Value-Based Compensation

An MGMA Research & Analysis Introduction

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Where do compensation plans stand today?

What is driving the demand for value-based plans?

How should our practice implement value-based plans?

What challenges will we encounter?

How do value-based compensation plans affect the patient?

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MGMA developed this content based on discussions with medical practice management experts. It is intended to be a primer for those readers who are less experienced in the field of value-based compensation. The compiled websites and products are meant to provide resources to those who are researching the adoption of quality metrics for their practice.
MGMA believes that providers should be rewarded for providing the best possible patient care, experience and outcomes.

Rewarding performance through provider compensation can be a very effective method of placing greater focus on patient outcomes.

While potentially effective, implementing these value-based compensation models poses difficult challenges. The MGMA Data Solutions team talked with a practice executive who implemented value-based compensation plans and one of the Association’s healthcare consultants who specializes in this area. This summary highlights these conversations and the most recent findings from the MGMA DataDive 2014: Physician Compensation and Production Module to help industry members navigate this relatively new path.

Value-based compensation plans include target quality metrics that providers/practices must meet. Some examples* include medical assistance with smoking and tobacco use cessation, breast cancer screening, and adult body mass index (BMI) assessment.

Insight from Jeffrey B. Milburn, MBA, CMPE, consultant, MGMA Health Care Consulting Group, who specializes in value-based compensation issues

“Recently there has been no shortage of articles, papers, webinars, presentations and conferences on the subject of value in healthcare. **Payers have generally defined the term ‘value’ as reducing costs and increasing quality.** Healthcare organizations have embraced the value concept to help increase quality and control healthcare expenses. The value concept generally includes a **transition from fee-for-service payment to a reimbursement system driven by value metrics.**

“The value concept is still relatively new, and it is promoted by a variety of government and private sector payers with different definitions and metrics. Providers are left to sort out their level of participation in the different value initiatives.”

Visit the MGMA Government Affairs website for more information on federal quality reporting programs and our link to value-based reimbursement.
“Pay-for-performance compensation, which was introduced a number of years ago, provides a foundation for value-based plans because additional compensation was added to the base provider compensation agreements if the providers met certain specific metric goals and objectives.” There are many challenges in moving to value-based methodology, such as EHR flexibility and payer negotiation creativity.

Quality is currently a small, albeit increasing, component of physician compensation, according to data from the MGMA 2014 Physician Compensation and Production Survey: primary and specialty care physicians reported medians of 3.57% and 3.00% in 2013, respectively.

Further insight: When groups had quality as a component of compensation for primary care physicians, nearly half of those physicians reported 10% or more of their salary at risk in 2013.

Practices have an opportunity to show payers their adaptability by demonstrating:

- Satisfactory PQRS measure reporting
- Patient satisfaction scores at or above CG-CAHPS benchmarks
- Ability to report population health metrics and standards of care
“Although providers generally embrace the lower cost/increased quality concept, they are naturally wary of any new methodology that is difficult to understand and manage. **Providers must cover operational expenses and maintain adequate compensation to recruit and retain physician staff.** These are some of the reasons why there has been slow implementation of the value concept in some environments.”

**Subsidy for Value**

If you are:

- **Private practice receiving subsidies:** Consider applying a portion of those dollars to specific **quality metrics like performance on medicine reconciliations or hospital readmissions.**

- **Part of a large integrated system:** First quantify the amount of subsidy received, then **advocate for funding of quality measures.**
Interview with David Taylor, FACMPE, FACHE, vice president of regional services, CoxHealth, Springfield, Mo., who recently implemented value-based compensation models

“The environment is driving how everyone is looking at physician compensation incentives as we are on a cost trajectory that is not sustainable,” says Taylor, who guided a multispecialty group of more than 300 providers in 80 clinics through the creation of value-based compensation models.

“Starting with Medicare, there is both a carrot and a stick approach to how physicians are now paid. The PQRS and Meaningful Use programs are great examples of this. The programs require that very specific criteria be met and, depending on the level of success, determine whether physicians receive an increase or decrease in payment for their services. For many specialties it is too early to tell if there will be a return on investment. During the next few years it will be critical to track how the payers are defining quality and value in their contracts, and how everyone quantifies success.”
“There is also a shifting of risk from the payer to the provider. An example is the organizations that participate in Medicare’s Bundled Payments for Care Improvement Initiative. Participants discount their prices for hospitals’ services to patients with specific diagnoses. This payment specifies a defined period of time beyond the patient’s discharge from the hospital. If the hospital is able to reduce readmissions and other associated costs, the savings to Medicare are shared with the provider. The ultimate goal is to redesign how healthcare is delivered and lower the cost of that care.

“The government, commercial payers and employers are increasingly interested in incorporating value and risk into the healthcare compensation system. The industry is struggling with how to best address this. Physician groups making changes to compensation plans must balance their traditional production models with elements that focus on outcomes.”
“In an effort to prepare for these market changes, CoxHealth has focused on obtaining National Committee for Quality Assurance (NCQA) level 3 patient-centered medical home (PCMH) status for its primary care clinics. Five clinics have received the designation and one specialty clinic has obtained NCQA patient-centered specialty practice recognition. There are efforts to have all remaining primary care clinics apply this year.

“How should our practice implement value-based plans? CoxHealth established a care management team (CMT) that identifies gaps in data collection and reporting, as well as gaps in patient care. They work with a variety of reports that come from payers like Anthem and United Healthcare. The CMT is integral to CoxHealth’s Medicare Bundled Payment Initiative that focuses on patients who were hospitalized for pneumonia. Upon discharge, the team works to identify these patients and ensure that they are getting back in to the clinic to receive the care they need from their primary care physicians. This team is comprised of licensed practice nurses (LPNs), clerical staff and a department manager who leads the team. CMT created structure and process changes for the accredited PCMH clinics. Another value is the Cox Family Medicine Residency. Each year there are eight graduates of the program and they try to keep all of them. They hired six this past year. These physicians have been exposed to PCMH in the residency program, which helps the culture in their clinics as they move toward PCMH in all 35 to 40 of their primary care clinics. CoxHealth also has an endocrinology group that is the first in the state and 28th in the country to receive PCMH designation for a specialty clinic.”
The CMT was developed with a centralized approach to provide consistency and much-needed resources for the organization’s clinics. Most of the CoxHealth clinics have fewer than 2.5 support staff per provider. They do not have care managers for all of the clinics, which is why they try to centralize processes, such as:

- Pre-visit planning
- Follow-up with non-attending patients
- Filling gaps on HEDIS* indicators

The CMT calls patients to remind them of upcoming visits or outstanding issues to ensure personalized care. As a result, team members build relationships with physicians, staff and patients at each of the clinics, yet the tasks are centralized, which increases efficiency.

Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure performance on important dimensions of care and service. HEDIS consists of 75 measures across eight domains of care.

More info
What challenges will we encounter?

The use of data and technology is critical. CoxHealth also has invested in products like Crimson and Phytel to obtain comparative data for physicians, identify care gaps and reach out to patients who need to come into the clinics. Overall, the care management team includes approximately five or six people. Taylor expects this team to grow to 15 to 20 in the next three to four years.

The varying specialties and needs of the service line play an integral part in building a successful compensation plan. A practice leader needs to sit down with each of the people in the different specialties and understand what makes the most sense in terms of the incentives tied to them. There might be several criteria that are applicable from the clinical and business sides of the clinic.

Cost plays a large factor in building the infrastructure and implementing value-based compensation, including:

- Information technology infrastructure
- Administrative time
- Access to comparative data
- Patient registries
- Patient satisfaction surveys
Decision Pathway to create a compensation plan

**Define problem or opportunity.** What are the goals and objectives for your organization’s plan?

**Collect data.** Gather provider compensation and productivity data. Accurate, reliable and detailed data are of critical importance. Look at the following data sources: financial, patient care and payer analysis.

**Interpret the data.** Benchmark compensation and productivity data, as well as quality and patient satisfaction scores.

**Size up the alternatives.** Develop a compensation plan that meets practice goals and objectives, adheres to legal and regulatory compliance, and aligns practice and provider incentives. Are there existing methodologies that can be used and expanded? A primary goal will be to recruit and retain physicians.

**Present the information.** Translate the data into usable information and distribute your recommendations along with individual physician scorecards.

**Determine the outcome.** Vote on whether to implement the new plan, as applicable to your practice leadership structure. Decide on implementation methodology and next steps.

**Evaluate and monitor how the plan will affect the group and what the outcomes will be.**

Learn more in Strategies for Value-Based Physician Compensation.
Patient satisfaction surveys can cost $1,000 or more per provider — a sizeable investment for CoxHealth considering that the system employs a few hundred physicians. Some payers have helped support these costs by funding infrastructure through per-member-per-month payments or other mechanisms. Grants are another possible revenue source. For example, CoxHealth has received nearly $250,000 in grants from the Missouri Foundation for Health over the last three years, which helped the system begin to implement PCMH in rural health clinics.

Taylor says that it is still too early to determine how value directly affects patients and to determine whether they have noticed any changes in their care. At the end of the day, Taylor does not think compensation plans will be completely based on value, but estimates that 70 to 80% will be based on production and the rest on the quality, outcomes and improvement metrics.

“At this point, because practices are still trying to understand what ‘value’ is, depending on the payer’s definition, it might be hard for a patient to understand as well.”
A final note from Milburn:

“The evolution from volume to value will take time and resources. It won’t happen overnight, and most entities will be dealing concurrently with volume and value metrics for at least three to five years. **Productivity metrics to some extent may always be a compensation plan component because it is necessary to provide incentives to see and treat an appropriate number of patients.** The goals of lower costs, or at least stable expenses, with improved quality are attainable with focused management and coordination among all participants. Addressing implementation now will go a long way to ensuring success by determining start-up goals and objectives and vision of where you want to be in three years. This includes determining benchmarks and targets, along with rewards.”

*Look for a spring 2015 MGMA Research & Analysis report on value-based reimbursement.*
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