           | HbA1c control: If 10% of diabetes patients or more have score >9, then 0%; if none have score >9, full score | • Easy to describe and understand  
• Dollars available to all | • Must gain consensus on metric                                   |
| Relative Performance to Peer Group       | Patient Satisfaction Scores  
Top quartile – 100%  
2nd quartile – 75%  
3rd and 4th quartiles – 0% | • 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 |
Emerging Math: 1001 Options

**Standard Productivity Model**

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRVUs</td>
<td>5,600</td>
</tr>
<tr>
<td>Conversion Factor</td>
<td>$62.50</td>
</tr>
<tr>
<td>Total Compensation</td>
<td>$350,000</td>
</tr>
</tbody>
</table>

**Preferred "Typical" results**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Base Salary</td>
<td>$300,000</td>
</tr>
<tr>
<td>WRVU Threshold</td>
<td>5,000</td>
</tr>
<tr>
<td>Actual WRVUs</td>
<td>5,600</td>
</tr>
<tr>
<td>Productivity Incentive</td>
<td>$42.50 per WRVU $25,500</td>
</tr>
<tr>
<td>Value Based Incentive</td>
<td>$25,000</td>
</tr>
<tr>
<td>Total Compensation</td>
<td>$350,500</td>
</tr>
</tbody>
</table>

**WRVUs Plus VB Metric scale**

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Base Salary</td>
<td>$300,000</td>
</tr>
<tr>
<td>WRVU Threshold</td>
<td>5,000</td>
</tr>
<tr>
<td>Actual WRVUs</td>
<td>5,600</td>
</tr>
<tr>
<td>Value based Metric Scale (0-100%)</td>
<td>100%</td>
</tr>
<tr>
<td>Incentives</td>
<td></td>
</tr>
<tr>
<td>Productivity (WRVUs)</td>
<td>$42.50 $25,500</td>
</tr>
<tr>
<td>Value based (metrics)</td>
<td>100% score $35,000</td>
</tr>
<tr>
<td>Total Compensation</td>
<td>$360,500</td>
</tr>
</tbody>
</table>

**WRVUs plus VB Metrics per WRVU**

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<thead>
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<td>Actual WRVUs</td>
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</tr>
<tr>
<td>Value based Metric Scale (0-100%)</td>
<td>100%</td>
</tr>
<tr>
<td>Incentives</td>
<td></td>
</tr>
<tr>
<td>Productivity (WRVUs)</td>
<td>$25 per WRVU $15,000</td>
</tr>
<tr>
<td>Value based (metrics)</td>
<td>@ 75% = $6.50 $36,400</td>
</tr>
<tr>
<td>Total Compensation</td>
<td>$351,400</td>
</tr>
</tbody>
</table>

Most comp plans look like this

Want about half incentive VB

VB incentive scaled to metrics

Hey this guy got more!

Typical quality?

VB incentive scaled to metrics and total WRVUs
Measuring Value

Improving outcomes requires well-designed incentive programs

- **Achieve something new and significant** rather than simply maintain current standards
  - Sometimes, this is just documentation!

- **Maintenance metrics** after achieving a strong standard are temporary
  - Metrics should change

- Reserve a **meaningful percentage** of total compensation for quality or cost incentives

- **Sufficiently challenge** the majority of physicians to achieve improvement

- **Robust measurement and communication** critical with providers
Setting Priorities
Connect the dots

● Engage CFO and Physician Enterprise Leadership

● Reinforce commitment to **strategic vision** of delivering value and operationalize steps to increasing quality or lowering episodic costs

● Focus on **reducing leakage** (from both employed and independent physicians)
  o Capitalize on shared EMR
  o Employed physician networks typically lose approximately $200,000 per physician – **cutting losses is often the top focus**

● **Increase payor incentives** to a level where they offset losses

● **Align compensation** incentives with payor contract performance measures and amounts
  o Pass payor incentives through in compensation
  o Requires medical staff engagement and management

Especially the docs!!
1. **System goals** for payers need clarity

2. Promote and influence high quality and efficient performance across the Network
   
   A. Components should encourage improved payer contract performance (get the money in the door).

3. “Real” risk – **Performance differences** should be recognized

4. Eyes on **meaningful performance** metrics vs outcomes

5. Measures should:
   
   A. **Impact** contract performance
   
   B. Be **actionable** for the “risk unit”
   
   C. Be clearly **measurable**
   
   D. Be reportable in a **timely** manner

6. Unearned funds may be reallocated
# Strategy Development: Defining Physician Enterprise Goals

<table>
<thead>
<tr>
<th>Clarity and Cohesion</th>
<th>Value Proposition</th>
<th>Risk/Pop Health Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phys Enterprise functions cohesively, in close coordination with the ACUs, hospital, and a larger merged entity in support of shared population health goals</td>
<td>Each ACU, and Phys Enterprise overall, is 10% more efficient than each payer’s average health status adjusted TME</td>
<td>At least 50% of hospital revenue is derived from value-based contracts</td>
</tr>
<tr>
<td>Phys Enterprise is operationally and financially self-sustaining</td>
<td>Each ACU, and Phys Enterprise overall, delivers aggregate quality scores 10% better than network average for each payer</td>
<td>Phys Enterprise distributes at least $10 PMPM in quality and surplus distributions</td>
</tr>
<tr>
<td>Phys Enterprise Board is highly engaged, participatory, and dedicated to Phys Enterprise success</td>
<td>75% of Phys Enterprise providers surveyed agree that the network offers excellent services</td>
<td>MACRA/MIPS strategy yields positive adjustments for at least 75% of hospital-ACO providers</td>
</tr>
</tbody>
</table>
Value Frameworks

- **Patient Experience**
- **Health Outcomes**
- **System Performance**

### Accountability for Perfect Care
- 40%

### Patient and Family Centered Care
- 20%

### Transitions in Care/Coordination Of Care
- 15%

### Reducing Unnecessary Variations in Care
- 20%

### Provider Engagement, Leadership, and Advocacy
- 5%

**TOTAL**

100%
Lessons: Expanding Engagement

- **Data “Grief”** – with apologies to Kubler-Ross
  - Denial – “That couldn’t be MY performance”
  - Anger – “Why do we have to manage this, what value is there for the patient”
  - Bargaining – “This data can’t be right, can we recast it”
  - Depression – “I have too much to manage”
  - Acceptance – “Can you help me improve...”

- **“Actionability” of the data/measure:** individual or group

- **Balance**
  - Data is neither perfect nor perfectly controlled
  - Don’t address too much, too soon
  - Prioritize network “Needs”
  - Fewer areas of focus (measures) leads to more engagement
  - Be prepared to compromise

- **Engagement is the most critical component**
  - Allow for early and frequent participation in process
Compensation Model
Design and Implementation
Considerations
Parallel impact of value-based contracts

1. Engage physicians in payer contract opportunities

2. Must simulate metrics, comp and payer incentives to understand impact

3. Identify the winners and losers and make adjustments if necessary

4. Manage the transition to a new compensation model
Making the transition

Many options for phasing in the new plan

**Physicians Impacted**

- Start with a single specialty
- Start with a section of the organization
- Let each physician decide

**Timing**

- Phase in the incentives over two years
- Minimize/eliminate downside risk during phase-in
- Run as a “shadow program” for a year

*Bottom line: It’s generally best to transition*
Making the transition....

Things to think about

**Messaging and roll-out of the new plan to the physicians**
- Involve physicians
- Notice periods
- Openly compare old and new models

**Be careful with physician employment contracts**
- Compensation terms
- Term lengths
Summary

- Physician/practitioner compensation is a gateway issue to many underlying concerns
  - Integrating and aligning medical staff is hard enough
  - Shifting practice AND patient behaviors for value-based care

- Physician enterprise: New competitor class
  - Purpose-built primary care (Oak Street, ChenMed, Cano Health)
  - Aggregators (Agilon, Privia)

- Value based care opportunities generally come with increased risk (less certain payment). How can that be managed? Transition is at least half the battle
  - Value based care says to docs: you are the boss. We lost that with FFS.
  - Health systems distinct disadvantage to the new entrants
  - Physicians that join a new entity have self-selected into a new construct
  - Post-COVID pressure on all medical groups for financial performance not just direct but beyond their P&L

- “Why bother” when VBC components generally remain small?
  - In current operating environment top line is being squeezed while expenses rise
  - Alternative physician entities are adapting, and getting patients to adapt, to take advantage of these opportunities
Questions?

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