PROVIDER COMPENSATION

Current Practice and Future Trends

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Webinar housekeeping

TODAY'S SPEAKER

Alexia Eslan
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Overview

- ❑ Current Research
- ❑ Provider Compensation Assessment
- ❑ Opportunities
- ❑ Make a Plan

CURRENT RESEARCH

Quality Improvement

- ❑ Strong Leadership
- ❑ Provider Buy-In
- ❑ Policies Created in Advance
- ❑ Testing and Assessment: Feedback and Modifications

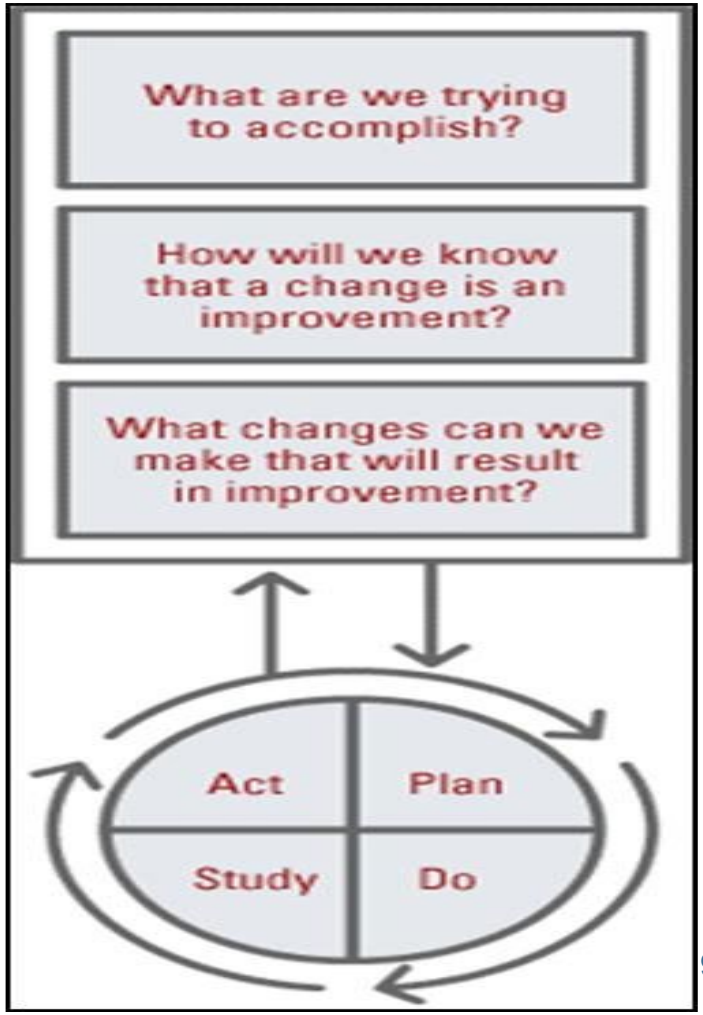
Model for Improvement

Plan
- Forming the Team
- Setting Aims

Do
- Establishing Measures
- Selecting Changes

Study
- Testing Changes

Act
- Implementing Changes
- Spreading Changes



Plan

- **Forming the Team**
  - Administrative Leadership
  - Providers
- **Setting Aims**
  - Major Goals and Anticipated Benefits
  - Define Policies
  - For Example:
    - Who is eligible? (Types of Providers/others; part-time/full time; years in practice)
    - Compensation Model
    - Distribution Methods

Study

- **Testing Changes**
  - Conduct a shadow compensation period
    - Test system without any penalties
    - Measure and report as if in full implementation for 3-6 months
    - Report back to providers
    - Obtain feedback
    - Make modifications
  - Repeat shadow compensation period, if necessary

Act

- **Implement Changes**
  - Implement compensation system in steps
  - Over time, add components incrementally
  - Study the impact of the changes, moving through the Plan – Do – Study – Act cycle

Compensation Models

- Straight Salary
- Production-Based Salary
- Salary Reduced by Withhold
- Salary Plus Bonus

Production Based Salaries

- **Gross Charges or Billings**
  - Immediate feedback
  - No penalty for payor mix differences
  - Danger of paying more than net revenues
- **Net Revenue or Collections**
  - Recognizes payor mix differences
  - Minimizes risk of paying more than net
  - Removed in time from work performed

Production Based (cont.)

- **Patient Visits or Encounters**
  - Direct tie to productivity
  - Doesn't account for acuity/differences in visit types
  - Could be negative if more care provided telephonically or via electronic means
  - Could negatively impact practice for capitated patients
- **Relative Value Units (RVU)**
  - Accounts for acuity
  - Physician Work RVU recognizes professional component

Withhold Versus Bonus

- Providers generally prefer lower salary plus bonus to higher salary minus withhold, even when equal value
- Withholds may better serve to drive performance improvement than rewards, but are harder to implement

Quality Incentive (Pay for Performance)

- **Moves model closer to Accountable Care Organization Model**
- **Need to be careful that measures reflect goals and are in physician's control**
  - "We shouldn't incent what we can't change and can't measure what we can't capture." Cantlupe
- **Can't be too narrow (no spill over effect)**
- **Can't be too broad (dilute impact)**
  - "Even when aiming for simple models, formulas can often become more complex due to efforts to be fair." Tobey

Hay Group Survey

Measure Included in Incentive Plan	% in 2012	% in 2013
Patient Satisfaction with Individual Physician Performance	66	70
Quality Metrics for Individual Physician Performance	77	86
Outcome Metrics for Individual Physician Performance	39	54
Patient Satisfaction with Physician Group Performance	50	60
Quality Metrics for Physician Group Performance	56	69

Incentive Components Advantages and Disadvantages

Observed Options	Advantages	Disadvantages	Key Success Factors
Productivity 50% - 100%	· Can increase bottom line financial performance	· Provider resistance	· Pick something already being measured
		· Some evidence that incentivizing professional activity (for which people feel intrinsic motivation) can be detrimental to motivation	· Message that being more productive is a form of increasing quality (access for patients)
Quality 30 - 50%	· Providers feel it is an important aspect of medicine (more than productivity)	· Some evidence that taking incentive away can reduce quality	· Pick something already being measured
		· Some reports that physicians do not pay attention to metrics	· Measurement and monitoring itself is the biggest step toward increasing quality
			· Use outside standards
Patient Satisfaction 10 - 30%	· Important to patients	· Can be influenced by specialty (ex. Pain clinic)	· Use existing measure tailor by specialty
Citizenship 10% - 20%	· Rewards community involvement, development of programs, engages passions of providers	· Can be seen as a "gimme"	· Reward work that is above and beyond expectation of basic job

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Seven Design Features That Could Improve Pay-for Performance Programs

Commonly Used Design	Suggested Improvement
Incentive given as a lump sum	Divide the lump sum into a series of smaller incentive payments
Relative thresholds (e.g., top 25% of physicians)	Use tiered absolute thresholds (e.g., 25%, 50%, 75%, and 90%)
Long lag time between care and receipt of incentive	Shorten lag time to as short as possible
Use of withhold payments	Consider bonus payment or use of deposit contracts
Complex uncertain structure of program (e.g., shared savings program)	Simplify program so that uncertainty is minimized
Incentive often given as an increase in fee schedule reimbursement	Decouple incentive payment so that it is given separately
Monetary incentives	Use in-kind incentives

(Table excerpted from Mehrotra, 2010)

PROVIDER COMPENSATION ASSESSMENT

Step 1: Conduct a Compensation Assessment

- **Look at all parts of compensation package**
  - Salary/Bonus
  - Benefits
    - Holiday, Sick, Vacation Time
    - Health and Dental Insurance
    - Pension/401K
    - Other benefits – loan repayment, etc.
- **Compare to local and regional benchmarks for each provider type**
- **How does each individual stack up?**

Step 2: Conduct a Provider Practice Assessment

- **Review current state of potential incentive measures**
  - Productivity by provider
  - Panel Size by provider
  - Clinical measure performance by provider
  - Patient satisfaction by provider
  - Administrative performance by provider
  - Actual clinical hours worked compared to contract

Step 3: Opportunities

- **Identify opportunities for improvement, within budget constraints**
  - Pay equity
  - Improvements in
    - Hours worked
    - Productivity
    - Quality
    - Team participation
    - Administrative Roles
- **Conduct individual provider meetings to document any concerns or individual provider goals that may impact planning**
- **Use data collected in assessments to begin compensation planning**

CASE STUDIES

Pay for Performance Early Adopters

- **Fairview Health Services – Minneapolis, Minnesota**
  - Dropped RVU model
    - Still productivity based, but defined by acuity adjusted panel size and clinical activities (not RVUs)
  - Established compensation framework tying 40% to quality metrics; 10% to patient satisfaction
- **ProHealth Care – Waukesha, Wisconsin**
  - Bases 10% on quality metrics

Lessons Learned

1. **Share Data**
   a. Gain Buy-In
   b. Ensure accurate data
2. **Tie Compensation to Desired Behaviors**
3. **Choose Metric Wisely**
   a. Make sure metrics are not too narrowly or broadly defined
4. **Provide the Tools**
   a. Behavior change requires the tools and support to facilitate the change
5. **Modify Model over time**
   a. Constantly analyze data and improve model

Questions?

THANK YOU!

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