Tackling the Complexities of Value-Based Physician Compensation

Rudd Kierstead, MBA, MPP
Principal, Veralon

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Introduction

Rudd Kierstead, MBA, MPP

rkierstead@veralon.com

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.

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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

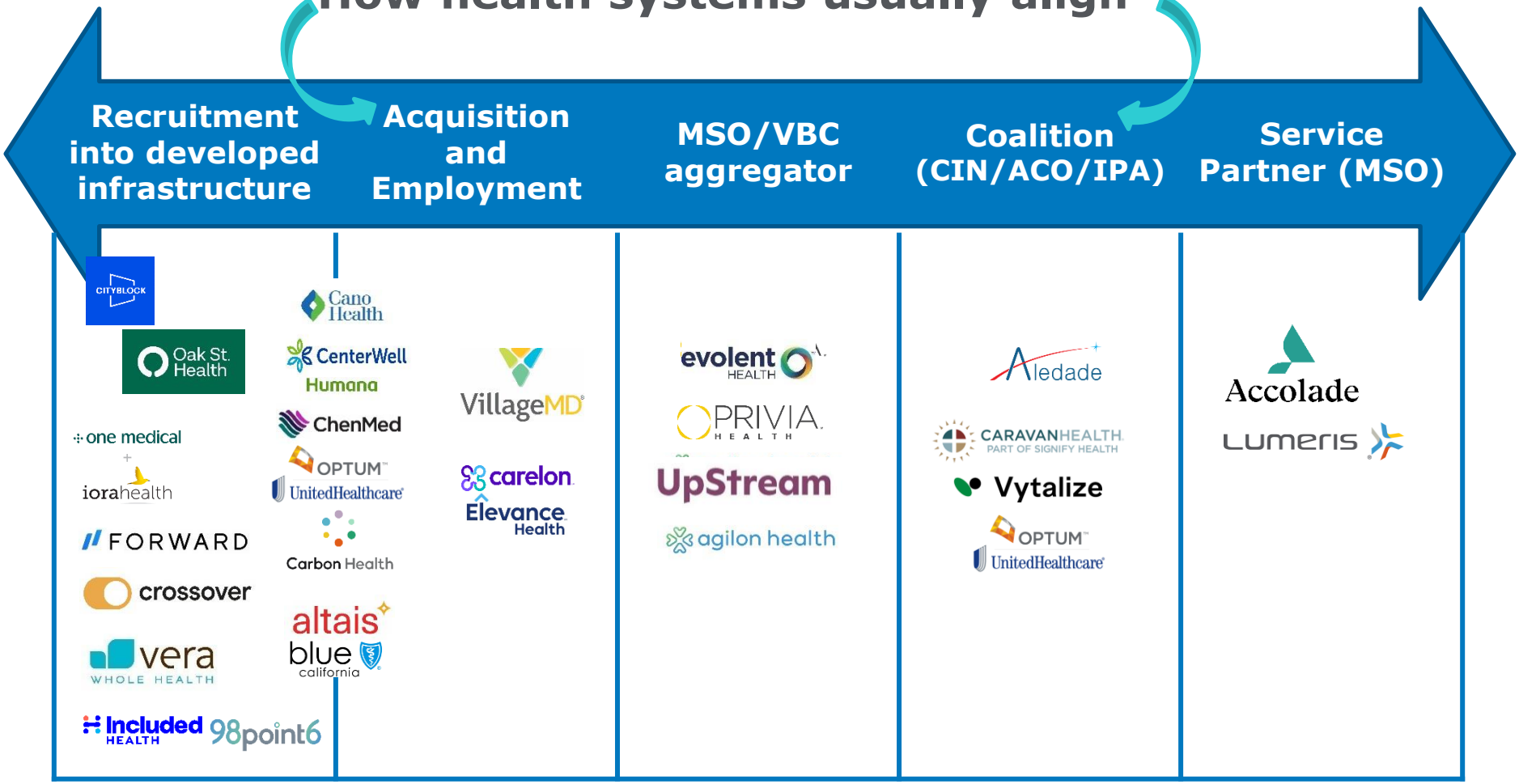
How to successfully engage and transition providers to a new compensation model

Drivers for Change

Physician Enterprise Alternatives

Rehab your existing home or move into new construction?

How health systems usually align



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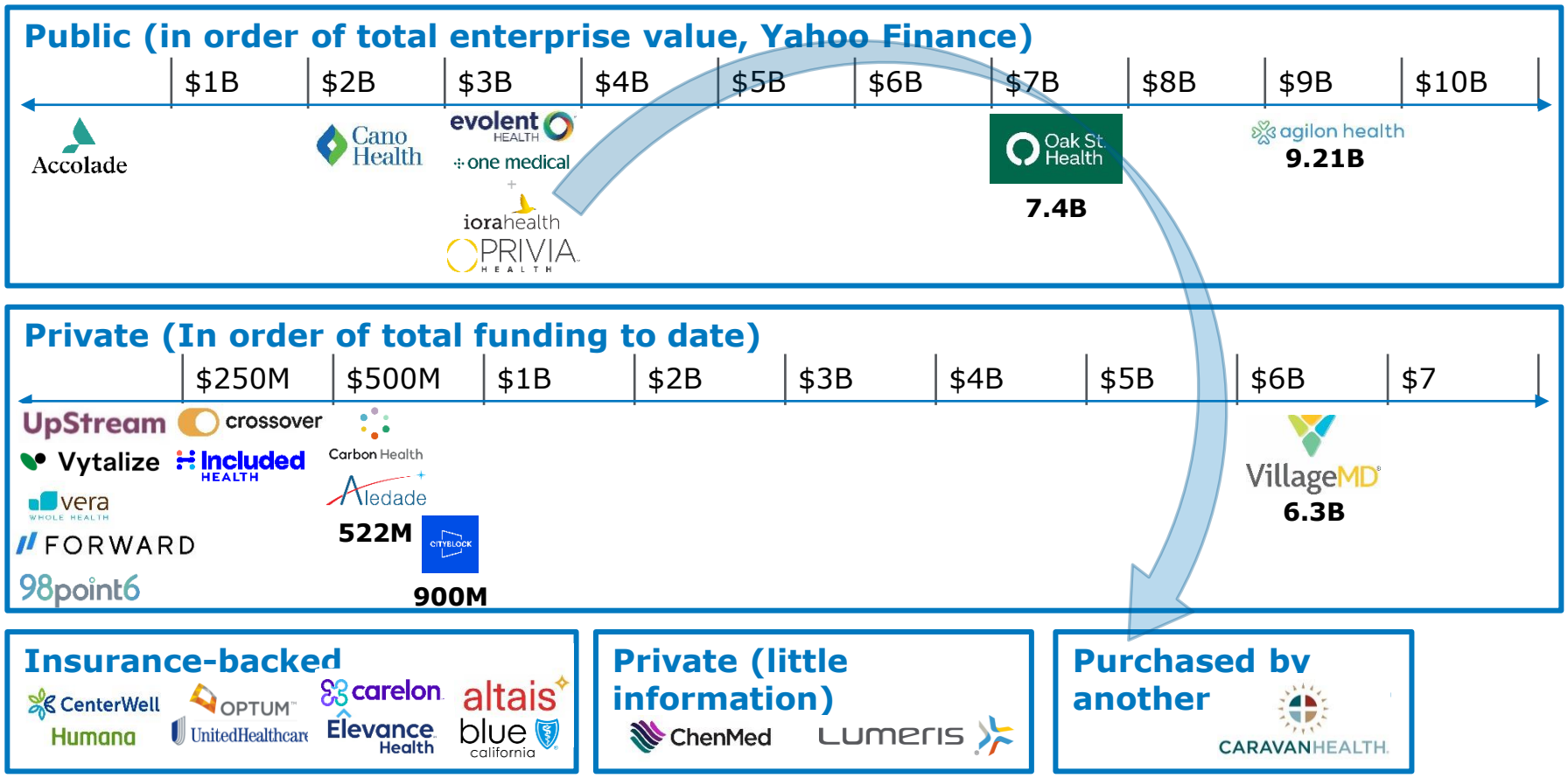
Chutes and Ladders



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Volume to Value

A focus on value, changes the business model

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

- 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

Employed	Independent
EMR – Robust and Integrated	Many different EMRs
Care management support provided	Care management at extra cost
Quality measurement support	Bootstrap on quality measurement
Compensation model focused on productivity or salary	Compensation focused on total revenue
Compensated for meeting time	Not compensated for meeting time
Shared savings used to off-set hospital losses	Shared savings boosts compensation
Protected from risk-contract losses	At-risk for risk-contract losses

Aligning providers: Compensation is a Gateway Concern

Employed

Not engaged with contract performance

- **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**

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

Source: Medscape Physician Burnout & Depression Report, 2022.

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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
  - "Preferred" by whom?
  - 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**
  - Transparency, simplicity, frequency, fairness, aligned with payers

What Are Value Based Incentives

High-value measures are increasingly being used

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

Value Measures

- Frequently used
- Sometimes used
- Rarely used

Performance Metrics: Substantive Content?

Patient Experience	• Patient satisfaction • Access to care and information • Practitioner communication
Process	• Use of clinical pathway • Safe procedure checklist utilization • Clinical disease care indicators
Operational Efficiency	• Utilization of block time • Schedule utilization measures • Timely completion of revenue cycle
Practitioner/Employee Engagement	• Citizenship and leadership • Employee engagement scores and retention • Meeting attendance (practice management) • Medical record completion and coding accuracy
Care Management	• Care plans • Receipt of specialist report • Potentially preventable ED visits
Population Health	• PCMH indicators
Outcomes	• Admissions/24-hour post procedure holds • Unplanned 30-day readmission rates
Financial Performance	• Performance against operating expenses • Cost per case

Performance: Incentive Method

May need to create an overall score for each practitioner

Cascading Goals				Successful Performance Range		
	Department Metric	Baseline	Weight %	Threshold (Weight * .8)	Target (Weight * .9)	High Performance (Weight * 1)
Quality	Commercial Quality Composite Aggregate Score - Ambulatory Process & Outcome)		5%	2.5	3.5	4.5
Quality	Hierarchical Condition Category (HCC) Gap Closure - Risk Assessment Factor (RAF) Capture Rate		5%	70%	85%	90%
Strategy	Growth in Total Panel Size	122,236	5%	2.5%	5.0%	7.5%
				3,056	6,112	9,168
Strategy	Patient Experience		5%	40th Percentile	70th Percentile	80th Percentile

Performance: Meaningful Structure?

Basis for Payment	Example	Pros	Cons
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		
WRVUs		5,600
Conversion Factor	$	62.50
Total Compensation	$	350,000

Most comp plans look like this

Preferred "Typical" results		
Base Salary		$300,000
WRVU Threshold	5,000	
Actual WRVUs		5,600
Productivity Incentive	$42.50 per WRVU	$25,500
Value Based Incentive	**how??**	**$25,000**
Total Compensation		$350,500

Want about half incentive VB

WRVUs Plus VB Metric scale		
Base Salary		$300,000
WRVU Threshold	5,000	
Actual WRVUs		5,600
Value based Metric Scale (0-100%)		100%
Incentives		
Productivity (WRVUs)	$42.50	[illegible]
Value based (metrics)	100% score	$35,000
Total Compensation		$360,500

VB incentive scaled to metrics

Hey this guy got more!

WRVUs plus VB Metrics per WRVU		
Base Salary		$300,000
WRVU Threshold	5,000	
Actual WRVUs		5,600
Value based Metric Scale (0-100%)		100
Incentives		
Productivity (WRVUs)	$25 per WRVU	$15,000
Value based (metrics)	@ 75% = $6.50	$36,400
Total Compensation		$351,400

Typical quality?

VB incentive scaled to metrics and total WRVUs

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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~~ docs

- 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)
  - Capitalize on shared EMR
  - 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
  - Pass payor incentives through in compensation
  - Requires medical staff engagement and management

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Principles for Value Based Funds Flow

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

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

Value Frameworks

- Chronic Care Management
- Health and Wellness
- Efficiency
- Care Coordination
- Patient Experience

- Patient Experience
- Health Outcomes
- System Performance

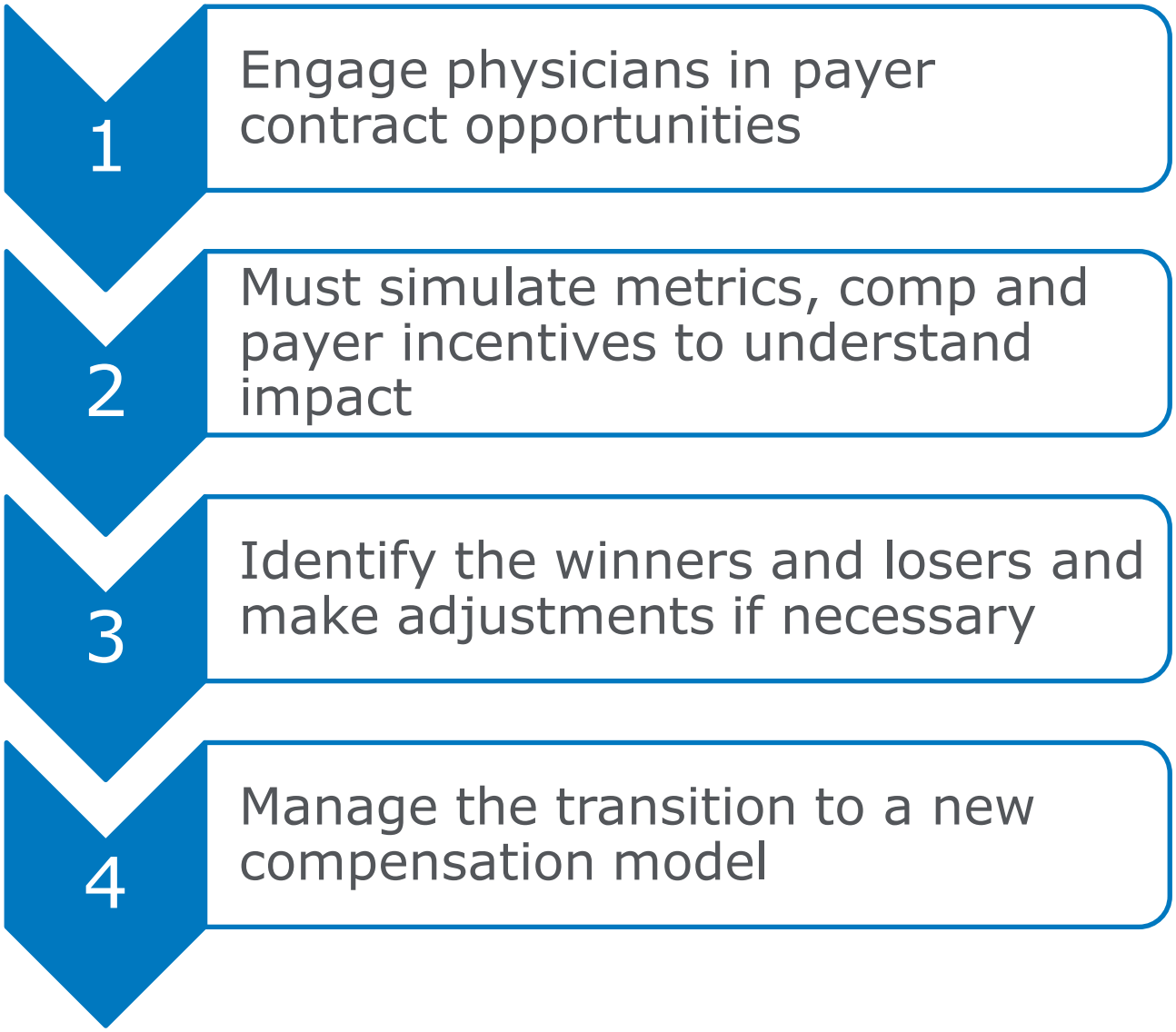
Accountability for Perfect Care	**40%**
Patient and Family Centered Care	**20%**
Transitions in Care/Coordination Of Care	**15%**
Reducing Unnecessary Variations in Care	**20%**
Provider Engagement, Leadership, and Advocacy	**5%**
TOTAL	**100%**

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



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 <u>transition</u>**

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?

Rudd Kierstead, MBA, MPP

Principal

rkierstead@veralon.com

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