Physician Compensation Methodologies and Building Clinically Integrated Communities

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Outline

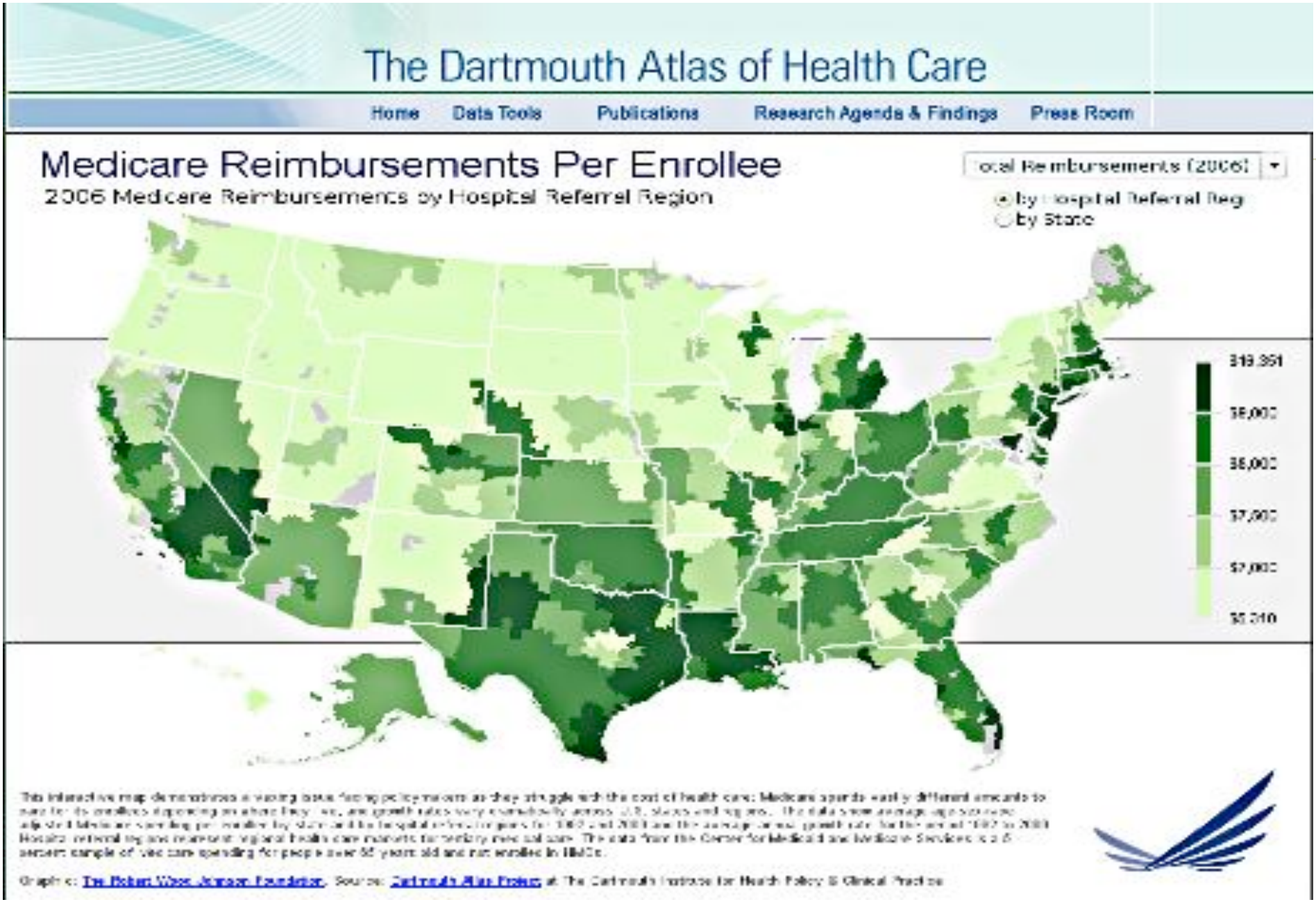
- Analysis of Physician Compensation Methodology
- How compensation relates to Clinically integrated Communities
- Why Clinically Integrate?
- Evolution of Quality Metrics
- Current Applications of Pay-for-Performance Programs
- National Health Reform: An Overview of Key Changes
- Accountable Care Organizations: An Overview
- Implications for Care delivery
- Aligning Incentives
- Discussion

Analysis of Physician Compensation Methodology

- Initial rates were set up based on physician and market dynamics
- Compensation methodology was based on RVU productivity
- Rates per RVU vary greatly because of historical compensation
- Productivity per RVU also varies greatly
- A consistent compensation methodology needs to be adapted

How compensation relates to Clinically integrated communities

- Need for consistency
- Need to integrate with quality metrics
- Need to create incentives to improve productivity as well as individual and group quality performance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Why Clinically Integrate?

- Healthcare reform creates incentives for Providers and Payors to work together, share data and manage chronic conditions across a population
- Large systems like Kaiser, have set the standard for how clinically integrated systems can work…and they are sharing their methods
- For providers to survive they must lower their unit costs and increase their effective management of a larger population
- Negotiations between payors and providers will result in changes in the allocation of the premium…more like Kaiser…less for health plans and hospitals…more for physicians
- Quality metrics & outcome data will drive reimbursement.

Evolution of Quality Metrics

- Quality Metrics and the value produced monitoring chronic conditions will become the benchmark for how we determine value…experience to date includes
  - Integrated Healthcare Association
  - Bridges to Excellence
  - National Committee for Quality Assurance (NCQA)
  - Leapfrog Group
  - Institute for Healthcare Improvement
  - Checklist Manifesto
  - Pacific Business Group on Health

Evolution of Quality Metrics (cont)

- Federal Government's Increasing Role In Coordinating And Integrating Quality Metrics That Are Measured And Reported
  - National Quality Forum Endorsed AHRQ Quality Indicators
  - CMS (Medicare) Quality Metrics
  - Meaningful use of Electronic Health Records Financial Incentives Links With Reporting Quality Measures
  - National Health Care Quality Strategy and Plan
    - To be published January 2011.
    - An effort to coordinate and align quality measures in the public and private sectors
- California Hospital Patient Safety Organization (CHPSO) 164 Hospitals coordinating a standard method for collecting and reporting patient safety metrics

National Quality Forum (NQF) Endorsed AHRQ Quality Indicators

- Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) – June 2010

  http://www.qualityindicators.ahrq.gov

  - Prevention Quality Indicators
  - Inpatient Quality Indicators
  - Patient Safety Indicators
  - Pediatric Quality Indicators

Examples of National Quality Forum (NQF) Endorsed AHRQ Quality Indicators

Inpatient Quality Indicators

Esophageal Resection Volume
Pancreatic Resection Volume
Abdominal Aortic Aneurysm (AAA) Repair Volume
Esophageal Resection Mortality
Pancreatic Resection Mortality
Abdominal Aortic Aneurysm (AAA) Repair Mortality
CHF Mortality
Acute Stroke Mortality
Hip Fracture Mortality
Pneumonia Mortality
Incidental Appendectomy in the elderly
Bi-lateral catheterization

CMS (Medicare) Quality Metrics

- Process of Care Measures
  - Heart attack (7)
  - Heart Failure (4)
  - Pneumonia (7)
  - Surgical Infections (5)
  - Prevention of Blood Clots in Surgical Patients (2)
- Outcome of Care Measures
  - Heart Attack
  - Heart Failure
  - Pneumonia
- Outpatient Imaging
  - Low Back Pain
  - Mammogram
  - Abdominal Scans
  - Chest CT

Source: National Summary Statistics as reported on Hospital Compare March 2009

"Meaningful Use" Model

Federal government linking "meaningful use"of electronic health records with **financial incentives** to achieve five health care goals:

- To improve the quality, safety, and efficiency of care while reducing disparities
- To engage patients and their families in their care
- To promote public and population health
- To improve care coordination
- To promote the privacy and security of EHRs

Demonstrating "meaningful use" is the key to receiving financial incentive payments

Patient Safety

California Hospital Patient Safety Organization (CHPSO) Patient Safety Indicators

- Death in Low Mortality DRGs
- Death among Surgical Inpatients with Serious Treatable
- Foreign Body left in During Procedure
- Iatrogenic Pneumothorax
- Postoperative Respiratory Failure
- Postoperative PE or DVT[1]
- Postoperative Wound Dehiscence
- Accidental Puncture or Laceration
- Transfusion Reaction
- Birth Trauma - Injury to Neonate[1]

[1] Time limited Endorsement.

Integrated Healthcare Association

- IHA.org has been refining and implementing criteria to measure medical quality since 2003.
- "Pay for Performance" has resulted in a list of quality measures that are agreed upon by all health plans and capitated medical groups in California.
- Providers have been given bonus payments over the past 6 years based on their performance on these measures.
- Some current frustration with use of metrics.

Bridges to Excellence

- A national quality measurement program that has developed a series of measures and a standard protocol for reviewing them that has been accepted by most health plans.
- These measures are automatically determined from review of claims data.
- Incentive payments are distributed based on compliance with the measures.

National Committee for Quality Assurance (NCQA)

- NCQA has established measures that include HEDIS and quality measurements
  - used in many health plans
  - and increasingly medical groups
- Established the criteria for certification of the **Patient Centered Medical Home** (PCMH) that is currently in demonstration projects in CMS for Medicare and is being considered for funding by many health plans.

Leapfrog Group

- Leapfrog is dedicated to "mobilizing employer purchasing power to alert America's health industry that big leaps in healthcare safety, quality and customer value will be recognized and rewarded."
- Leapfrog works with its employer members to encourage transparency and easy access to healthcare information, as well as rewards for hospitals that have a proven record of high quality care.

Institute for Healthcare Improvement

- An organization dedicated to improving quality standards. IHI.org has developed a series of well-documented checklists that are becoming the standard for delivery of care. (Implementation Plan)
- These checklists are increasingly being used by providers who want to learn about best practices and how to implement them.
- Don Berwick, the former CEO of IHI, has recently been appointed to head CMS. His focus on checklists and use of quality metrics is expected to be incorporated in the implementation of national healthcare reform.

Checklist Manifesto

- By Atul Gawande MD
  - A thought leader in the areas of quality measures and use of resources
  - Wrote *The New Yorker* article on McAllen, Texas
- Read *Checklist Manifesto*
- Learn about the developments in clinical integration

Pacific Business Group on Health (PBGH)

- PBGH is a coalition of large employers who have been negotiating health plan contracts for over 20 years.
- Then have insisted on the implementation of quality metrics in their contracts.
- Former head of PBGH, Peter Lee, has recently been appointed to lead the Administration's effort to implement national healthcare reform.
- His focus on the use of quality metrics is expected to be a key element in the implementation of reform.

Lessons Learned from Applying P4P: Case Study IHA-P4P

- Successfully monitoring and rewarding metrics since 2003
- Empirical evidence P4P changes behavior (care treatment)
- Helped establish national standards for clinical quality
- Increasing focus on efficiency and utilization
- P4P is used for payment reform
- National Quality Forum endorsed 615 measures
- Uses EMR to assist quality-based decision support

P4P Results

- Wide variation in performance
- Physicians think payments are too low
- Health plans think payments are too high
- National P4P incentive averages 7% of total compensation, including efficiency
- Quality metrics are affecting affordability

Keys for Clinical Integration

- Collect data (Hawthorne effect)
- Integrate data -EHR, CPOE, EHR (consistent data)
- Provide meaningful, specific feedback to physicians
  - Hedis, RVU, P4P, Pt Satisfaction, other quality metrics
  - Kaiser and PAMF use hundreds of data points
- Focus on your disease burden and high costs
- Invest in information technology
- Invest in PCP resources- PCMH
- Understand the goals of each party
- Work toward common goals
- Share benefits of savings

More Keys for Clinical Integration

- Use checklists (IHA.org..checklist manifesto)
- Decision support tied to your goals
- Invest in better outcomes (Mayo intake process)
- Outbound disease management (Chronic disease screening)
- Education/ Wellness centers (St Joes)
- Patient engagement (Kaiser check in, PHR - online ordering, test results, appointments, prescriptions, branding)
- Employer engagement (Cisco and PAMF CalPERS and Kaiser)
- Risk (CalPERS, Hill Physicians, Blue Shield)

Clinically Integrated Communities

Physicians
PCP's
Specialists
PCMH
Chronic Disease
Population management
Medical Management

Hospitals
Inpatient
Outpatient
Surgery Centers

Ancillaries
Pharmacies
Laboratory
Radiology
PT
Other professionals
Palliative Care
Hospice

Health Plans
Underwriting
Claims
Marketing
Medical Manag

Buy only what you need

Redesign Imperatives

- Redesign care processes
- Effective use of information technologies
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services and settings over time
- Use of performance and outcome measurement for continuous quality improvement and accountability

- Francis J Crosson, MD, Kaiser Permanente

Case Study - Brown and Toland

- History: FTC antitrust price-fixing lawsuit
- Built virtual clinical integrated model with IT and quality metrics
- Tracks all aspects of care with community-wide HIE
- Uses case mix adjusted predictive modeling to anticipate needs
- Uses “Episode of Care” Management
- Provides community wide EMR with online registration, eligibility, authorization. Decision support based on high cost metrics.

Case Study - MSIPA/MMPC

- Marin/ Sonoma Independent Practice Association (MSIPA) and MMPC built an excellent community-wide shared billing service
- Installed billing for most physicians and adjudicates health plan claims paperlessly
- Installed electronic health record that allows physicians to share patient data across the community
- Installed a health information exchange that transfers patient data between providers, pharmacies, laboratories and hospitals
- Virtually all specialists must participate in the program now to obtain referrals
- Specialists agreed to reduce their compensation to support the development of the system and subsidize the primary care physicians.
  - also increased compensation to primaries through the medical group.
  - And helped form a new integrated medical group that subsidizes the primaries
- Meet all of the quality metrics identify by IHA and distribute bonuses to physicians for meeting metrics
- Built excellent model that expanded beyond core area and attracted physicians from other communities

Healthcare reform encourages Clinical Integration

- Expanded coverage (Uninsured…Medicaid)
- Delivery Reform (ACOs)
- Payment Reform (Never events, ACOs)
- HITECH
- Effect on uninsured and community clinics

Demonstration Projects

- Patient Centered Medical Home
- Innovation Center
- Value-Based Purchasing for hospitals, SNFs HHAs, Ambulatory Surgery Centers
- Hospital readmissions reduction program
- Pediatric ACO's
- Pilot program for Bundled Payments
- Quality Reporting for LTC, Rehab and Hospice
- Payment Adjustment for Hospital-Acquired Conditions

Accountable Care Organizations

- Medical groups with 5000 Medicare lives may apply in 2014
- Hospital participation not required
- Savings from reduced costs will be shared with ACO
- Creates incentives for physicians to manage care and benefit from the savings
- Best if hospitals and physicians learn to work together to control costs and produce better outcomes
- What implications will this create for how hospitals and physicians work together to care for a community?

Establishing ACOs

- Eligible Organizations
- Assigning Medicare beneficiaries to the ACO
- Setting spending benchmarks
- Performance Measurement and accountability
- Distributing Savings
- Hospitals can assist medical groups to get prepared with an EHR and an organized system that can attract patients and manage care cost effectively with better outcomes

Keys for Building a Successful ACO

- Know your costs and utilization issues
- Build physician leadership that understands Utilization Management and Chronic Disease Management systems that can reduce costs and increase health outcomes
- Have an integrated Electronic Medical Record with community-wide integration and coordination
- Understand your community health profile and how you have delivered care in the past
- Patient-Centered Medical Home structure
- Financial models and performance metrics
- Become a real health center

Identifying Best Practices for ACOs

- Take the Cleveland Clinic to McAllen
- Understand
  - Acuity adjusted cost per discharge
  - Cost (management) vs. Utilization (MD) issues
  - Cultural Barriers
  - Data Barriers
  - Understand Google diagnostics
  - Quality Monitoring
- Use checklists
  - *Checklist Manifesto*, Atul Gawande, MD
  - Clinical Judgment
  - Evidence-based Guidelines
  - Apply best practices
- IHI.org Implementation Map (Don Berwick- CMS)

ACO Implementation Issues

- Will your physicians engage?
- Will they accept checklists and protocols?
- Will they react to the incentives?
- What is right for your community?
- Understand what for-profit ACOs are planning with Wall Street
- Will CMS develop an NTSB approach?
- The advantage of plane crashes

Payment To ACOs

- Payments will continue to be made to providers of services and suppliers participating in ACOs under Medicare's FFS Program for Parts A & B
- ACO is entitled to receive payment for shared savings if it meets certain requirements: Quality performance standards established by the Secretary
- Reporting requirements
- Benchmark target

Partial Capitation Is An Option

- Secretary has option to use partial capitation model to make payments to ACOs
- ACO at risk for some, but not all, of the items and services under part A & B
- Secretary may limit partial capitation model to ACOs that are highly integrated and capable of bearing risk (as determined by Secretary)
  - Secretary may use other payment models s/he determines will improve quality and efficiency of items and services
- ACOs exclude Medicare Advantage members
- Should providers consider forming insurance companies?

Provider Implications

	Costs	Quality	Coordination	Risk
FFS	+++	?	--	0
P4P	++	+	--	0
Bundled Pmt	--	+	+	0
PCMH	-	+	++	0
Profit Share	--	?	+	0
Risk Share	--	?	++	+++

Payment Implications

Payer	Clinics	Hospitals
Medicaid	same	negative
New Medi-cal	positive	negative
Medicare	same	same/negative
Commercial	positive	same/negative
New commercial*	positive	positive
Still uninsured	same/negative	same/negative
Undocumented	same/negative	same/negative

*formerly uninsured

Aligning Incentives

- Do we understand how each party is affected?
- Can we identify common strategies that help both parties?
- What resources are needed to be effective?
- How will each party benefit from these changes?

Implications for Community Clinics

- Community Health Center expansion: $11 billion in new funding over 5 years, starting in FY 2011
- Expanded National Health Service Corps
- Medicaid expansion to 133% of poverty with no restrictions
- Exchanges and community clinics: private insurers in exchanges cannot be paid less than Medicaid rate and requires plans to contract with exchanges
- Medicare: FQHCs will be paid for preventative services
- Development and support of residency programs in FQHCs

Questions for Community Clinics

- Will Clinics continue to grow and serve low-income populations?
- What will happen to funding for clinics and DSH?
- Where will clinics refer patients in the future?
- Will private physicians and integrated groups compete for newly insured patients?
- How will community clinics continue to serve undocumented and still serve uninsured patients?

Implications for Hospitals

- Understand implications of different payment methods, ACO, bundled payments
- Find constructive ways to work with your medical staff or local IPA
- Consider investments in integrated groups
- Evaluate your system's ability to manage care and control costs
- Evaluate your market opportunities and how they will change as more get insurance
- Consider branding strategies that position your organization to market directly to patients as an organized system of care (electronic ID card, benefits of membership in your organized system of care)

Implications for Medical Practices

- Medical groups can form ACOs directly with Medicare and other payers
- Medical groups with capitated experience are well-positioned
- Aggressive medical groups are trying to expand their market
- Capital investment is needed to meet ACO requirements
- Working with hospitals and health plans can help control costs and be a source of capital

Implications for Hospital-based Clinics

- Hospitals can organize their affiliated groups and clinics to form ACOs with them
- If hospitals do nothing, physicians can organize around them and profit from reducing services
- Better integration and coordination of care works to the benefit of the hospital and overall costs
- Better to be part of it than just sit back and have it done to you

Implications for Health Plans

- Health plans can form ACOs with physicians
- Health plans can change reimbursement methodology to align goals with physicians
- Health plans can be a source of data and capital to help facilitate the development

Discussion

- What role models can communities learn from that have implemented quality metrics and clinical integration (e.g., Kaiser, PAMF, Mayo, Gisenger, and?)
- What's the best way to develop an integrated medical community that can work to improve outcomes at lower cost?
- How can providers and payers best benefit from federal Health Reform (ACA)
- How long do you anticipate implementation will take to unfold once final regulations are issued?
- Do you think payment incentives and utilization management will change the way we deliver care?

Thanks for listening

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