A BALANCING ACT:
EMPLOYMENT COMPENSATION & P4P

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INTRODUCTIONS

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✓ Previously worked in VMG Health’s Business Valuation division

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✓ Managing Director in the Compensation Division and Chief Commercial Officer at VMG Health
✓ Served as Fair Market Value expert witness and peer review editor for the Journal of Hospital Administration
✓ Previously with KPMG’s litigation department and held position as finance professor at the University of North Texas

Together – published & presented nearly 100 times
SHIFTING TO P4P
INCREASED FOCUS ON P4P

Transitions in reimbursement based on quality and cost savings is happening now.

Local and national hospital ratings are based on quality scores.

Hospitals need physician participation/alignment in order to improve quality and cost efficiency.
FFS AND P4P CO-EXIST DURING TRANSITION
P4P EVOLUTION & REGULATORY GUIDANCE

- **QUALITY:** Primarily quality payment focus during 2003-2010 (sharing savings was a slippery slope)
  - Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals: 2003-2009
  - Physician Group Practice Demonstration for ten physician groups: 2005-2010
  - Third-party payors and health systems start incentivizing for quality
- **SAVINGS:** Numerous favorable OIG gainsharing opinions early 2000s and new shared savings opinion from December 2017 shows consistent guidance
- Multiple models and arrangements exist today beyond commercial and Medicare ACOs
  - Medicare Shared Savings Program
  - Bundled Payments for Care Improvement
  - Commercial payor P4P programs growing exponentially
  - Government launching of numerous APMs – ahead of schedule!

*These models were meant to successfully co-exist with fee for service models*
EMPLOYMENT MODELS TODAY
EMPLOYMENT MODELS

1. The percent of physicians working in wholly physician owned practices has steadily declined over the last decade
   - Per the AMA’s Physician Practice Benchmark Survey, the % of physicians working in wholly physician owned practices has dropped steadily since 2008 while all other categories have increased (i.e. At least some hospital ownership, direct hospital employee, wholly owned by a not-for-profit foundation, and Other)
   - Physicians are migrating out of private practice seeking an escape from the reimbursement, administrative and capital risks incurred in the private practice setting.

2. The increasing demand and stagnant supply in the physician workforce has led to greater consolidation

3. Hospitals need the goals of their employed physicians aligned to achieve the Triple Aim

WHY ARE WE TALKING ABOUT EMPLOYMENT?
EMPLOYMENT MODELS

TYPES OF EMPLOYMENT COMPENSATION MODELS

1. Salary
2. Production-Based
   ✓ $/WRVU
   ✓ % of Collections
   ✓ Tiered Incentive Rates
3. Combination of Salary & Production-Based
4. Stacked Add-On Components
   ✓ Directorships/Administrative/Leadership Roles
     • Hourly Pay, Fixed Stipends or Incorporated in Production Models
   ✓ On-Call Coverage
     • Per-Diems, Hourly Pay, Per Shift, or Incorporated in Production Models
   ✓ Rural/Outreach Work or Extra Shift Pay
   ✓ Quality or P4P Incentives
EMPLOYMENT MODELS

SALARIED PHYSICIANS
• Oftentimes, initial periods of employment (i.e. Year 1 or 2) may be salaried as the Physician builds their practice and ramps up production
• Risk is on the Employer in that salaries generally would not fluctuate directly with productivity so the financial economics of that relationship need to be carefully understood.
• Certainly more common in recruitment situations where a provider within a particular specialty is needed in a market.

FMV CONSIDERATIONS
• If it’s a recruitment situation, is the physician coming from in-market or out of market?
  ✓ If in-market, is the salary reasonable within the economics of their current practice?
  ✓ If out-of-market, have all measures been taken in determining the salary to be the best fiscal option in securing the coverage.? More of a qualitative approach
• How does the salary benchmark to national survey rates in the specialty? Do expected production levels once practice is mature align?
EMPLOYMENT MODELS

PRODUCTION-BASED PHYSICIANS

- These would be physicians who’s compensation varies based on how personally productive they are.
- Compensation can be based on WRVUs, Professional Collections, Encounters (rare), or any tiered combination of the above.
- Depending on the compensation metric (ex. $/WRVU), the financial economics of the relationship may or may not be in-line.

FMV CONSIDERATIONS

- Does the selected compensation metric and estimated annual production produce an annual compensation level that corresponds with annual productivity?
  - ✓ Inverse Relationship in $/WRVU and productivity
- Do you know the limitations of the compensation model? In other words, at what levels of productivity does the compensation not make sense?
EMPLOYMENT MODELS

STACKED COMPONENTS

- Adding additional services/compensation to a compensation model
- Examples include on-call pay, medical directorship/admin roles, research/teaching stipends, outreach or rural work, NP/PA supervision, extra shift-pay, etc.
- P4P/Quality Pay Incentives – to be addressed in the slides to follow

FMV CONSIDERATIONS

- Be cognizant of what is already “baked-into” the base level compensation model
- Survey compensation rates reflect Total Cash Compensation paid. Theoretically and practically, the data reflects the total take-home pay for all services rendered
- On-call pay should be derived based on the burden of that coverage. See OIG Opinions for burden factors
- Medical Directorship – how is the hourly rate/stipend derived? Does it appropriately capture the breadth of the role and the physician’s experience/credentials? Will hours be tracked (CR)?
- Are there enough hours in the week/month for the physician to realistically provide all of these services without compromising on clinical work/quality of care?
- Is there a track record to point to? Can all parties attest to the hours as being reasonable?
P4P IN EMPLOYMENT

TYPES OF QUALITY INCENTIVES IN EMPLOYMENT ARRANGEMENTS

• Quality Pools (Most Common in Employment)
  ✓ Set-in-advance pools of dollars tied to performance/achievement of pre-set measures
  ✓ Typically these are self-funded in that the hospital/employer is not receiving any additional 3rd party reimbursement for these quality outcomes

FMV CONSIDERATIONS

• How was the pool determined? Withholds or “cushions” between base pay and FMV can be used to establish pools
• How many metrics are there?
• What types of metrics are being measured?
  ✓ Does the Physician have a demonstrable impact on these metrics?
  ✓ Are they process or outcomes based measures?
• Do you know how the physician performed with these metrics historically? Are payout tiers established such that these are stretch goals or maintenance goals?
P4P IN EMPLOYMENT

TYPES OF QUALITY INCENTIVES IN EMPLOYMENT ARRANGEMENTS

• Shared Savings Allocations
  ✓ Physicians are compensated for managing the service line efficiently resulting in an allocation of any savings
  ✓ Could be a specific metric within a quality incentive or could be the entire quality incentive

FMV CONSIDERATIONS

• Are these specific physician, service line or hospital wide efficiency goals?
• Does the Physician have a demonstrable impact on the economic performance being measured?
• Ensure that quality gates/minimums are in-place before any shared savings are paid out to the Physician
• Establish a measurement year with that physician to have a base-line from which you can assess performance going forward
• Reassess/rebase annually
• No cherry picking or lemon dropping
P4P IN EMPLOYMENT

TYPES OF QUALITY INCENTIVES IN EMPLOYMENT ARRANGEMENTS
• Third-Party Funded Incentive Programs
  ✓ When “new money” is coming in from third-party/unrelated payors for the performance of certain quality improvement measures or shared savings programs
  ✓ Determination of what the reasonable split/allocation of those dollars are between the hospital/health system and the physicians

FMV CONSIDERATIONS
• Understand the risk and responsibility of the physician compared to the hospital/health system
  ✓ How much of an impact does the physician have on the generation of these third party dollars?
  ✓ Do IT Costs and/or nurse care managers generate funds? If so, what party is incurring those expenses?
P4P IN EMPLOYMENT

1. Self Funded Quality Payments
2. Allocating Shared Savings
3. Allocating Third Party Reimbursement
STACKING P4P WITH EMPLOYMENT COMPENSATION

POTENTIAL ISSUES TO ASSESS WHEN STACKING COMPENSATION

• Employment model structure and level of risk
  ✓ Salaried vs. Production-Based
  ✓ Has employment model been tested for FMV?
  ✓ Address how TCC survey data should be normalized, if applicable

• P4P Component - has the P4P component been individual assessed in light of the following:
  ✓ The physician’s relative risk & responsibility over the metrics
  ✓ Consider the current regulatory guidance. To be discussed in the slides to come
  ✓ Outcomes vs. Process Metrics
  ✓ Stretch vs. Maintenance Goals

FMV CONSIDERATIONS

• How do you value specifically value P4P and what types of models are commonplace?
# Types of Arrangements

## Co-Management / Service Line
- Understand and value each service
- Identify savings or quality metrics
- Benchmarking
- Consider OIG’s gainshare and co-management opinions

*Less Common with Employment models*

## Individual Performance
- Understand market reimbursement for physician services and quality
- Identify risk and responsibility of all parties

*Consider Metric Strength*

## ACO / CIN / Population / HEIP Distributions
- **Balanced approach for overall model should be assessed**
  - Opinion on allocation to parties (physicians, hospital)
  - Opinion on distribution among physicians
- **Value Drivers**
  - Third party funded or from hospital
  - Infrastructure cost recovery
  - Buy-in or participation fee
  - Time spent/effort – hourly rate paid/existing compensation model
  - Split of savings – existence of minimum savings threshold
  - Split of quality - benchmarks utilized, targets tough
  - Upside and downside risk
  - Care coordinator payments – i.e.: Nurse care manager
  - Available data key to determining support for individual performance payments

*Consider all when stacking*
VALUE DRIVERS THAT IMPACT P4P COMPENSATION

- Source of Program Funding
- Level of Responsibility of Parties/Participants
- Degree of Risk &/or Expense of Parties/Participants
- Specific FMV Considerations Related to Arrangement Type
KEY VALUE DRIVERS QUALITY

*QUALITY METRIC CONSIDERATIONS

Selection and Number of Meaningful Metrics

Aggregate Physician Responsibility

Metric Type

Metric Source

Benchmark Source

Likelihood of Achieving Maximum Payout
**KEY VALUE DRIVERS COST SAVINGS**

<table>
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<tr>
<th><em>PROGRAM REQUIREMENTS</em></th>
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<tr>
<td>Focus to reduce waste and increase efficiency</td>
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<tr>
<td>Physicians required to work with hospital(s) to evaluate and conduct clinical reviews of various processes</td>
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<td>Clearly defined participation criteria</td>
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<td>Processes include standardization measures and best practices</td>
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<td>No savings paid unless quality criteria thresholds are met or exceeded</td>
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<td>Certain safeguards are in place to ensure patient safety and quality are not negatively affected</td>
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<tr>
<td>Objective and credible support for cost reductions are considered, as well as, historical performance related to the subject cost reduction benchmarks</td>
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<td>Metrics/benchmarks/initiatives will be reassessed and/or rebased annually</td>
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01 Potential Savings Opportunity

02 Physician Responsibility

03 Minimum Savings Threshold

04 Quality Gates

05 Program Requirements*
RED FLAGS WHEN REVIEWING QUALITY METRICS

- Time based metrics that are already paid for under hourly rate (common with employment), or have substantial value assigned that cannot be supported by time

- Low hanging fruit metrics that don’t appear commercially reasonable
  - Several where historical performance already hits stretch goal
  - Tiny improvement earning large payout

- Billing/coding metrics or staffing metrics are not driven by physicians (more of nursing/admin staff responsibility)

- Financial metrics related to service line margin

- Any metric measuring referrals or accounting for an increase in volume

- Metrics that overlap or provide payment for following protocols or procedures that are already part of your hospital’s medical staff bylaws

- ALOS – to discuss (great for cost savings but careful with protocols = patient safety)

Remember to rebase annually!
COMPLIANCE CHECKLIST P4P ARRANGEMENTS

QUALITY PAYMENTS
- Metrics outlined
- Primarily outcomes metrics (versus process or reporting)
- Be careful with low hanging fruit metrics
- Benchmark performance against medical credible evidence
- Ensure physician(s) will have demonstrable impact on quality
- Check for overlap of payments from co-management, bundled payments, etc…

COST SAVINGS
- No cherry picking or lemon dropping
- Identify separate identifiable cost savings opportunities in advance
- Ensure physician(s) will have demonstrable impact on cost savings
WE VALUE HEALTHCARE

QUESTIONS?

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