Compensation Techniques Used to Improve Provider Performance and Organizational Alignment

Tuesday, March 24, 2015
9:00 a.m. – 3:00 p.m.
# Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 to 9:10</td>
<td>Welcome and Introductions</td>
<td>Tom Dobosenski</td>
</tr>
<tr>
<td>9:10 to 9:30</td>
<td>Key Trends in Physician Compensation</td>
<td>Wayne Hartley</td>
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<tr>
<td>9:30 to 10:30</td>
<td>&quot;Aligning compensation plan design with the transition to value based care delivery: Aurora's early experience.&quot;</td>
<td>Jeffrey W. Bailet, M.D. Executive Vice President, Aurora Health Care Medical Group</td>
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<tr>
<td>10:30 to 10:45</td>
<td>Break</td>
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<tr>
<td>10:45 to 12:00</td>
<td>Volume to Value</td>
<td>Richard Bone MD - Vice President Medical Management and Lee Sacks MD - Executive Vice President and Chief Medical Officer - Advocate Health Care</td>
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<tr>
<td>12:00 to 1:00</td>
<td>Lunch</td>
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<tr>
<td>1:00 to 1:45</td>
<td>Compensation Alignment – The Journey to One Dartmouth-Hitchcock</td>
<td>Clifford J. Belden, MD - Chief Clinical Officer and Executive Vice President, Integrated Delivery System - Dartmouth - Hitchcock</td>
</tr>
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<td>1:45 to 2:00</td>
<td>Break</td>
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<tr>
<td>2:00 to 3:00</td>
<td>“A Brave New Compensation Model For A Brave New World: The Evolution of A Value Based Compensation Model.”</td>
<td>Hal Teitelbaum MD, Managing Partner &amp; CEO and Scott Hines, MD Co-Chief Clinical Transformation Officer - Crystal Run Healthcare</td>
</tr>
</tbody>
</table>
Speakers

Wayne Hartley, MHA
Principal, AMGA Consulting Services, LLC

Jeffrey W. Bailet, M.D.
Executive Vice President,
Aurora Health Care
Co-President, Aurora Health Care Medical Group

Lee Sacks, M.D.
Executive Vice President and Chief Medical Officer, Chief Executive Officer of Advocate Physician Partners

Rick Bone, MD
Vice President of Medical Management, Advocate Medical Group

Clifford J. Belden, MD
Chief Clinical Officer and Executive Vice President, Integrated Delivery System, Dartmouth-Hitchcock

Hal Teitelbaum, MD, JD, MBA
Founder, Managing Partner and Chief Executive Officer, Crystal Run Healthcare

Scott Hines, MD
Co-Chief Clinical Transformation Officer, Medical Director and physician leader, Crystal Run Healthcare
Key Trends in Physician Compensation: How the Environment Shapes Compensation Strategy and Design

Wayne Hartley, Principal

March 2015
Key Trends in Physician Compensation

• Most organizations have a strong sense of the direction they are heading; however, there is uncertainty about the degree and pace of change.

• As a result of the changing environment, key trends include:

  1. The burden of chronic illness is a major factor driving utilization and, therefore, expense.

  2. Accordingly, the focus on population health continues.

  3. Information technology investment is key to effective risk stratification and overall population health management.

  4. IT capability must be coupled with a care delivery model that works.

  5. Physician compensation plans are increasingly focused on value-based outcomes to align physician incentives with these environmental changes.
Burden of Chronic Illness

• In the U.S. as of 2012, about half of all adults – **117 million people** – have one or more chronic health problems.

• In 2010, two chronic diseases, heart disease and cancer, accounted for 48% of all deaths.

• More than 1/3 of adults, or 78 million people, are obese. Many more are over ideal weight.

• Diabetes is a leading cause of kidney failure, amputation and new cases of blindness.

• These conditions, along with others like asthma, have received significant focus in the broader health care system for years.

Data Sources: www.cdc.com, “Chronic Diseases: The Leading Causes of Death and Disability in the United States.” See website for additional detail references on individual statistics.
16-fold cost difference

Average spending for Medicare FFS beneficiaries: $9,738

$2,025

2 to 3

$5,698

4 to 5

$12,174

6+

$32,658

Source: “Chronic Conditions among Medicare Beneficiaries, Chartbook: 2012 Edition”
Population health management is the current focus:

- Identify the population
- Assess community health
- Stratify risk
- Determine interventions
- Measure outcomes

Population Health Models Simplified

**PHASE I**
- Episode-based care (non-metric driven)

**PHASE II**
- Improved data collection and reporting
- Simple non-productivity based metrics

**PHASE III**
- UM/CM protocols adopted
- Begin to realize cost savings/utilization reductions

**PHASE IV**
- Strong utilization management
- Greater accountability for outcomes
Population Health: Risk-Based Models

If risk-based models become more common, what does the organization need to do to better manage risk? Where do you begin?

**INITIAL ENTRY**
- Reporting or process measures
- E.g., early PQRS or core measures
- Developing data infrastructure
- Refining performance improvement methodologies

**EXPERIENCED PARTICIPANT**
- Clinical quality outcomes
- Financial / efficiency measures
- Proven analytics and process improvement

**ADVANCED PROVIDER**
- Full quality and outcomes
- Total cost of care focus
- Disease management / coordination of care working effectively

Time and Experience

Less risk → More risk
Information Technology Investment

• A large part of the answer of where to begin is a function of what you understand about your patient population.

• Population health models are based on assessing and responding to the needs of many.

• To manage that level of data, future success is dependent upon an effective IT strategy.

• Data will enable performance improvement; when coupled with an effective care delivery model, improved outcomes can be realized.

• The expected IT investment over the next several years – billions and billions – is staggering.
Information Technology Investment

Why has growth in spending exponentially increased in recent years?

- MU/PQRS and desire by Medicare to orchestrate care versus pay claims.
- Care management necessary to move to next level and compete in new era.
- New technologies promise solutions:
  - Predictive modeling
  - Utilization profiles
- The ability to take on risk for ACOs and other organizations:
  - Consider CMS’s recent announcement of *Next Generation ACOs*
  - Even if you don’t voluntarily pursue risk-based payment, it’s on its way in some form
EHRs and other IT tools are essential to support PHM functions.

Care Delivery Models Evolve

• In order to improve outcomes and better target patient interventions, healthcare organizations are adopting new models of care.

• Some of these are fairly well-defined models that are selected for implementation such as the patient-centered medical home (PCMH).

• Others may be less deliberate, such as a gradual increase in use of advance practice clinicians.

• And some evolution is a function of relatively new entrants to the market (compared to traditional hospitals and clinics), such as convenient care clinics in pharmacies and other retail locations.
Care Delivery Models Evolve

- One change we have observed is the expansion of the role of nurse practitioners and other advance practice clinicians (APCs) like physician assistants.

- This expansion of non-physician services is supported by many states:
  - Effective January 1, 2015, New York State no longer requires a written practice agreement with a physician for nurse practitioners with 3,600 hours or more of experience.
  - Known as the Nurse Practitioners Modernization Act, the law does not change the scope of practice.
  - At least seventeen (17) states and D.C. no longer require written practice agreements.

Care Delivery Models Evolve

With these changes, APCs are practicing more and more independently and more often carrying their own primary care panels.

### Primary Care Panel Size: AMGA 2014 Survey

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Group Count</th>
<th>Provider Count</th>
<th>50th Percentile</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>26</td>
<td>876</td>
<td>1,827</td>
<td>1,897</td>
</tr>
<tr>
<td>Family Medicine with Obstetrics</td>
<td>8</td>
<td>70</td>
<td>1,966</td>
<td>1,908</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>25</td>
<td>760</td>
<td>1,837</td>
<td>1,828</td>
</tr>
<tr>
<td>Pediatrics &amp; Adolescent - General</td>
<td>22</td>
<td>423</td>
<td>2,003</td>
<td>2,036</td>
</tr>
<tr>
<td>Nurse Practitioner - Primary Care</td>
<td>9</td>
<td>77</td>
<td>1,180</td>
<td>1,425</td>
</tr>
<tr>
<td>Physician Assistant - Primary Care</td>
<td>6</td>
<td>52</td>
<td>1,369</td>
<td>1,517</td>
</tr>
</tbody>
</table>
Care Delivery Models Evolve

• In addition to expansion of APC professional services, locations and levels of care have expanded... such as retail clinics:
  – Today, there are an estimated 1,600 retail clinics nationally
  – CVS Caremark has added 200 clinics since ‘11 with another 850 planned by ‘17
  – Interestingly, WalMart has indicated drops in retail clinic visits in the recent past
  – There may be a regional or demographic component to acceptance

Physician Compensation Models

The net effect is that most physician compensation plans are adopting more value-based measures ... but in a way that doesn’t risk focus on the current importance of productivity.

Goal is better alignment between the behaviors and outcomes!
Physician Compensation Models

• Most compensation models today maintain a **large productivity element**.

• **Quality/clinical outcomes** have moved beyond process measures for many.

• **Patient satisfaction** (or proxy) has become a standard measure, but it represents a small percentage of pay.

• Use of **citizenship** varies by organization (behavioral or service to group/organization).

• Few groups have 20% or more at risk for non-productivity metrics.
### Physician Compensation Models

**AMGA Survey Results on Incentive Measure Prevalence**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>Individual Financial Goals</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>Clinical Outcomes</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>HEDIS</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Cost Containment</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Citizenship</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Dept RVU Goals</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Peer Chart Review</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Dept Budget</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

- **Patient Satisfaction**: 62% in 2013, 43% in 2014
- **Individual Financial Goals**: 48% in 2013, 62% in 2014
- **Clinical Outcomes**: 43% in 2013, 20% in 2014
- **HEDIS**: 27% in 2013, 25% in 2014
- **Cost Containment**: 25% in 2013, 24% in 2014
- **Access**: 25% in 2013, 22% in 2014
- **Citizenship**: 24% in 2013, 21% in 2014
- **Dept RVU Goals**: 22% in 2013, 20% in 2014
- **Peer Chart Review**: 21% in 2013, 19% in 2014
- **Dept Budget**: 21% in 2013, 19% in 2014
Physician Compensation Models: Sample Non-Productivity Metrics

<table>
<thead>
<tr>
<th>Primary Care Metrics</th>
<th>Preventive Metrics</th>
<th>Specialist Metrics</th>
<th>Quality Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient access</td>
<td>Mammogram screening</td>
<td>Post-discharge summary to PCP</td>
<td>Inpatient SCIP &amp; Core Measures</td>
</tr>
<tr>
<td>Panel size</td>
<td>Colon cancer screening</td>
<td>Readmission reduction</td>
<td>NCQA/HEDIS/NQF Standards</td>
</tr>
<tr>
<td>Mid-level provider supervision</td>
<td>Cervical screening</td>
<td>On-time surgical starts</td>
<td>Care model development/adopti on</td>
</tr>
<tr>
<td>Care coordination fee (e.g. per patient per month)</td>
<td>Osteoporosis screening</td>
<td>Discharge planning</td>
<td>Patient outcomes around identified conditions</td>
</tr>
<tr>
<td>PCMH development</td>
<td>Flu vaccination</td>
<td>Patient access to specialist appointment</td>
<td>Completed health risk assessments/screeni ng exams</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Pneumonia vaccination</td>
<td>Supply standardization</td>
<td>33 ACO quality metrics</td>
</tr>
<tr>
<td></td>
<td>Blood pressure screening</td>
<td>Timely consults (measured by PCP survey or set timeframe)</td>
<td>Use of disease registries</td>
</tr>
<tr>
<td></td>
<td>Eye/foot exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cholesterol screening</td>
<td>Care coordination</td>
<td></td>
</tr>
</tbody>
</table>
## Physician Compensation Models: Sample Non-Productivity Metrics

<table>
<thead>
<tr>
<th>Patient Satisfaction Metrics</th>
<th>Citizenship Metrics</th>
<th>Finance Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AMGA, Press-Ganey, Avatar and others</td>
<td>• Timely medical records completion</td>
<td>• Expense control – department or location</td>
</tr>
<tr>
<td>• Peer-peer reviews</td>
<td>• Successful coding audits</td>
<td>• Meet or exceed budget – department or location</td>
</tr>
<tr>
<td>• Staff-peer reviews</td>
<td>• MU adoption</td>
<td>• Profitability of physician group</td>
</tr>
<tr>
<td>• Patient phone or email surveys</td>
<td>• Meeting attendance</td>
<td>• ACO shared savings</td>
</tr>
<tr>
<td></td>
<td>• Call coverage</td>
<td>• Timely submission</td>
</tr>
<tr>
<td></td>
<td>• Risk management/compliance education</td>
<td>• Meaningful Use dollars</td>
</tr>
<tr>
<td></td>
<td>• Provider flu and tuberculosis vaccination</td>
<td></td>
</tr>
</tbody>
</table>
Physician Compensation Models: Contemporary Concerns

• Anecdotally, we are also seeing more emphasis on **supervisory stipends** for advance practice clinicians (APC):
  – Stipends appear to be increasing in areas where care models include more physician extenders (from levels of $8 - $12K per year to $20K or more for each APC supervised)
  – Limited or no survey data exists to support these levels

• There is also some concern about **efficiency metrics:**
  – What is considered rationing of care versus desirable efficiency?
  – What are potential regulatory and public relations implications?

• In markets with moderate to rapid changes, survey data will lag changes in pay practices... so document your rationale for changes when needed.
Physician Compensation Models: Take-Aways

• Understand your patient population and how care delivery may need to change.

• Assess your current and future payer environment, especially the likelihood of more risk-based payments.

• Set up a compensation program that is *flexible* given the environment:
  – Incorporate value-based incentives in a way that can be “scaled up” over time
  – Involve physicians in discussions about market changes, especially risk-based models

• Consider the change management needs of providers when transitioning from pay-for-volume to pay-for-value (e.g., practice style, individual views of best practices, compensation impacts).

• Consider how your care model, including use of advance practice clinicians, impacts the way you should pay your physicians.
Thank You

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whartley@amgaconsulting.com