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3 strategies for aligning with physicians in a value-based world

AT A GLANCE

- > As hospitals consider their strategies for value-based payment, they are increasingly looking to physicians as integral contributors to those strategies.
- > Alignment arrangements between hospitals and physicians can be useful in helping both parties work toward common goals in a value-based system.
- > A health system's decision to enter such an arrangement should be predicated on whether that the arrangement will promote its own goals and strategy.

Quality and efficiency have become paramount in health care as organizations move toward value-based payment models. Because physicians are integral to the provision of care, alignment strategies between health systems and physicians are evolving rapidly. Prior to aligning and ultimately compensating physicians for quality and/or cost savings, a health system must understand myriad factors, including what specific impact is being measured.

Specifically, health system leaders should determine the extent to which each the following serve as the basis for the performance and anticipated quality and/or savings payments:

- > Personal performance of a single physician
- > Excellence achieved at a service-line level
- > Triple Aim success for an entire population through integrated care

Once the goal and alignment strategy are identified, a physician's impact and contribution can be properly measured. As part of any value-based payment strategy, identifying each party's responsibility and risk for both quality and financial outcomes is necessary to allow for monitoring progress and rewarding the appropriate party for results.

Alignment Strategies

Many health systems, looking to succeed in a value-based world, enter arrangements with a physician or physicians to improve quality outcomes and/or cost efficiencies. These alignment strategies often are referred to as "pay-for-performance" programs because the physicians are rewarded incentive compensation based on quality and/or cost metrics. In some cases, health systems are internally creating and self-funding these programs in anticipation of future changes to payment. In other cases, health systems are eligible for incentive payments in the form of health plan payment and want to share a portion that compensation with the physicians who helped the organization achieve this eligibility.

The healthcare organization's desired impact or scale will determine which specific pay-for-performance program it should utilize as an alignment strategy. Programs are variously designed to focus on individual performance, service-line performance, or population or systemwide performance.

Individual performance. The purpose of bundled payment programs, in general, is to reduce costs related to a specific episode of care. In a bundled payment arrangement between a health system and physicians, the health system may allocate a portion of the achieved savings to the physician who performed the services and directly contributed to reducing costs for the defined episode of care. These allocations often are contingent upon the physician's meeting certain quality thresholds to ensure that patient care is not negatively affected by the cost reduction. Typically, the payment to the physician under this model is a percentage of achieved savings and may be subject to a cap, as is the case under the Bundled Payments for Care Improvement initiative administered by the Centers for Medicare & Medicaid Services (CMS).

Another common alignment strategy on an individual physician level is a quality payment stated in an employment arrangement between a health system and an individual physician. In most cases, the quality compensation is a fixed fee or a percentage tied to clinical outcomes. In addition to individual clinical performance, quality compensation also may be tied to on-call or medical director services. In such arrangements, metrics may be based on individual performance or service-line performance. Such incentives also are sometimes applied in independent contractor arrangements.

Service-line performance. A common alignment strategy is service-line co-management, where a health system targets a specific service line and focuses on quality metrics specific to that medical specialty or service line. Health systems engage eligible physicians who choose to participate and meet the participation criteria, which include having the ability to exert a direct and demonstrable impact on the chosen quality metrics. Payment typically is structured as an annual maximum incentive bonus,

which varies based on the performance related to service-line quality metrics. In addition to performance compensation, physicians also may receive an administrative fee based on an hourly rate for attending committee meetings or spending time dedicated to the development of protocols and care pathways that will help to improve quality outcomes. Finally, some co-management arrangements encompass other services such as call coverage, medical directorships, and/or nonclinical management services.

Co-management arrangements may include both quality and cost metrics. In some cases, there are stand-alone cost savings arrangements (also referred to as gainsharing or shared savings) between a health system and physicians related to a specific service line. The metrics typically are related to a supply, device, or DRG, where physicians can have a direct impact through product standardization or reduction in waste. Payment to physicians may be a percentage of savings or a maximum savings amount calculated based on historical cost and actual reduced cost. In some cases, caps on payments based on savings have been observed. However, not all health systems require a cap, likely because savings represent new funds and are typically short-lived. As with bundled payment arrangements, physicians often must meet quality requirements to qualify for payments based on shared savings.

Population or systemwide performance. Accountable care organization (ACO) models are focused on cost efficiencies related to a specific patient population across the continuum of care, which often includes the health system, primary care physicians, and specialists. Payments to physicians are based on achieved savings related to the patient population and typically contain minimum quality thresholds. There may be other factors that should be considered prior to compensating the physician participants (such as the expenses incurred by the health system related to infrastructure).

Unlike ACOs, which focus on a specific patient population, hospital efficiency improvement programs (HEIPs) typically focus on systemwide initiatives. Staff physicians commonly participate in a

clinically integrated network (CIN), which contracts with the health system to generate cost savings for the HEIP. When savings are achieved, the health system compensates the CIN, and the physician participants receive incentive compensation payments based on achieved savings generated through care coordination, best practices, and improved quality initiatives. It is important to note that CINs are used across the healthcare industry, under various models, to compensate physicians for their participation in improving the cost and quality of a patient population.

Common Factors in Value-Based Models

Because drivers of incentive compensation in a value-based payment model may not always be a direct result of the physician's services, it is important to understand the other factors that are required for successful implementation and operation of the programs. Perhaps more important, these factors, discussed below, represent significant value drivers that must be considered when determining the allocated share of pay-for-performance compensation to a physician.

IT infrastructure. In almost every case, IT infrastructure is necessary to justify payments for any of the pay-for-performance arrangements previously discussed. One must be able to track quality metrics on an individual, group, or population/systemwide level. Similarly, one must be able to track cost savings on an episode-of-care level; group level for each specific supply, device, and DRG; and population or systemwide level. Without historical and actual data, tracking improvement would be impossible, and the lack of solid data would make it challenging to compensate physicians in a way that complies with regulations governing physician compensation.

Healthcare leaders should understand the importance of the IT infrastructure in generating the actual payments. For example, in some cases, incentive payments from third-party insurers are based solely on the ability to report data. In such situations, the party responsible for the IT expense should be rewarded. In other cases, assuming outcomes drove the payments, IT costs should be considered prior to determining the amount of pay-for-performance funds allocated to the physician participants, given

that IT was required to earn the incentive (and paid for by the health system).

Care coordination. Care coordination may be provided at the physician level, where an individual physician either assumes responsibility for coordinating care or hires a care coordinator to do so. On a broader scale, such as at the service-line or system level, certain physicians within the larger participating group of physicians may be responsible for directing other physicians to follow certain pathways and protocols to standardize care.

Many health systems hire nurse care managers or incur costs related such managers. In such instances, the health system costs should be considered in relation to payments to physicians. Specifically, if savings were generated primarily due to the work of the nurse care manager employed by the health system (versus the physician), then the pay-for-performance payments should consider the nurse care manager costs and be allocated properly between the health system and the physician.

Risk-adjusted data. In any pay-for-performance program, it is common for health systems or physicians to be compensated based on risk-adjusted quality metric data, particularly where the program focuses on the measurement of quality outcomes or threshold requirements.^a If a program's patient population poses challenges for care delivery (from an age or acuity perspective), the payments should be adjusted. Patient risk consideration is one of the most challenging topics in pay-for-performance programs.

Compliance Considerations

There are several key compliance factors that health systems should consider when entering into a pay-for-performance program or alignment strategy with physicians. Because referring patients to hospitals is a responsibility assigned to physicians, there are regulations requiring that physicians are paid at fair market value.^b It therefore is important to

a. "Risk Adjustment Fact Sheet," Centers for Medicare & Medicaid Services, April 2015.

b. U.S. Department of Health and Human Services, "Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships," *Federal Register*, Jan. 4, 2001.

understand and properly reflect value drivers associated with value models.

Program funding. Healthcare leaders must be able to determine whether payments are self-funded from the health system or come from a third-party insurer. Generally, there is more flexibility with incentive compensation payments to physicians if the payments come from a third party. If the program is self-funded, additional compensation based on a portion of any savings may be easier to justify than quality payments from a compliance perspective because the former do not require financial support.

Responsibility. It is essential to understand the responsibility of the participating parties, starting with the health system level of responsibility versus physician level of responsibility, for achieving quality outcomes and cost efficiencies. A health system then must identify each physician participant who has had a demonstrable impact on quality and/or cost savings. This information should help in determining which party or physicians warrants the greater share of payment received under a pay-for-performance model.

Risk. Of the participating parties in the pay-for-performance arrangement, the party or parties who take on more risk may warrant more compensation, while those with limited risk may have limited upside potential. In arrangements where health systems bear necessary and substantial infrastructure costs, these costs should be considered prior to compensating the physicians for the achieved outcomes.

Selected metrics. The quality or cost savings metrics should be clearly defined and benchmarked against credible medical evidence and historical costs, respectively. The chosen metrics should consider the patient population, service line, peer group, and/or the health system's mission and values. Perhaps most important, the physicians should have a direct and demonstrable impact on the selected metrics.

Overlap. With any physician alignment strategy that compensates physicians for services or outcomes, the services, quality, and cost savings measures should be subject to an aggregate review to help ensure that

there is no overlap of services or duplication of payments for the same services or metrics with other programs or arrangements with the physicians.

Patient safety. A health system should have mechanisms in place to ensure that patient safety is not negatively affected by a pay-for-performance program. Further, the program should prohibit "cherry picking" (where the cases that are easiest to treat or patients with low-acuity conditions are selected) and "lemon dropping" (where the difficult-to-treat cases or patients with higher-acuity conditions are eliminated).

Incentive payments. As previously mentioned, compensation to physicians, including quality and cost savings incentives, should be set in advance at fair market value, and should not consider the volume or value of referrals.^c Therefore, there should be an agreement between the parties that details the services to be provided, metrics to be used, payment structure, and fair market value compensation to the physician participants.

Bottom Line

Health systems cannot achieve improved quality outcomes and cost efficiencies on their own. Thus, alignment strategies with physicians are necessary and becoming more commonplace as payment moves in the direction of value. Whether on an individual physician level, service-line level, or broader population level, a variety of alignment strategies and payment mechanisms are available to help achieve these goals. The keys are to understand the scale of impact, goal of the arrangement (quality improvement, cost reduction, or both), and responsibility of the parties, and to ensure the payments to physicians are consistent with fair market value. ■

c. U.S. Department of Health and Human Services, "Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II)," *Federal Register*, March 26, 2004.

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