A Brave New Compensation Model For A Brave New World: The Evolution of A Value Based Compensation Model

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Crystal Run Healthcare
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Outline

• Prior formulas
• Why change?
• New formula
• Evolution of the value factor
• New definition of “ancillary income”
About Crystal Run Healthcare

- Physician owned MSG in NY State, founded 1996
- 350+ providers, 30+ locations
- ASC, Urgent Care, Diagnostic Imaging, Sleep Center, High Complexity Lab, Pathology
- Early adopter EHR (NextGen®) 1999
- Accredited by Joint Commission since 2006
- Level 3 NCQA PCMH Recognition since 2009
About Crystal Run Healthcare ACO

• Single entity ACO
• April 2012: MSSP participant
• December 2012: NCQA ACO Accreditation
• 30,000 commercial lives at risk
• MSSP
  • 11,000 attributed beneficiaries
  • 82% primary care services within ACO
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Compensation 1996-2011

• **Partners**
  • 100% Productivity
  • Productivity defined by professional receipts
  • Overhead allocated equally, regardless of specialty
  • Ancillary Income ("group income") shared equally
  • Relatively simple to administer
  • Specialty withhold redistributed to PCP Partners
Compensation 1996-2011

- Employed Physicians
  - Market aligned guarantee
  - Productivity bonuses
  - Productivity defined by professional receipts
Compensation 2011-2013

• Partners
  • 99% Productivity plus specialty related income
  • Productivity defined by interplay of wRVUs and receipts (MGMA benchmark for wRVUs)
  • Overhead allocated by specialty and individual
  • Ancillary Income (“group income”) shared equally
  • Physician Matrix added
Compensation 2011-2013

• Employed Physicians
  • Market aligned guarantee
  • Productivity bonuses
  • Productivity defined by professional receipts
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Why Change?

• Insanity: Doing the same thing over and over again and expecting different results
  - Albert Einstein
Why Change?

• “Every system is perfectly designed to achieve to get the results it gets.”
  - Dr. Paul Bataldan
Why Change?

• Evolving market
  • Practice focused on value
  • Physician engagement
  • Market slowly evolving to value
Why Change?

• Partner compensation too complex
  • Allocating overhead
  • Limited benchmarking information
  • Payer mix adjustments
  • Benchmarking adjustments as payments and wRVUs often not linearly related between specialties
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<table>
<thead>
<tr>
<th>General Goals</th>
<th>Solutions</th>
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<tbody>
<tr>
<td>Simpler</td>
<td>Only 3 inputs: Specialty, Productivity, Value</td>
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<tr>
<td>Adaptable to changing definition of “productivity”</td>
<td>Can swap wRVU for panel size</td>
</tr>
<tr>
<td>More reliable benchmarks</td>
<td>Combine AMGA + MGMA</td>
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<tr>
<td>Simplify overhead</td>
<td>Overhead is included in benchmark compensation</td>
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<tr>
<td>Correlate productivity benchmarks with compensation benchmarks</td>
<td>Improved correlation seen</td>
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<tr>
<td>Transition to value</td>
<td>Increase value contribution over time</td>
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<td>Compensate partners and employees similarly</td>
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Starting with the RCI & Productivity

- **Comp Benchmark (Weighted)**
- **RCI Relative Comp Index (Comp / Comp “FP”)**
  - **Comp “FP” Benchmark**
  - **PR Prod Ratio (Aggregate wRVU / wRVU)**
- **II Income Index (PR * RCI * RIF I)**
  - **RIF I RVU Income Factor I ~ 1.0**
  - **NCF National Conversion Factor (Comp “FP”)**
  - **Comp “FP” Benchmark**
- **UC Unadjusted Comp (II * NCF)**
- **PAC I Preliminary Adj Comp I (UC * MA)**
- **Market Adjustment (MA)**
Adding non-wRVU revenue and VALUE

Non-RVU Revenue → PAC I(a)
  Preliminary Adj Comp I(a)
  PAC I + (Non-RVU Rev * (1 – OHAF))

PAC I(a) → OHAF
  Overhead Adjustment Factor 25.0%

PAC I(a) → PAC I(b)
  Preliminary Adj Comp I(b)
  (PAC I(a) * RIF II)

RIF II
  RVU Income Factor II ~ 1.0

PAC I(b) → VCF
  Value Comp Fraction ~ 10.0%

VCF → VBC
  Value Based Comp (PAC I(b) * VCF) * VCS

VBC → VCS
  Value Comp Score 0 - 1.0

NVC
  Non-Value Comp
  PAC I(b) * (1 – VCF)

VCF

PAC II
  Preliminary Adj Comp II
  NVC + VBC
Considering individual items...
Partnership Specific Issues

• If Aggregate Partnership Income is greater than aggregate partner compensation as determined by the formula, overage is allocated equally among the Partners

• If Aggregate Partnership Income is less than aggregate partner compensation as determined by the formula, the shortfall is allocated equally among the Partners
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Aligning Compensation With Value

• **The Market**
  - Traditionally fee for service
  - April 1, 2012 – Participate in MSSP
  - 2013 – Engaging commercial payers in value

• **Physician Compensation**
  - Prior to 2011: 100% productivity
  - 2011-2013: Physician Matrix
  - 2014: Value Compensation Score
Step 1: Physician Matrix (2011-2013)
- Improving Quality of Care (30%)
- Reducing Cost of Care (10%)
- Improving Patient Experience of Care (25%)
- Administrative Responsibilities (35%)
- Leadership Development (“Extra Credit”)
Aligning Compensation With Value: Physician Matrix

- **Improving Quality of Care (30%)**
  - Three quality measures per specialty

- **Reducing Cost of Care (10%)**
  - Charges per patient

- **Improving Patient Experience (25%)**
  - Patient satisfaction survey
  - Access (3rd Next Available)
Aligning Compensation With Value: Physician Matrix

• **Administrative Responsibilities (35%)**
  - Coding, note completion, vacation requests, meeting attendance, standard schedule

• **Leadership Development (“Extra Credit”)**
  - Committee involvement, CME presentation or attendance, interview dinners, honors & awards, community involvement
### Aligning Compensation With Value: Evolution of the Value Compensation Score

<table>
<thead>
<tr>
<th>Administration’s Priorities</th>
<th>Partners’ Priorities</th>
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<tbody>
<tr>
<td>Increase worth of value component (10% to start)</td>
<td>Change access measure from third next available appointment</td>
</tr>
<tr>
<td>Remove “administrative” tasks</td>
<td>Improve benchmarking for charges/patient when compared with peers</td>
</tr>
<tr>
<td>Focus on improving quality, patient experience, reducing cost</td>
<td>Don’t force rank the final score</td>
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<tr>
<td>Align quality measures with payer metrics</td>
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<tr>
<td>Individual &amp; group measures</td>
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**AMIGA 2015 Annual Conference**
Value Compensation Score: Administrative Tasks

- Meeting attendance
- E&M coding
- Medical record completion
- Vacation requests <3mo
- Atypical office schedule
  - These are expected behavior
  - These will continue to be tracked and reported to division leaders
QUALITY

The Race for Quality has no Finish Line—so technically, it’s more like a Death March.
Value Compensation Score: Quality Improvement Project

- Participation in two QI projects each year
  - Examples include variation reduction, mentoring, smaller, independent projects
  - Division leader reports if project is completed
  - Worth 2% of income
Value Compensation Score: Scoring Overview

• Quality – 40 points
  • Individual 30 points, Group 10 points

• Patient experience – 40 points
  • Individual 25 points, Group 10 points, Practicing Excellence 5 points

• Cost – 20 points
  • Individual 10 points, group 10 points

• Leadership – Extra credit
  • 10 point cap
Quality:
Individual Measures (30 points)

- Each division chose from a menu of choices that align with payer metrics (if applicable)

- Resulted in asymmetry between specialties (Range 3-10 measures per specialty)

- Surgical measures are outcome based
Quality: Group Measure (10 points)

• Medicine – align payer specific measures with pertinent specialty

• Surgery – process measure chosen by each division (i.e. wrong site/side, unlabeled syringes, other patient safety measures)
Patient Experience:
Individual Measure (25 points)

- Individual patient satisfaction survey
  - Rolling 30 responses or all responses in current quarter, whichever is greater
  - If <30 responses, points awarded will be proportional to number of surveys returned
Patient Experience:
Group Measure (10 points)

• Growth of distinct and/or new patients

• Goal is currently set at 3% for each specialty
Patient Experience: Practicing Excellence Campaign (5 points)

• Participation in practice wide initiative to improve the patient experience (90% required)

• Involves web based modules and shared learnings
Cost of Care
Individual Measures (10 points)

• Charges/patient compared to peers (5 points)
  • Using standard deviations, not percentiles

• Charges/patient compared to self (5 points)
  • Points awarded if cost is decreasing or within 3% of previous
Cost of Care
Group Measure (10 points)

• Least costly site of care
  • Medicine: ER and/or Urgent Care utilization

• Surgery: ASC vs. hospital; hospitals tiered based on commitment to value
Leadership (10 point cap)

- Committee chair CRHC/hospital (3 points each)
- Committee member CRHC/hospital (1 point each)
- Achieves community honor/award (2 points each)
- Provide CME event at CRHC/hospital (2 points)
- Attend CME event at practice (0.5 points each)
- Attend practice sponsored event (1 point each)
- Attend an interview dinner (0.5 points each)
Scoring:
Benchmarks

- **Unchanged from current process**
  - If national benchmarks exist, they are used
  - If national benchmarks do not exist, CRHC benchmarks are created and frozen for 1 year
Scoring:
Overall Value Compensation Score

• Providers will receive a score XX out of 100
  • ≥ 50: VCS is 1.0
  • 40-49: VCS is 0.75
  • 30-39: VCS is 0.5
  • 20-29: VCS is 0.25
  • <20: VCS is 0
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New Ancillary Income

**Volume World**
- Labs
- Imaging
- Procedures
- Facility Fees

**Value World**
- Shared Savings
- Care Management Fees
- Value Incentives
New Ancillary Income

• **Shared Savings**
  • Distributed equally among all partners

• **Care Management Fees**
  • Distributed to primary care by panel size

• **Value Incentives**
  • Distributed to involved specialties by panel size
Moving forward...

• Increase the share of compensation “at risk” for value to 15% by Q3 2015 and at least 33% within 5 years

• Improve alignment of performance metrics with desired quality and cost outcomes

• Increased accuracy and automation of performance metrics
Questions

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