# Staking a Claim on Success in the Future of Accountable Care: \*Reimbursement through Quality Incentives\*

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### Agenda

- I. The Accountable Care Realities for Private Practices
- II. The Growing Focus on Quality
- III. Economic Structures for Incentivizing Quality
- IV. Optimizing Reimbursement
- V. The Columbus Clinic Story
- VI. Closing/ Q&A



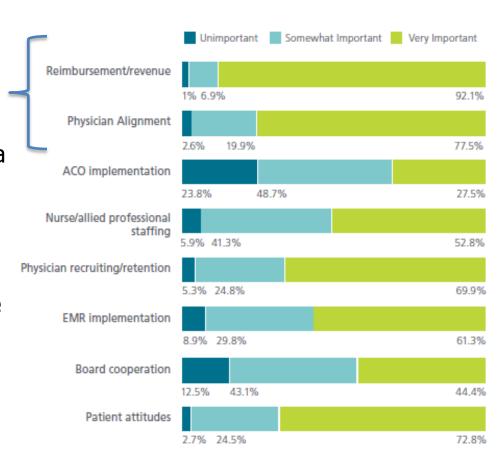
#### Section I:

## THE ACCOUNTABLE CARE REALITIES FOR PRIVATE PRACTICES



### Provider Concerns in 2013

- Reimbursement and alignment top the charts as the two most important concerns for a provider
- Alignment is still considered a primary strategic response to the continuing financial challenges
- Alignment is also Stage I of an organization's accountable care strategy (without alignment, clinical integration is highly unlikely)





### Common Provider Concerns

### 10 Most Pressing Career Concerns for Physicians

- Compensation and/or reimbursement 53.9 percent
   Work/life balance 45.2 percent
  - 3. Work-related burnout and stress 22.1 percent
  - 4. Impact of healthcare reform 16.6 percent\*
  - 5. Lack of autonomy or control in my practice 11.8 percent
    - 6. Quality of healthcare 10.8 percent\*
  - 7. Finding a new practice opportunity 7.3 percent 8. Malpractice issues 6.7 percent
    - 9. Patient-physician relationships 5.2 percent
  - 10. Implementing electronic medical records 5 percent\*

\*Likely to significantly rise in priority throughout 2014



## Comparative Look at the Industry in 2013 and 2014

#### Review of 2013

- Preparatory year for ACA's "Full Implementation Year"
- Increasing efforts toward alignment and integration
- Shift in reimbursement methodologies\*
- Care process delivery transformation initiatives\*
- Progress within ACO/CIN development/population health management ("PHM") efforts
- Primary care development efforts to combat workforce shortages

#### Projections for 2014

- Major ACA provisions rolled out January 1, 2014
  - Individual mandate
  - Comprehensive insurance plans/coverage
  - Medicaid expansion
  - Meaningful Use Stage II
- Accelerated movement within 2013 trends
- Big year for information technology ("IT")
  - ICD 10 Implementation
  - Population health mgmt solutions
  - On-premise to cloud-based systems
- Growth of quality improvement efforts via clinical integration and care delivery transformation



### 2014: Paradigm Shifts Continue

#### Traditional healthcare delivery model

Fragmented care management treating primarily sick people

Integrated care management focusing on preventative care

Episodes of care; utilization management

Coordinated delivery of care rendering appropriate services at appropriate place and time

Production (volume)/Fee-for-service payments

Performance (value); Quality/cost control; bundled payments; capitation; risk-based Disjointed provider base

Collaboratives: ACOs/CINs/PCMHs/ QCs

Accountable care era health care delivery



As Accountable Care concepts become more common, key stakeholders of healthcare will expect private practice physicians to demonstrate quality and cost effective care for their patients.

### Driving Forces for Change

## Economic and regulatory squeeze on independent physicians prompts strategic action

- Financial burdens of maintaining independent practice are proving to be overwhelming
- Many (perhaps most) physicians can no longer afford to maintain a reasonable income compared to amount of risk and effort due to such things as:
  - Cuts in payments/reimbursement
  - Threats to revenue from ancillaries' reimbursement reduction
  - Perceived obligations to patients (more demanding consumers)
  - Added administrative responsibilities for tracking/reporting quality (resulting in increased costs)
  - Increased overhead costs, in general
  - Mandatory EHR implementation/Meaningful use requirements
  - Performance reports



## Driving Forces for Change: Evolving Payment Models

## Risk **Provider** sing Increa

Fee-for-Service

Providers paid a specified amount for each service provided

Pay-for-Performance  Incentives for higher quality measured by evidence-based standards

Value-Based Purchasing

 Percentage reimbursement at risk, earned back by high quality outcomes

**Bundled Payments** 

 Single payment for episodes of treatment, shared by hospital and physicians

**Shared Savings** 

 Percentage of savings from reduced cost of care shared with hospitals and physicians

Global Payments

 All services compensated in one payment that manages the patient across the delivery system

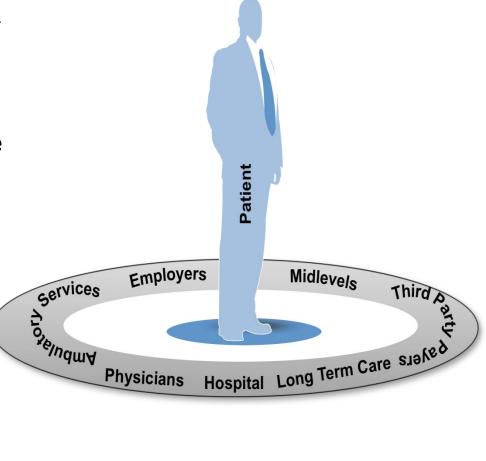


### What to Expect?

- Growing prevalence of organizational structures that require high levels of integration
- Evolution of payment contracts that entail high degrees of risk
- An accelerated movement toward capabilities that support population health management ("PHM")

### Population Health Management

- Strategically, it is the practice of engaging a clearly defined group of patients across the care continuum to drive the value proposition
- Population health is supported by and based on the Triple Aim of the Institute for Healthcare Improvement:
  - ✓ Provide better health outcomes for the population served
  - ✓ Enhance each individual's experience of care
  - Reduce the per capita cost of care



### Population Health Management

- PHM be accomplished by an organization with a structural and functional care model that supports:
  - Prevention and chronic disease management
  - IT tools that can capture and provide needed information allowing for the tracking and analysis of quality/cost metrics
  - Care processes that are data driven and continuously improving
  - Embedded training and population health support

### It All Culminates to Value

#### **Quality (Outcomes)**

- Patient safety and satisfaction
- Physician-led metric development
  - Process and true outcomes measures
- Evidence-based medicine protocols and practices
- Patient-centered care
- Care coordination efforts
- You can't change what you can't measure

#### **Cost Reduction**

- True costs, not proxies (e.g. ratio of costs to charges)
- Activity-based costs of providing care for common clinical conditions (e.g. heart failure)
- Proactive tracking of medical/personnel utilization
- You can't change what you can't measure





## The Ultimate Provider Challenge

- High quality clinical care delivery
- Cost efficient clinical care delivery
- Population health management
  - -Providers must do all simultaneously
  - to deliver value (Outcomes / Cost)
  - all with limited funds



Section II:

## THE GROWING FOCUS ON QUALITY



## Key Foundational Elements Necessary for Providing Quality

- Stage I: Alignment
  - Amongst providers
  - Between providers and their organization
- Stage II: (Clinical) Integration
  - Care coordination
  - Interdependence among participating parties
  - Performance metrics that assess outcomes and costs
  - Robust IT infrastructure that allows data sharing and meaningful data utilization (relative to the performance metrics)

### Alignment vs. Integration

#### Alignment Entails:

- Common goals and objectives
- More structural than functional
  - Medical Staff Membership
  - Joint Venture
  - Common employer
- Tied together by legal and economic connections

#### Integration Entails:

- Merged clinical and business models
- More functional than structural
  - PCMH
  - ACO
  - Quality Collaborative
  - CIN
- Tied together by <u>clinical</u> and <u>cultural</u> connections



### Stage I: Alignment Models

#### **Limited Integration**

Managed Care Networks (Independent Practice Associations, Physician Hospital Organizations): Loose alliances for contracting purposes

**Recruitment/Incubation:** Economic assistance for new physicians

**Group (Legal-Only) Merger:** Unites parties under common legal entity without an operational merger

**Call Coverage Stipends:** Pay for unassigned ED call

**Medical Directorships:** Specific clinical oversight duties

#### **Moderate Integration**

#### **Service Line Management:**

Management of all specialty services within the hospital

**MSO/ISO:** Ties hospitals to physician's business

**Clinical Co-Management:** Physicians become actively engaged in clinical operations and oversight of applicable service line at the hospital

**Equity Group Assimilation:** Ties entities via legal agreement; joint practice ownership

**Joint Ventures:** Unites parties under common enterprise; difficult to structure; legal hurdles

#### **Full Integration**

#### **Group (Legal and Operational)**

**Merger:** Unites parties under common legal entity with full integration of operations

**ACO/CIN/QC:** Participation in an organization focused on improving quality/cost of care for governmental or non-governmental payers; may be driven by practices or hospital/groups

**Employment "Lite":** Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) through which hospital engages physicians as contractors

**Employment:** Strongest alignment; minimizes economic risk for physicians; includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model





Typically Physicianto-Physician



Typically Physicianto-Hospital



Either Physician-Physician or Physician-Hospital

## Stage I: Alignment Models

#### **Non-Employment Models that Allow Practices to Prepare for Integration**

Medical directorships

·Clinical comanagement

agreements

Recruitment

Independent practice associations

Joint ventures

Service line

management ·Professional

services

agreements

Quality

**Collaboratives** 

·ACOs/CINs

Private Practice Alignment Model Options

**Hospital Employment** 

#### **Increasing Integration**



**Independence** 

Private practices have a host of available options that can facilitate their eventual movement toward clinical integration without having to relinquish full autonomy to a hospital partner

## Stage II: Clinical Integration

Clinical integration that advances the value proposition (and thus, the tenets of the IHI's Triple Aim) are predicated on a set of key metrics and data systems:

#### Value-Based Metrics:

- True Outcome Measures
  - Doing what we do differently
    - Care ProcessDesign System
      - Population Health Management
      - » High Value Acute Care
- Cost/Efficiency Measures
  - Doing what we do costeffectively
    - True Costs
    - Throughput
    - Waste Elimination: Savings

#### Volume-Based Metrics:

- Quality Metrics
  - Doing what we do better:
    - ProcessMeasures
    - Harm Measures
- Performance Metrics
  - How well we produce:
    - Patient Visits
    - Procedures
    - wRVUS
    - Revenues



## Establishing Value-Based Metrics

Three general "buckets" of measures:

**Outcomes** 

**Process** 

Costs

- Establishing effective metrics requires significant physician buy-in
- Application of evidence-based medicine



## Sample Value-Based Metrics for Orthopods

- High levels of efficiency within the orthopedic operating rooms
  - Outcome Measures
    - OUTCOME Patient throughput (i.e., number of orthopedic surgical cases per day)
    - COST FTE staffing level
  - Processes (Outcome Drivers)
    - Improved on-time start for first orthopedic surgery
    - Hiring and training of dedicated orthopedic OR team

## Sample Value-Based Metrics for All Providers

- Achieve and maintain low mortality rates for patients receiving elective care
  - Outcome Measures
    - OUTCOME Risk-adjusted mortality rates for patients receiving elective care
    - COST Cost per case for elective cases
  - Processes (Outcome Drivers)
    - Utilization of evidence-based best practice guidelines for VTE prophylaxis, antibiotic prophylaxis and appropriate perioperative beta blocker therapy

## Why Quality Metrics Matter for Private Practices?

- Differentiation in the market
- Maximizing revenue
- Recruiting providers
- Retaining providers
- Retaining high quality staff
- Maintaining independent practice in a position of strength

Section III:

## ECONOMIC STRUCTURES FOR INCENTIVIZING QUALITY



## Change the Incentives, Change the Behavior

- The accountable/value-based care movement represents a significant cultural shift away from the traditional care delivery structure
- In order to continue promoting quality improvement, providers may need a financial "kicker" for their efforts
- Private practices can utilize a number of quality incentive structures, including:



1.
Comp
carve-out/
at-risk

2. Performance bonuses 3. Shared savings plans

Performance fee schedules 5. Quality Grants

### 1. Compensation At-Risk

## **Compensation At-Risk**

Organization establishes specific quality metrics and appropriate baseline values

Compensation framework includes a risk component (i.e. not guaranteed)

Providers paid ONLY when thresholds are met with payment gradations as performance improves



Usually 5-10 percent of total compensation dependent on performance (percentage will continue to increase as push toward accountable care)

## 1. Compensation At-Risk Structures

#### Most Common Structures:

- Fixed Dollar Amount
  - \$10,000 \$40,000
- Percentage of Base Compensation
  - 5% 10% of base compensation\*
- Usually set aside in a pool to be distributed, as earned
- Can be earned and paid out regardless of productivity level

**Key Consideration: Can you afford to implement as an "add-on"?** 

<sup>\*</sup>This value will likely grow as value-based payments continue to rise

## 1. Compensation At-Risk: Practice Examples

### Allocation of Remaining Net Income

- If compensation formula does not distribute all of the Net Operating Income, a distribution of the remainder can be based on performance incentives (i.e. demonstrable quality improvement or cost reduction efforts)
- Example: A practice allocates approximately 90% of its available distributable net income through a percentage of collections model. The remaining 10% (equates to approximately \$15,000 per MD) is tied to certain key performance metrics



### 2. Performance Bonuses

#### Performance Bonuses

Organization establishes specific quality standards, appropriate baseline values and protocols for measuring performance

Amount paid to physician is additive to their annual compensation (salary and/or productivity) and paid annually

Usually within 5-10 percent of total compensation

Providers given bonuses ONLY when thresholds are met

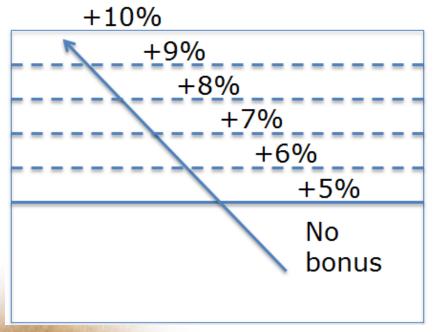
Incremental payments as performance improves

Re-evaluated and adjusted annually



## 2. Performance Bonuses: Compensation Modeling

#### **Breaking the Quality Threshold**



- Establish a bonus pool with all funds in the pool being paid out annually
- 2. Size of the pool dependent on the number of qualifying physicians
- 3. Based on established criteria, physicians eligible for bonuses of pooled funds are those who perform between the baseline and the designated tiers



## 2. Performance Bonuses: Example

- The timeliness of antibiotic administration to a patient presenting with a fever in pediatric oncology weighs heavily on the patient's outcome; an industry-wide recommendation is to administer antibiotics within one hour of seeing the patient
- Bonuses are being given to physicians for achieving this standard

Percent of Patients Receiving Antibiotics within 1 Hr						
	Low	High	Bonus %			
Tier I	50%	59%	5			
Tier II	60%	69%	6			
Tier III	70%	79%	7			
Tier IV	80%	89%	8			
Tier V	90%	99%	9			
Tier VI	100%		10			



## 3. Shared Savings Plans

- Most, if not all, value-based contracts offer its participating providers shared savings funds
  - These funds can supply a private practice with a substantial pool of dollars for distribution to high performing providers
    - These dollars may also be added to an existent pool of internal and external funds for distribution at the end of each quarter or the year



## 3. Shared Savings Model Example

- Example of shared savings model within a quality collaborative's orthopedic surgery program
  - Savings calculated on a cumulative basis each quarter
    - Payout: 50% payer, 25% QC, 25% private practice
  - After direct overhead and administrative costs, the remaining funds are distributed to the orthopods who participate in the QC and perform knee replacements, based on the quality metrics below:
    - SCIP Missed Opportunities
    - A1C for Diabetic Patients
    - Total Joint Class Attendance
    - Completion of Rehab Assessment
  - All measures are weighted at 20% and all funds distributed based on the weighted percentage of the total knee replacements the individual surgeon performed



## 3. Sample Shared Savings Distributions for a CIN

#### **Sample Results of Shared Savings**

	Start-Up	Year One	Year Two	Year Three	Year Four	Year Five
Shared						
Savings	\$0	\$620,000	\$1,800,000	\$2,000,000	\$3,200,000	\$4,000,000
Distributed						

## Sample payer partners shared savings arrangement (varies depending on risk levels assumed)

Payer	Medicare/Medicaid	Commercial Payers
Arrangement	<ul><li>25-60%</li><li>50/50 split is typical</li></ul>	<ul> <li>50-80%; some even offer 100% of shared savings</li> <li>More likely to have downside risk for failure to achieve quality/cost metrics</li> </ul>



### 4. Performance Fee Schedule

- Similar to the fee schedules used by CMS, performance based fee schedules are an extra set of fees based on a provider's performance against established criteria
- Physician reimbursement rates adjusted to meet their performance
- Organizations may pay physicians a percentage of the Medicare fee schedule, as earned
- The better the performance, the higher the percentage rate/payout

# 4. Performance Fee Schedule Example

### Quality Measure: Hypertension Screening

- Percentage of adult patients diagnosed with hypertension who have had at least 2 office visits with blood pressure recorded
  - Goal: 50%

#### Performance fee schedule:

- Physicians with percentages less than 50% paid at 85% of the Medicare fee schedule
- Physicians meeting the goal paid at 100% of the Medicare fee schedule
- Physicians surpassing 50% paid at 115% of the Medicare fee schedule

### 4. Performance Fee Schedule

- In fact, CMS is considering modifying its own fee schedule codes with a new a value modifier
- The intent is to financially reward providers for high value (high quality and low cost) health care via direct reimbursement
- Timeline for this anticipated addition:

Phase I (2015): Practices with 100 or more professionals Phase II (2016): Expand to include practices with 10 or more

Phase III (2017): All physicians



# 4. CMS Value-Based Payment Modifier Project

- Payment scale
  - Max bonus: 2% of Medicare fees
  - Max penalty: -1%

Value-Based Payment Modifier Amounts for the Quality-Tiering Approach

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

<sup>\*</sup> Groups of physicians eligible for an additional +1.0x if reporting measures and average beneficiary risk score in the top 25 percent of all risk scores.



## 5. Quality Grants

- These are the dollars earned by a provider or an organization from its participation in a subsidized quality program (excluding ACOs)
  - Example: Physician Quality Reporting System (PQRS)
    - Uses incentive payments and payment adjustments to promote reporting of quality information
    - Report nine measures across three National Quality Strategy domains to gain incentive

#### The Affordable Care Act authorized incentive payment through 2014:

- · 2011 PQRS 1.0%
- 2012 PQRS 0.5%
- 2013 PQRS 0.5%
- · 2014 PQRS 0.5%



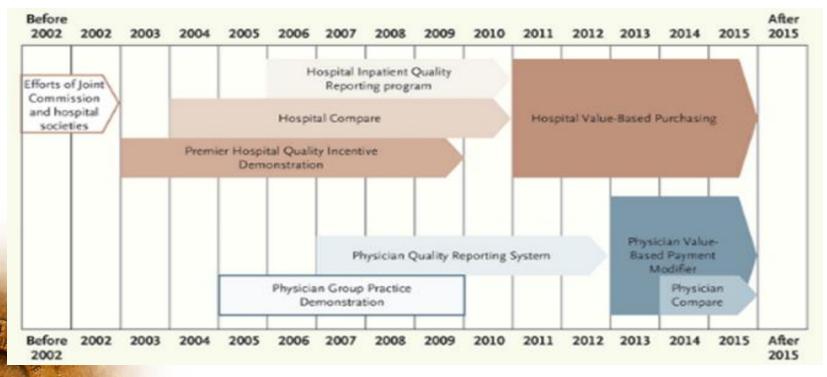
## 5. Quality Grant Example

- Harvard Pilgrim Health Care's Quality Grants Program
  - Aimed at improving care delivery and reducing costs within care delivery models of the hospital's community
  - Since 2010, the program has focused on the development of Patient-Centered Medical Home (PCMH) components
  - In 2013, gave grants totaling \$1 million to fund 14 initiatives from 13 physician groups



## Quality Incentives Over Time

Brief look at government-sponsored quality incentive programs and their evolution



Source: New England Journal of Medicine

# What Do These Incentive Structures Have in Common?

- They are all methodologies for promoting:
  - Team-based care
  - Care delivery transformation
  - Physician champions/leaders
  - Robust IT infrastructures
  - Feedback loops
  - Population health management pillars: IHI Triple Aim
  - "Novel" payment models
  - Regulatory compliance
  - Proactive care providers
    - Advancing the cultural shift necessary for moving an organization into the accountable care era

Section IV:

## OPTIMIZING REIMBURSEMENT



## Preparing for Accountable Care

- Requires a shift of the mind-set from quantity to quality and patientcenteredness
- Quality of care and evidence-based results will become focal points
- Earlier preparation gives practices the ability to work through transition on their own timeline

	Now	2 years from now	Change
Fee-for-service + shared savings	8%	13%	+5%
Bundled payments	1%	6%	+5%
Partial and global capitation	5%	8%	+3%
Total	14%	27%	+13%
Bundled payments			
Currently in bundled payment arra	ingement		***************************************
Negotiating for private bundled pa	yment in n	ext 12 months	***************************************
Considering applying for bundled	payment ar	rangement	
in next 12 months			
III HEXUIZ INOHUIS			

### However....

- Practices must be cognizant of its market trends and reimbursement landscape when modifying its compensation structure
- Simply put, if an organization is still in a predominantly FFS environment with very little indication of change over the short-term, it can slowly phase in quality incentives into the overall compensation structure
- The key is to balance FFS and FF-value such that the providers' rewards match the organization's reimbursement



# Industry Overview: Physician Productivity Incentive

- Production Incentive
  - wRVU-based models are still very common
  - For primary care, some are beginning to augment wRVUs with panel size incentives



# Industry Overview: Physician Performance Incentives

- Quality/Non-Productivity Incentives
  - These incentives continue to gain greater prominence in the industry
    - However, for most organizations, due to reimbursement structure, volume is still very important
  - Shift in focus from simply foundational expectations to value drivers
    - Often tied to any quality-based reimbursement initiatives
    - Minimum work standards (MWS) are established to address other foundational expectations

## Blending FFS and FFV

#### Key Considerations:

- Provide a reasonable base level of compensation
- Focus on wRVU productivity, without overemphasizing it
- Consider panel sizes for primary care providers
- Recognize administrative positions
- Provide a means of incentivizing non-productive criteria (quality, patient satisfaction, citizenship, etc.)
- Distribute the majority of funds through a <u>defined</u> methodology: the internal distribution fund



# Establishing an Internal Distribution Plan (IDP)

- Establishing a group's IDP can be one of the most challenging pieces of the compensation puzzle
  - Some of the key qualities a practice's IDP must embody are:



- Easily adjustable values to remain responsive to changes in reimbursement mix
- Limited number of moving parts without sacrificing effectiveness
  - For example, an IDP that "levels the playing field" for providers in a multispecialty setting can allay compensation disparities. Inclusion of data-driven, metrics-based incentives also promote value-generating efforts.
- Application of similar metrics/variables to each specialty, allowing for equality to exist
- Use of objective productivity or other data for distributing the majority of funds

#### Section V:

# THE COLUMBUS CLINIC STORY



## The Columbus Clinic Story

- Columbus Clinic founded in 1990
- 27 Physicians, 15 Mid-level Providers, 240 employees
- ~100 Miles Southwest of Atlanta, GA on the Georgia/Alabama line separated by the Chattahoochee River
- 2<sup>nd</sup> largest city in Georgia with ~200,000 residents
- Home to Ft. Benning
- Employers Ft. Benning, AFLAC, Muscogee County School District, TSYS, CRHS, St. Francis, Blue Cross Blue Shield of Georgia, Synovus, Columbus State University
- Top 100 Best Places to Live by Livability.com



### Columbus Healthcare Market

- Columbus Regional Healthcare System
  - Midtown Medical Center 413 bed tertiary care facility
  - Doctors Specialty Hospital 219 bed acute care facility (previously HCA facility)
  - Northside Medical Center 100 bed primarily orthopedic facility
  - John B. Amos Cancer Center
- St. Francis Hospital
  - 376 bed not for profit, faith based community hospital; Primary heart hospital in community

## Value-Driven Options

- ACO Medicare Shared Savings Program ACO of Western Georgia, LLC
  - Partnership with local IPA and funded by national insurance company. January 2013 Roll Out
- Patient Assessment Forms (precursor to a lot of these programs)
- Primary Care Value Based Program
  - Started in July 2013. National insurance company paying the Clinic (as well as a few other small groups to meet attributed lives thresholds) \$3.70 PMPM to assist in population management.
    - Hot Spotter Reports measuring the prospective risk
  - PCMH Application submitted to NCQA on December 31, 2013. Awaiting results

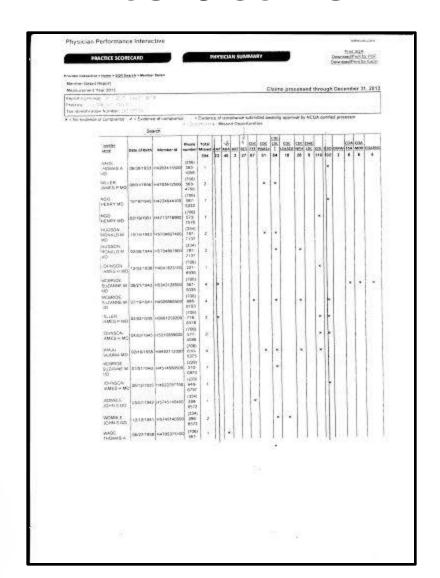
### The Process

- June 2012, invited AMGA leadership to present to our Executive Committee
- June 2012, CEO attended Sectional Conference in Charlotte
- July 2012, Columbus Clinic joined AMGA
- February 2013 approached by CRHS to become employed group
- WHOA!
- March 2013, Chairman, CEO, CFO attended annual AMGA conference

## The Process (cont'd)

- March 2013 invited Coker Group to give presentation to our Shareholders
- April 2013 engaged Coker Group
- Summer 2013 evaluated strategic alternatives
- December 2013, signed exclusivity agreement with St. Francis Hospital
- January 17, 2014, signed LOI/Term Sheet with St. Francis Hospital
- January 17 March 31 negotiated definitive agreements and completed all due diligence
- Closed April 1, 2014

## Physician Performance Interactive





Section VI:

### **CLOSING REMARKS**



## The Shifting Horizon

- With or without the ACA, the healthcare landscape will continue to change as it has for the last year and private practices are likely to be the most impacted
- Every sector of the industry has realized shifts from the norm toward transformative models and trends that have quality and cost at the forefront
- Great care and regulatory consideration will be needed to stay in-sync with the current market and prospective changes
- Private practices can certainly respond via alignment and integration but the ultimate goal will be to deliver value

## Q&A





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