Scripps Clinic Medical Group
Journey from Volume to Value
Lessons Learned from “The Field”

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Presentation Outline

- Introductory comments on challenges of transition.
- Background- organization and environment.
- History of compensation program and plans.
- Current plan.
- Incentives that drive transition from volume to value.
- What is working.
- What is challenging.
- Next 5 years.

The Shift from Volume to Value

- Medicare is no longer content with a role as a passive payor of claims and is now becoming an architect of care.
- This movement, in turn, has led to developments related to:
  - Quality
  - Technology
  - Risk
- As Medicare goes…so goes the payor world.
  - In past applied mainly to rate setting.
  - It now means others want to define care delivery.

The Shift from Volume to Value

- The result is that in nearly every market, there has emerged a focused shift, or promise of a focused shift, from volume to value.
- Yet the actual rules of the game are far from defined, the metrics and measurement systems are, at best, untested and the overall details are less than clear.
- So…systems and provider groups, in preparation for participation, are struggling with the transition.

An Analogy

- 100 meter dash- very clear and aligned incentives.
  - Clear rules
    - Wait for the gun
    - Stay in lane
    - Run as fast as you can…for the whole 100 meters
  - Clear incentives
    - Gold
    - Silver
    - Bronze
  - Clear metrics
    - Seconds via stop watch
  - Clear outcomes
    - Except in a photo finish, but…let's not get picky

Volume to Value "Playing Field"

- A very different sport, we will use football as an example
- Team sport- added complexity and interdependence
- However, let's adjust the typical game to reflect what it is like for organizations to play in the game of "volume to value" vs. the example of the 100 meter dash

Playing Field

- Rules- not all known, many conceptual, most changing, some varying from field to field
- Team- has never played a game or even practiced under the new set of rules
- Team- lacking even routine data on historical performance, no old game films, no stats on players, etc
- Refs- not entirely sure who they are, but know they have not refereed before and do not know the final rules either
- Score- not sure what will be counted
- Scoreboard- unsure if it will count all it is supposed to count or how if it will truly work

Playing Field

- Practice- not able to have any in advance of live game
- Coaches- haven't played game either and also in the dark on rules
- Owners- will either win or lose on outcome, feel their team may be comprised of underperforming assets
- Chain gang- may not have yardage and down markers, not sure their distance is correct, may vary from field to field
- Turf- may be artificial or may be real
- Fans- pretty angry and unsupportive
- Reporters- selling papers, never accurate, seldom in doubt

Playing Field

- Everyone wants the team to take risk
- Everyone wants the team to focus on new rules, whatever they are
- Everyone wants the team to agree to play under these conditions
- Team is dazed and confused and haven’t even got on the field yet

Volume vs. Value

- While it would be unlikely any team would want to play under the ridiculous situation laid out, it is a useful analogy of the environment organizations face when they play the volume to value shift game
  - Unpublished, though very much anticipated rules
  - Unclear metrics
  - Lacking of history
  - Lacking of practice, preparation for and experience with, new game
  - CEO's who haven't been there
  - Tools and technology that is uncertain
  - A community that is fed up and not supportive of systems
- And yet…it is reality

Scripps Clinic Medical Group

- We will share the bold and brave approach that Scripps Clinic Medical Group is taking to shift from volume to value.
- Their journey contains some of the same characteristics that one would expect from any team that played the fictitious game of football:
  - Some success
  - Some failure
  - Lots of challenges
  - Tenacity to play

Background

- Scripps Clinic Medical Group (SCMG) is a 500 physician multispecialty medical group located in the competitive San Diego, California marketplace.
- Given California's Corporate Practice of Medicine regulations, SCMG has a Professional Services Agreement (PSA) with Scripps Health (as opposed to physician employment.)
- As part of the PSA, there is a Supplemental Agreement that calls for an increasing at risk portion of compensation to be tied to incentives that are performance based.
- The total of the at-risk incentives for 2014 add up to a pool that is funded by each party.
  - Total pool is approximately $22,000,000
  - This represents up to 10% of total physician compensation.
- This pool, and the embedded incentives, represents a very strong shift from volume to value.
  - Connects with consumerism and satisfaction.
  - Is dependent upon cost performance.
  - Is dependent upon Meaningful Use and advancing the combined technology platform.
  - Is linked to patient access and growth.

Background

- There is an annual negotiation between the parties (SH and SCMG) each year to finalize the incentive plan:
  - Select and finalize incentives.
  - Determine weighting.
  - Determine time period for baseline and improvement measures.
  - Determine language of final agreement.
  - Determine issues related to non-performance, appeals, etc.
- In 2013, the process began in July of 2013, with general agreement reached around January of 2014 and final details in March, 2014.
  - A very challenging process, given uncertainty and unchartered territory.
  - Yet very necessary to ensuring the system and its parties are aligned and able to succeed in the extremely competitive environment.

Compensation Plan History

- SCMG, not unlike any large multispecialty group, has had a couple compensation plans over the years.
  - Percentage of collections for non-salaried divisions
  - Dollar per Work RVU
  - Dollar per Work RVU with Quality Incentive Component
- Also, not unlike other groups, it sees that exclusively volume-based plans will not serve the group well into the future:
  - High likelihood of not capturing quality based revenue in marketplace
    - Meaningful Use and PQRS
    - Risk based contracts that align incentives in care management
  - Non-productivity aspects increasing in importance and relevance
    - Patient satisfaction
    - Access

Compensation Plan Evolution

- For 2012, SH and SCMG began to redefine the terms of the PSA that would allow for less focus on volume and increased focus on non-productivity incentives.
- The result of these efforts is a rather complex plan that provides for alignment of incentives and performance in areas that are important to the long term success of the parties.
- The plan is based upon productivity and tracks to wRVUs, but also contains significant at-risk components.

Incentive Transition

Year 1 - 2012

SH Funded New Dollars
$5,000,000

SCMG Funded Portion
$2,000,000

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Funding Available for Variable Incentives
$7,000,000

$1,600,000	*22.5%*	Physician Tracking Compliance
$1,600,000	*22.5%*	On Time Results Verification
$1,600,000	*22.5%*	Patient Satisfaction (Overall Score)
$1,600,000	*22.5%*	Patient Satisfaction (Instructions Follow-Up)
$700,000	*10.0%*	Acute Senior Bed Days

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Incentive Transition

Year 2 - 2013

Total Available Incentive Pool A
$3,200,000

–

Half Fixed MU/CI Incentive
$900,000

Total Available Incentive Pool B
$4,900,000

–

Half Fixed MU/CI Incentive
$900,000

=

Funding Available for Variable Incentives
$6,300,000

Pool A = $2,300,000				*Pool B = $4,000,000*
$1,300,000	*40%*	**Senior Acute Bed Days Bonus**	*40%*	$1,600,000
$500,000	*15%*	**Patient Satisfaction Bonus**	*20%*	$800,000
$500,000	*15%*	**Primary Care New Patient Access Bonus**	*20%*	$800,000
$0	*15%*	**Readmission Rates Bonus**	*0%*	$0
$0	*15%*	**Costs PMPM Bonus**	*0%*	$0

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Principles of Pool A and Pool B

The following principles agreed to in the 2013–2014 Supplemental Agreement have been applied to setting Pool A and Pool B performance thresholds and targets:

1. ***New Incentives*** – If SCMG is already performing at a high level relative to national or regional benchmarks, it shall be expected that some payment will be earned by SCMG from Pool A if there is some improvement above current performance. If available, reliable and verifiable peer group benchmarks shall be used to compare performance to outside organizations and the Parties shall take into account such peer data when setting performance targets.
2. ***Existing Incentives*** – SCMG may receive payment for maintaining existing levels of performance that have been strong compared to national or regional benchmarks. In setting the targets to earn the Incentive, the Parties will take into account the performance of SCMG relative to such benchmarks; however, payment of the maximum bonus from Pool A will require improvement over prior performance.

Unique Aspects That Impact Transitioning

- SCMG only employs physicians
- SH Foundation employs and supervises all non-physician clinical staff
- SH Foundation manages the IT infrastructure
- SH Foundation manages the hospitals
- SCMG is at risk for performance, yet staffing levels are dictated via funds flow from SH Foundation
  - Example: Hospitalist staffing
- SH will be the immediate benefactor of Meaningful Use and will control the processes to attestation

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The Result (some examples)

- Perceptions that the “other party” controls aspects, such as:
  - SCMG controls utilization
  - SH Foundation controls the hospitalist staffing
  - SH Foundation controls the infrastructure
  - SH is the “score keeper” as it controls the data
  - SH Foundation controls the staff
    - Hospital Setting
    - Clinic Setting
    - Levels, hiring, firing, annual reviews and pay rates

The Result

- A very challenging environment in which to align incentives in a manner that transitions from volume to value
- Production is fairly clear, but the at-risk components are very, very difficult to determine risk and reward and who truly controls
- Thus the analogy to the unbalanced and unaligned game of football

SH Proposed Incentive Metrics Overview

2014 Incentive Measures

- ***Meaningful Use (MU)/Clinical Integration (CI)*** – Achieve all CMS Meaningful Use Measures defined by Stage 1/Year 2: 365-day reporting period or Stage 2/Year 1: CMS calendar quarter (i.e., 90 days).
- ***Senior Acute Bed Days*** – Reduce acute care days for Medicare Advantage patients by improving preventive care, directing treatment to the most appropriate care setting, and improving discharge planning.
- ***Patient Satisfaction*** – Increase patient satisfaction scores tied to the Press Ganey Associates, Inc., survey.
- ***HCC Code Recapture Rate*** – Increase the percent of 22 HCC chronic condition codes that are recaptured from the prior year's HCC assessment and is an indicator in the quality of HCC coding
- ***Allscripts v11.4 & ICD-10 Training & Proficiency*** – Ensure SCMG Providers complete training and demonstrate proficiency in both Allscripts v11.4 and ICD-10 coding.
- ***Patient Access Collaborative*** – Complete key milestones in an operational improvement initiative directed at identifying and implementing patient access improvements.
- ***Patient Access Measurement*** – Improve patient access above baseline performance for selected pilot departments.
- ***Senior Cost of Care*** – Identify and define three Senior HMO cost reduction opportunities and develop action plan to address cost during 2015.

Estimated Available Incentive Funding 2014

Funding Pool	Description	Maximum Available Funding
Pool A (Fixed)	Contribution of 5% to Base Rate (i.e., 95% to 100%)	$ 7,800,000
	Contribution of 5% above the Base Rate (i.e., 100% to 105%)	7,800,000
	Total Pool A incentive pool for 2013 (95% to 105%)	**$15,600,000**
Pool B (Variable)	Contribution of 75% of the reconciliation funds, based on an estimated reconciliation of 3.5% per year.	**$7,900,000**
	Total	**$23,500,000**

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Funding Distribution Per Metric

Total Available Incentive Pool A
$15,600,000

Total Available Incentive Pool B
$7,900,000

Full Fixed MU Incentive
$1,200,000

=

Funding Available for Variable Incentives
$22,300,000

Pool A = $14,400,000				***Pool B = $7,900,000***
$3,600,000	*25%*	**Senior Bed Days**	*25%*	$2,000,000
$2,900,000	*20%*	**Patient Satisfaction**	*20%*	$1,600,000
$2,900,000	*20%*	**HCC Coding Recapture Rate**	*20%*	$1,600,000
$2,200,000	*15%*	**Allscripts & ICD-10 Proficiency**	*15%*	$1,200,000
		New Patient Access Measure	*10%*	$800,000

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How Does this Represent Shift from Volume to Value

- The plan is designed to provide base incentives for production (wRVUs).
- However, an ever increasing amount of payment per unit will flow into the incentive pool.
  - Year one base compensation at Median compensation per wRVU minus historical Trend Forward
  - Year two base compensation at Median compensation per wRVU minus historical Trend Forward plus 50% of any potential reconcile at risk
  - Year three base at 95% of Median with 5% of Compensation at risk, matched by 5% in new funds plus 75% of any potential reconcile at risk
  - Year four and beyond not yet contemplated, however, likely pressure to maintain approach.
    - As market continues to shift from volume to value, must be aligned.
    - More payment linked to areas included in the various incentives.
    - Both parties realize that while difficult, this is an extremely important shift to manage.
    - Also acknowledge this creates the workplan for the important aspects that must be addressed.
      - Voice of customer.
      - IT leverage.
      - Costs/Days.
      - Etc.

Assessment

- The reality, at this early phase of this program, is that it has been very difficult.
- In some ways, parties may have moved too quickly with the right solutions, prior to full development of the necessary infrastructure requirements.
- This is a significant lesson in shift from volume to value.
  - Must have experience.
  - Must not move too far ahead of market.
  - Must balance internal constituency and maintain credibility.
    - Accuracy and consistency of data and reports.
    - Ability to structure plans in manner that aligns incentives and also control.
    - Enough time to thoroughly test vs. implement too rapidly and face scrutiny.
- At the same time, if not now, when?
- We will review the aspects that have worked, as well as those that have not, on the next few slides.

What Has Worked with This General Model

- Has begun to align incentives toward today's and tomorrow's reimbursement environment.
- Has created new focus that is stronger than in the past.
- Has allowed each party to have input in each other's organization.
  - Infrastructure issues have been uncovered.
  - Care and cost issues are now linked.
  - Focus of daily work is intertwined.
  - Risk and reward makes need for success real.
  - Have accomplished much by charting this new course, which allows for future success as well.

What Has Not Worked as Well

- Difficult transition, given:
  - Uncertainty of new measures.
  - Too many metrics.
    - In 2014 started with 8 and ended at 6.
    - Typical group may have 2-4 incentives in at-risk component of compensation plan.
    - Too many provides inability for focus on most important and potentially lack of focus on organization.
  - Dollars are at risk for unproven metrics.
  - Uncontrollable aspects.
    - Either party may have more or less control.
    - Some elements out of control of either party (such as MU).
  - Measurement is uncertain.
  - Timelines may be too aggressive.
  - Still working on trust.
  - Either party, on any one measure, may have very different perceptions of issues.
  - Definitions difficult to agree upon.
  - Weighting of incentives has been challenging.
  - Did not start far enough ahead of deadline, regardless of when negotiation is initiated.
  - Lack of communication with Physicians

Next 5 Years

- While challenges are great, this is important work.
- Anticipate working on process itself in order to be able to move through negotiation faster and more efficiently.
- Do not anticipate moving away from shift however:
  - Believe will only increase focus on value.
- IT platform will continue to be honed and improved to support.
- Measurement should improve.
- Comfort should improve.
- Care management tools will evolve and improve.
  - Evolution of models.
  - Evolution of data and support.

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Q and A

- Thank you for the opportunity to share this presentation.
- We welcome your questions and comments.