Alignment Options in a Value-Based Reimbursement Environment

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Learning Objectives

This session will provide you with:

• Practical knowledge of specific alignment models in the PHM setting from case study examples
• Assistance learning the key components and “to-dos” within these models, considering “first generation” structures for 2017 and how “second generation” alignment transactions are best structured
• Knowledge of the legal/regulatory checklist relative to the alignment models
• Insights as to compensation model structure for 2017 (hybrid based FFS/FFV) and beyond
Agenda

• Industry Overview
• Impact on Alignment in FFV Environment
• Compensation Models
• Second Generation Structures
• Case Studies
• Conclusions and Q&A
Industry Overview
Industry Paradigm Shifts

**Traditional healthcare delivery model**

- **Fragmented care management treating primarily sick people**
- **Episodes of care; utilization management**
- **Predominantly Production (volume)/Fee-for-service payments**
- **Disjointed provider base**

**Integrated care**
- Management focusing on preventative care
- Coordinated delivery of care rendering appropriate services at appropriate place and time
- Performance (value); Quality/cost control; bundled payments; capitation; risk-based

**Collaboration:**
- ACOs/CINs/PCMHs/QCs

**Accountable care era health care delivery**
Impact of Changes - Consolidation

Alignment vs. Integration

Are they the same?
Alignment vs. Integration

• Last Seven Years
  – Consolidation
  – Creating Critical Mass
  – Gaining Market Share

• Next Five Years
  – Gaining efficiencies/reducing costs
  – Collaboration/sharing best practices
  – Improving quality
  – Enhancing patient experience
Alignment vs. Integration

• Why must we integrate? (clinically and operationally)
  – MACRA: MIPs/APMs
  – Shared Savings
  – Bundled Payments
  – Patient Centered Medical Home
  – Value-Based Incentives
  – Capitation

• Alignment/consolidation alone is not enough to drive success!
Impact on Alignment in FFV Environment
Physician Alignment and Value

Effectuating the fundamental changes that will create the movement toward value must begin with the providers (i.e., hospitals AND physicians). Alignment establishes the hospital-physician ties necessary for group-wide, value-centric initiatives.
Traditional 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**
- **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;
- **Group (Legal and Operational) Merger:** Unites parties under common legal entity with full integration of operations

*Includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model both of which allow the practice entity to remain intact even after employment of the physicians by the hospital.*
Traditional Employment Contract

Nonetheless, there are multiple forms of employment utilized by today’s hospitals.
Employment: Group Without Walls ("GWW")

For this type of model, the hospital establishes a separate management company dedicated to managing the physician business.

- Owns Assets
- Controls Financials
- Provides Infrastructure

*Physicians could oversee MSO

Hospital → Ownership → MSO*

Compensation → Support Services → Practice

- Employs Physicians
- Manages Clinical Operation

Provides:
- Staffing and Management
- Contracting
- Billing
- Managed Care Administration
- Recruiting
- IT Support
Employment: Group Practice Subsidiary (‘“GPS”’)

For this type of model, the hospital establishes a separate management company dedicated to managing the physician business.

- **Hospital**
  - Hospital-Based Physicians

- **Hospital Management Corp.**

- **Practice**
  - **Committees**
    - Governance
    - Compensation
    - Operating
  - **Compensation**
    - Productivity-based with some performance bonuses
    - Can include P4P, value-based purchasing & bundled payments
    - Contribute to strategic planning
    - Focus on clinical integration, quality of care, etc.
    - Typically retains IT platform during transition

- **Possible Assets to be Acquired by Hospital**
  - Ancillaries
Employment: Employed Physicians Network ("EPN")/"Dyad" Model

The network model typically has dedicated oversight but frequently segregates physicians by service focus.
### Contemporary Alignment Models

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>BASIC CONCEPT</th>
<th>COMPENSATION FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered Medical Homes</td>
<td>Team of providers and medical individuals collaborating to provide patient-centric care in a focused ambulatory care environment; can be part of ACO/CIN model</td>
<td>Varying incentives based on contractual relationships with payers</td>
</tr>
<tr>
<td>Quality Collaboratives</td>
<td>Consortium of providers focused on furthering the quality outcomes for a defined population</td>
<td>Internal or external funding sources determine scope and structure of available funds</td>
</tr>
<tr>
<td>Clinically Integrated Networks</td>
<td>Interdependent healthcare facilities form a network with providers that collaboratively develop and sustain clinical initiatives</td>
<td>Incentive (i.e. at-risk) compensation based on achievement of pre-determined measures</td>
</tr>
<tr>
<td>Accountable Care Organizations</td>
<td>Participating hospitals, providers, and other healthcare professionals collaborating to deliver quality and cost effective care to Medicare (and other) patient populations</td>
<td>Incentive (and punitive) financial impacts based on cost savings and quality</td>
</tr>
</tbody>
</table>
PSA Overview

**PURPOSE**
- Achieve clinical and financial integration without employment

**RELATIONSHIP**
- Contracted services, multiple options
  - Clinical (Professional) Services
  - Wraparounds (administrative, call, quality, etc.)

**SERVICES**

**REMUNERATION**
- Typically paid on a top-line basis per wRVU. Wraparounds can take other forms of payment for services, if included
Four Popular PSA Models

1. **Traditional PSA**: Hospital contracts with physicians for professional services; hospital employs staff and “owns” administrative structure.

2. **Global Payment PSA**: Hospital contracts with practice for Global Payment; practice retains all management responsibilities.

3. **Practice Management Arrangement**: Practice entity retained and contracts with hospital; administrative management and staff not employed by hospital, but physicians are employed.

4. **Hybrid Model**: Hospital employs/contracts with physicians; practice entity spun-off into a jointly-owned MSO/ISO.

**PSA Offerings**

- Flexibility in structure
- Opportunity to increase and enhance bottom-line for both hospital and the practice
- Stability in relationship with hospital
- Bonus opportunities for exceptional performance
- Opportunities to expand services together without being fully aligned (i.e., employment and/or clinical integration)
- Easier segue to full employment for physicians and staff
1. PSA – Traditional Model

Hospital/Health System

- Assumes responsibility for practice’s management and operations (includes lease/depreciation expense and other operating expenses)
- Pays the practice’s real estate lease
- Purchases or leases ancillary services
- Employs practice staff (both ancillary and non-ancillary staff)
- Contracts directly with payers for professional and technical fees

Deducted from professional service revenue to be paid to practice
Lease expense deducted from professional service revenue to be paid to practice
Fixed payment (upfront or annually) to the practice, set in advance
Fully loaded expense deducted from professional service revenue to be paid to practice

PRACTICE

- Contracted by hospital to provide professional services
- Practice providers (but not support staff) remain employees of the practice
- Payment to practice for professional services equal to net collections less direct costs paid by hospital (and any fixed payments for ancillaries) or a rate per wRVU for production by practice providers
2. PSA – Global Payment Model*

Hospital Board

- Asset Ownership/Lease
- Payer Contracting
- A/R Owned
- Billing***
- Establishes fee structure

Hospital (Integrated with Physician Division Infrastructure)

Practice Board

- Membership
- Compensation

Professional Services** & Non-compete Agreement

PSA Management Committee

- Approves Strategy/Finances
- Oversees Operations/Business Planning
- Establishes Compensation Principles
- Achieves Value-Exchange Objectives
- Is Typically Split 50/50 Between hospital and practice

PSA

- Global Fee:
  - Fixed Overhead
  - Variable Overhead
  - Rate per wRVU

Practice (For-Profit Entity)

- Group Governance
- Physician Hiring/Termination
- Income Distribution
- Clinical Practice/Quality
- Malpractice
- Management and Staffing
- IT Support
- Physicians and staff remain employed by practice

*Could be a portion of the practice

**Services to be provided can include: diagnostic and procedural services; clinical management and coordination; administrative, supervisory teaching and research functions; complete service line and clinical co-management; cost savings; quality incentives, etc.

***Billing could be performed by the practice as a third-party agent
3. PSA – Practice Management Arrangement

- Physicians retain ownership of their practice infrastructure
- Physicians operate as the managers of the practice, providing all administrative services, space, equipment, and support staff
- The hospital contracts with the practice entity for these services and pays a fair market value ("FMV") fee
- The compensation structure for the employed physicians is a productivity-based system (likely with some performance incentives as well)
- The arrangement can be easily dissolved, as the practice entity stays outside the hospital control structure
Clinical Co-Management Arrangements (“CCMA”)

Structure

- Clinical co-management agreements offer an alternative to employment or a professional services agreement (i.e. employment “lite”) relationship, but still serve as a form of moderate alignment between two parties.
- CCMAs offer a way for hospitals to align with providers within its service line.
- CCMAs can also be in conjunction with a full alignment transaction in the form of a “wraparound”.

Service Line Arrangement

- The purpose of the arrangement is to reward physicians for their efforts in developing, managing and improving the quality and efficiency of the hospital’s service line.
- A contractual relationship between the hospital and the management entity results.
- Compensation is in part performance-based, tied to achievement of specific quality objectives.
- Some shared cost savings initiatives may also be included.
CCMA Example: Orthopedic Service Line*

*Each service line/specialty can have its own CCMA, which can be included as a singular alignment strategy or as a “wraparound” (i.e., add-on) to another, major alignment strategy.
CCMA Takeaways

Size
- All providers within each applicable service line can participate in the CCMA
- Multiple CCMAs may occur simultaneously

Wraparound
- “Add-on” services such as medical directorships, management services agreements, etc. may be incorporated into the CCMA structure

Flexibility
- Can be implemented with or without additional alignment strategies and can be executed via a number of models

Stability and Improvement
- Providers are incentivized and rewarded for driving the value proposition (outcomes/cost)

Compensation
- Practice will be paid a base management fee for providing administrative services as well as value-centric incentives for the achievement of defined performance goals and measures
Using Alignment to Further Integration

<table>
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<tr>
<th>Stage I – Alignment</th>
<th>Stage II – Clinical Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Examples: Medical Directorship, CCMA, PSA, JV, Employment</td>
<td>• Examples: PCMH, ACO, Quality Collaborative, CIN</td>
</tr>
<tr>
<td>• Common goals and objectives</td>
<td>• Merged clinical and business models</td>
</tr>
<tr>
<td>• More structural than functional</td>
<td>• More functional than structural</td>
</tr>
<tr>
<td>• Overall structure and intent of the organizations do not really change</td>
<td>• Builds on the historical alignment models and strives to achieve value</td>
</tr>
<tr>
<td>• Tied together by legal and economic connections</td>
<td>• Tied together by clinical and cultural connections</td>
</tr>
</tbody>
</table>

*Can also be via physician-to-physician alignment; though below we focus on utilizing a hospital relationship to achieve clinical integration*
Clinical integration (CI) is a term used to describe a **collaborative** and **coordinated** approach to healthcare delivery.

CI’s focus is on reliably producing **high quality clinical outcomes** in the most **cost efficient** manner possible.

If value is defined as quality per unit of cost ($V = Q/C$), then CI is, quite simply, a method of providing healthcare **services that produce measurably higher value** (i.e. a high quality to cost ratio).

CI is especially important in the **US healthcare industry**, where the two overarching imperatives behind the recent reform efforts are also related to the variables in the value equation.
In either scenario, providers are a critical element as they are the ones delivering care and therefore controlling quality, cost, and overall success of the CIN – both operationally and financially.

*Could be either private practice or ASC collaborative*
Compensation Model Revisions: Challenges/Opportunities
Historical Compensation Plans

- Driven by sweeping consolidation trend
- Oftentimes high guaranteed pay and/or overall economics unsustainable
- Primarily focused on production, with no or not enough emphasis on value-based elements
- Value-based elements not truly “value-based”
- Requires a “re-visioning” of what a compensation model should look like...what is needed for the future.
- Remember that changing compensation structure is only one facet of movement to a value-based world!
Illustration of Changing Models

• Pre-MACRA

- wRVUs
- Rate per wRVU
- Compensation

• Post-MACRA

- wRVUs
- Rate per wRVU
- Compensation

- Quality
- Advancing Care Information
- Clinical Practice Improvement Activities
- Resource Use
Challenges

- Data Capture
- True External Drivers
- Lack of Cohesive Compensation Philosophy
- Perceived “Decrease” in Compensation
- Provider Buy-In
- Interpretation of Market Data
- Lack of VBR
Opportunities

“Stepping Off Point”

• Ability to better align future with physician compensation arrangements
• Shifting from multiple compensation structures within an organization toward a more consistent methodology, emphasizing a congruent compensation structure among all physicians/providers

Conform to Changes in Market

• Current and future
• Hybrid models of compensation

Revise Compensation Model Structure/Variables

• Ensure economics are financially viable
• Move to “top down” approach
• Proper balance between FFS and FFV
Practical Applications of Compensation Design in Value-Based Era
Top-Down Approach to Pay

- **Targeted Comp/wRVU Ratio**
  (Target %ile of Market Data)

- **wRVU Productivity**
  (75-85%)

- **Individual/Group Performance Incentive**
  (10-20%)

- **Other Components of Pay**
  (5%)

- Value (targeted comp/wRVU) is set and then allocated amongst the three components of the compensation model
- Full value is achieved through maximum performance in all areas
- Model creates flexibility to adjust value among components over time as changes in reimbursement occur
- The hybrid model is intact
Value-Based Incentives

- Introduce if not prevalent
- Balance with productivity incentives
- Part of compensation arrangement, not an “add on”
- Scorecard approach
- Focus on factors physicians can influence
- Make measuring meaningful
- Balance value of incentive and metrics
Panel Incentives (PCP Only)

- **Rationale**
  - Incentivizes access
  - Recognizes non-wRVU generating activities (continuing to expand)
  - Begins to develop capitated mindset

- **New Models**
  - Including panel as component of overall pay
  - wEVU (work equivalent value unit)
    - Blend of wRVU and Panel as measure of productivity
    - Can shift weight over time from wRVU to Panel
    - Panel size included to account for the increased likelihood of future capitated reimbursement, and to promote better patient access

- **Challenges**
  - Measuring
  - Alignment between panel data (internal vs. payer)
  - Toes in two different models
Panel Incentives (PCP Only)

- Illustration

<table>
<thead>
<tr>
<th>Amount</th>
<th></th>
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<tbody>
<tr>
<td>PCP wRVUs (Overall Group)</td>
<td>160,000</td>
</tr>
<tr>
<td>Rate per wRVU</td>
<td>$40.00</td>
</tr>
<tr>
<td>Panel Incentive (%)</td>
<td>10%</td>
</tr>
<tr>
<td>Panel Incentive Rate per wRVU</td>
<td>$4.00</td>
</tr>
<tr>
<td><strong>Panel Incentive Pool</strong></td>
<td><strong>$640,000</strong></td>
</tr>
<tr>
<td>Panel Size (Overall Group)</td>
<td>60,000</td>
</tr>
<tr>
<td><strong>Per Member Payment</strong></td>
<td><strong>$10.67</strong></td>
</tr>
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- Panel Incentive Pool Calculation
  - 160,000 x $4.00 = $640,000

- Per Member Payment Calculation
  - $640,000 / 60,000 = $10.67

- Physician A has 2,000 members in their panel
  - 2,000 x $10.67 = $21,340

- Physician B has 750 members in their panel
  - 750 x $10.67 = $8,003
Pulling Incentives Together

• The quality incentive opportunity is tied to productivity. In order to earn the full incentive, productivity has to be above the market median.

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Percentage Opportunity</th>
</tr>
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<tbody>
<tr>
<td>&gt; Median</td>
<td>100%</td>
</tr>
<tr>
<td>Median - 45th</td>
<td>95%</td>
</tr>
<tr>
<td>45th - 35th</td>
<td>85%</td>
</tr>
<tr>
<td>35th - 25th</td>
<td>75%</td>
</tr>
<tr>
<td>&lt; 25th</td>
<td>50%</td>
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• The productivity incentive opportunity is tied to quality. In order to earn the full incentive, the physician’s annual performance scorecard has to be above 85%.

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External Performance Incentives

- Do not pass-through external incentives
  - Equivalent to passing through 100% of FFS $

- Align drivers of value-based revenue with value-based incentive structure
  - No different than what occurs with FFS $
  - Calibrate the “value” of value-based revenue with value-based incentives

- Pace change in compensation structure with changes in reimbursement environment
  - Being too far ahead of or behind the curve can be detrimental
Private Practice Models

**Revenue:**
- Professional Fees (Fee for Service)
- ACO Income
- Call Coverage
- Third Party Payer Initiatives
- Capitation Fees
- Other

**Less: Overhead:**
- Direct Expenses
- Indirect Expenses
- Physician Base Salary
- Physician Benefits

**Equals: Distributable Net Income**

Non-Productivity Incentives (VBR incentives) are embedded into overall model
Second Generation Structures
“Second Generation” Alignment Models

• Traditional alignment models are starting to take on a new “look”
• For example:
  – *PSA models* include “carve-out” structures that either include a portion of the practice or its services
  – *Employment models* allow physicians more autonomy than ever before
  – *Joint equity ventures* becoming more common among ambulatory surgery centers/hospitals
  – *ACOs/CINs/QCs* gaining prevalence and function as an alternative to employment
“Second Generation” Alignment Models

- Second generation models seek a “happy medium” between hospital and physician control
- Key areas for negotiations include:
  1. Compensation Model
  2. Governance Structure
  3. Non-Compete Clause
  4. Income Distribution Plans

More heavily emphasized under an employment model than non-employment structures (i.e., PSA, CCMA)
1. Compensation Model

• Base pay and monetary incentives are *not* the only items to consider when negotiating
  – Benefits/PTO
  – Incentive programs
  – Retirement packages
  – Quality metrics/incentives
  – Hybrid models (FFS and VBR payments)
## 2. Governance Structure

<table>
<thead>
<tr>
<th>STRUCTURE</th>
<th>CENTRAL GOVERNANCE AND MANAGEMENT</th>
<th>BOARD STRUCTURE</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pod-Based</td>
<td>Limited central governance; practice has control of management structure</td>
<td>Practice</td>
<td>Limited economies of scale; difficult to share vision and mission</td>
</tr>
<tr>
<td>Hybrid Integrated</td>
<td>Shared central governance; shared control of management</td>
<td>Representation from each practice that report to a higher board structure</td>
<td>Tend to be in the areas of strategic planning, shared EMRs and billing, contracting strategies, and expansion/growth strategies</td>
</tr>
<tr>
<td>Fully Integrated</td>
<td>Common central governance, centrally controlled management</td>
<td>Committees have more authority over group and Board makes recommendations</td>
<td>Committees include controlled finance, operations, clinical/quality care, marketing, and information technology</td>
</tr>
</tbody>
</table>
3. Non-Compete

- Serves as a great leverage point
- May allow for return to private practice upon termination
- Consider both the *geographical* and *time* limitations
  - Must remain reasonable to be successful after the contract is terminated/expires
4. Income Distribution Plans

1. Equal Allocation
2. Collections Allocation Model
4. Percentage of Collections and wRVU Model
5. Productivity Model
6. Productivity Model with Withhold
Legal Considerations of Alignment

- Stark Law
- Anti-Trust
- Anti-Kickback Statute
Case Studies
Case Study #1: Comp Redesign for Health System in Midwest

• Situation
  – Decent foundational model, but limited focus on value-based incentives
  – Core structural issues - PTO payouts, external quality being “added on”
  – Wanted model that corrected structural issues and responded to changing reimbursement market

• Solution
  – Compensation committee process over 6-9 months to craft a new model structure
  – All models included some element of value-based incentives
    • Performance incentive 5% of total compensation
    • Specialty care opportunity of 5% of median rate per wRVU
    • Primary care opportunity on a per FTE basis
  – PCP model included a robust panel incentive
    • Panel incentive – 5% of total compensation
  – Physician group governance body formalized quality committee to “manage” value-based incentives going forward
  – Recognition that model will need to be “tweaked” over time
Case Study #2: Comp Redesign for Health System in East

• Situation
  – Reimbursement rapidly changing from volume to value
  – Core structural issues – wRVU based, difficult to shift value among components, structure of model different by specialty, cultural issues with base compensation and volume
  – Wanted model that corrected structural issues, could adapt to future reimbursement changes, and addressed cultural issues

• Solution
  – Worked with Compensation Committee, Administration, and IT department to design and implement a new model
  – Value-based incentives for Primary Care and Specialty Care – approximately 10% being phased in over 3 years
  – PCP panel incentive created a baseline expectation – 5% of total compensation
  – Physician leaders worked together to decide on best quality measures for each specialty
Case Study #3: CIN Development in the Southeast

• Situation
  – Hospital system with private physicians, employed physicians and academic providers
  – Faring well, but constantly working to hold strong given the competition in the market
  – Looking for a way to prepare for the future that would allow them to be proactive (not wait for payers to dictate their reality)

• Solution
  – Developed a CIN focused on their own health plan (at least initially)
  – Required minimal commitment from participating providers (small participation fee, reporting of data, attendance at meetings)
  – Was a fairly painless way to establish the infrastructure and garner physician support
  – Over time, model has morphed to include greater risk-based incentives, and expanded to more commercial payers
Conclusions and Q&A
Conclusions and Key Takeaways

• Rise of fee-for-value reimbursement has created an industry wide call-to-action (MACRA has led the way)
• Important to be proactive rather than reactive, without overreacting
• Alignment is a great avenue to mitigate numerous economic, strategic and operational concerns
• As population health management becomes more of a focal point, alignment will be even more important, if not essential
• While VBR has not become pervasive, it is “relevant” and should be considered as such
• Private groups and health systems should consider a pluralistic approach to alignment in 2017 and beyond.
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