HCCA Clinical Practice Compliance Conference San Diego, California

"Monetizing Quality-How to Align Quality with Compensation Models and Payer Contracts"

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Transformation of a 20th to 21st Century Healthcare Model

1. From a 'sickness' to a 'health' industry
2. From leaders of an organization (hospital) to an integrated healthcare delivery system
3. Line to matrix authority/accountability and partnership with other key leaders and stakeholders
4. Physicians as 'customers' (revenue generators) to strategic business partners (wRVU to at-risk co-management agreements)
5. Pay for volume to pay for value (Q/C)
   - (David Nash, MD: 'No outcome equals no income')

Commercial Payers are Committed to Value:

- **Aetna:** 50% shared savings/risk by 2018 (e.g. total joints)
- **Anthem:** 50% shared savings/risk by 2018
- **Cigna:** 50% shared savings/risk by 2018
- **Humana:** 75% of Medicare advantage value based (with and without shared risk) by 2017
- **United:** commitment to value based purchasing with capitated payment models

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How do Commercial Payers Incentivize Practices and Organizations based upon these measures?

Blue Cross and Blue Shield of Tennessee Value Based Managed Care Plans:

1. Metrics are collaboratively chosen by practitioners, management and payers based upon practice profile
2. Metrics are scored from 1-5 stars based upon negotiated benchmarks
3. Each star is valued at $2 per member per month
4. Impact on each practice is potentially $250,000-$500,000 (assuming a 2,500-5,000 panel)

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Methodology: All Steps Require Collaboration!

1. Align with all key physicians/practitioners first!
2. Hard wire regulatory quality into your system (requires physician approval and support)
3. Establish strategic quality goals/objectives (quality plan) consistent with your organization's strategic plan and payer contracts
4. Monetize those goals/objectives and create a pareto diagram to identify the 'vital few'
5. Create aligned co-management agreements with ALL employed/self-employed physicians/practitioners and stakeholders with a calculable ROI

1. Align with all Physicians/Practitioners and Stakeholders first

What is alignment?

When physicians', managements', and 'governing boards' self interests overlap with organizational interests (e.g. mission, vision, strategic plan, and values) in a synergistic and mutually beneficial way

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Mal-Alignment is everywhere! What is the impact of wRVU compensation on….

- Quality?
- Safety?
- Service?
- LOS?
- Documentation (revenue cycle)?
- Readmissions?
- Cost per case?
- Operating costs?
- Margin?

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2. Hardwire Regulatory Quality into your System

Key Components of 'At Risk' Contracts with Physicians (Intermountain Health):

1. Be willing to participate in 'at risk' contracts based upon strategic goals/objectives developed and approved by physicians and management
2. Comply with clinical and business 'best practices' as determined by peer group/management (and be willing to be peer audited for exceptions)
3. Agree to un-blinded transparency of all clinical and financial data/analytics
4. Be willing to comply with value analysis process
5. Disclose all potential conflicts of interest and accept determination of deliberative physician bodies

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What is regulatory quality?

- Core measures
- SCIP measures
- Specialty specific measures (e.g. STS, ACC etc.)
- NQF ‘never events’
- Patient safety measures
- HEDIS measures

Why are these important and what do you want to do with them?

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Hardwire regulatory quality!

- Clinical and functional pathways
- Standardize communications (e.g. SBAR) in high risk situations
- Manual checklists (pre-software)
- Decision support software and default functions
- Clinical and business analytics to monitor for variance (audit!)
- Many organizations are hitting 100% all of the time!

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3. Create a Draft Quality Plan

Where does a good Draft Quality Plan begin?

Your organization's:

- Mission
- Values
- Vision
- Strategic plan

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Methodology to Align Physicians with the Organization's Strategic Plan

Step 1: Create a MS Strategic Plan
Step 2: Create a MS Operating Plan
Step 3: Create performance metrics aligned with payer contracts and strategic goals/objectives
Step 4: Imbed all key performance indicators into all co-management agreements (both employed and self-employed practitioners) with significant incentives
Step 5: Create committee workplans (disease management or precision medicine) to support performance
Step 6: Create performance analytics (and decision alerts based upon benchmarks) to guide performance
Step 7: Create performance dashboards/scorecards
Step 8: Utilize results to inform strategic planning

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Monetize Quality into a Pareto Diagram to create a Strategic Quality Plan

Obvious ROIs for your organization: What would be the impact on cash flow (and clinical outcomes) if Physicians could lead the:

- Reduction of LOS by 1 days?
- Increase the CMI by 0.1?
- Reduction of adjusted cost/case by 5%?
- Optimization of top box HCAHPS scores?
- Reduction medical errors and avoidable readmissions by 5%?
- Reduction of clinical morbidity/mortality by 5%-10%?
- Reduction of non-value added clinical/process variation by 50%?
- Eliminate that disruptive individual costing the organization so much time and money?
- Reduce the labor (total cost/operating revenue) and supply chain (total cost/operating revenue) ratios?

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Please Assume that you are a healthcare system with $1,000,000,000 in operating revenues and:

- Medicare Part A revenue of $500,000,000
- Medicare Part B revenue of $100,000,000
- Average length of stay of 5 days with 10% of total costs generated in the final day and average expenses of $1,000/day (total of 80,000 patients)
- CMI of 1.7 with Medicare base rate of $7,000 and DRG weight of 1.7 with 40,000 Medicare patients
- Labor ratio of 60%
- Supply chain ratio of 20%
- Net operating margin of 4%

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Please Monetize for your 'Organization' the Estimated Dollar Value for the following:

- Reduction of ALOS by 1 day
- Increase the CMI by 0.2
- Optimization of value based purchasing from 'average' to 'top decile'
- Increase your MIPS from 'average' to 'top decile' (2018)
- Decrease your labor ratio from 60% to 55%
- Decrease your supply chain ratio from 20% to 17%
- Reduce your cost per case by 10% (total 80,000 patients)

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Calculations:

- Decrease LOS by 1 day = $500 costs (10% of $5,000) X 80,000 patients = **$40,000,000 cost savings**
- Increase CMI by 0.2 = $7,000 Medicare payment X 40,000 Medicare patients = $280,000,000; 1.11764706 (1.9/1.7) X $280,000,000 = **$312,941,176 or $32,941,176.50 incremental revenue**
- Increase VBP by 1% = $500,000,000 Medicare part A revenue X 1.01 = **$5,000,000 incremental revenue**

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Calculations (cont.):

- Increase MIPS by 5% = $100,000,000 Medicare part B revenue X 1.05 = **$5,000,000 incremental revenue**
- Decrease your labor ratio 5% = $40,000,000 (net operating margin) + $50,000,000 (5% of $1B) = $90,000,000 (new net operating margin) with = **$50,000,000 (incremental revenue)**
- Decrease your supply chain ratio 3% = **$30,000,000 incremental revenue**
- Reduce your cost per case by 10% = $500 (10% of $5,000) X 80,000 patients = **$40,000,000 cost savings**

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5. Create Aligned Co-Management Agreements with Calculable ROIs

Pareto Chart to Prioritize (first five make up > 95% of total): What makes this more strategic?

1. Decrease your labor ratio 5% = **$50,000,000**
2. Reduce your cost per case by 10% = **$40,000,000**
3. Decrease LOS by 1 day = **$40,000,000**
4. Increase CMI by 0.2 =**$32,941,176.50**
5. Decrease your supply chain ratio 3% = **$30,000,000**
6. Increase VBP by 1% = **$5,000,000**
7. Increase MIPS by 4% = **$5,000,000**

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Co-Management Agreements

- Partnering physician and managerial leaders to oversee inpatient/outpatient services, ancillary, multi-site specialty care (exclusives), service lines, clinical institutes, and enterprises for performance in:
  - Quality
  - Cost savings
  - Service
  - Safety
  - Efficiency
  - Marketing/branding

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Give Physicians a Choice to Go "At Risk":

90%tile MGMA

75%tile MGMA

50%tile MGMA: Minimum wRVU, quality, safety, service, cost-effectiveness expectations with a potential downside

25%tile MGMA

10%tile MGMA

Example of an ED co-management contract (Circa 2006):

- 50% base pay **(10%tile MGMA compensation)**
- 10% quality program and performance (2% bonus for every 20% departmental compliance with agreed upon quality targets)
- 10% patient satisfaction (2% for each 10%tile above 30%tile Press-Ganey departmental scores)
- 10% physician satisfaction (2% for each 10%tile above 40%tile for hospital survey of physicians)
- 10% corporate compliance (e.g. medical records) (2% for every 10% compliance over 50%tile)
- 10% evaluation by President MS and CEO (top potential pay – (**90%tile MGMA compensation**)

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Recent $1.3 M Contract for OBGYN in West Texas (from 'piece work' to clinical executive): Each segment monetized for HCA

1. Above average wRVUs (75%tile MGMA) **(FMV1= $400,000)**
2. Supervision of four APNs (allowed by Texas State Law) **(FMV2 = $200,000)**
3. Leadership of Charity OBGYN Clinic **(FMV3= $300,000)**
4. Leadership of OBGYN Service Line with negotiated clinical and business outcomes (FMV4)(all have calculated ROI for both clinician and management) **(FMV4= $400,000)**

ROI for HCA 3:1 ($3.9M incremental margin to system)!

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Strategic medical staff development plan

Board approved policy that recommends the specific:

a. Numbers of practitioners for each clinical specialty
b. Qualifications required within each clinical specialty
c. Economic relationship within each clinical specialty (e.g. employed, member of service line, exclusive agreement etc.)
d. Organizational fit (e.g. organizational culture, values, goals, objectives)
e. Personal and professional fit (compatibility of practitioner with organization)

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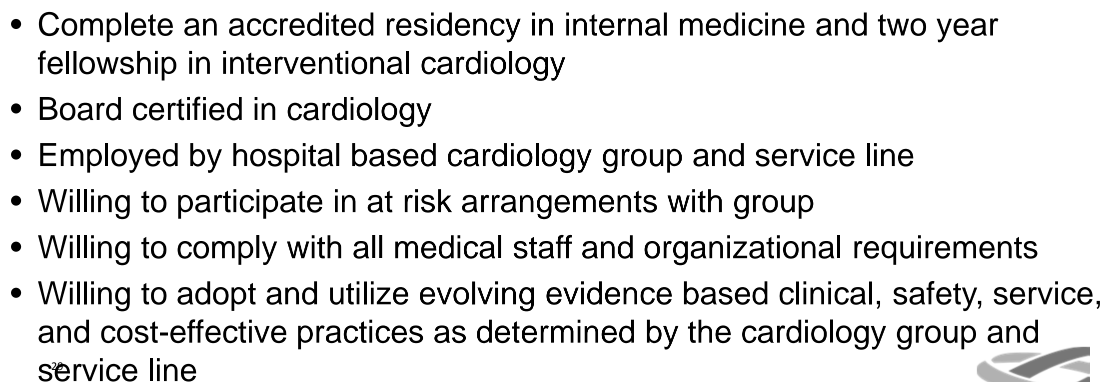
Sample 'economic' credentialing and privileging criteria

Cardiologist:



- Complete an accredited residency in internal medicine and two year fellowship in interventional cardiology
- Board certified in cardiology
- Employed by hospital based cardiology group and service line
- Willing to participate in at risk arrangements with group
- Willing to comply with all medical staff and organizational requirements
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the cardiology group and service line

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Many are "Raising the Bar":

University of Virginia, Charlottesville, VA MS Bylaws:

" Any practitioner who does not embrace evidence based practices and a high level of professional conduct as determined by the clinical specialties and MEC is hereby ineligible to apply or reapply to this medical staff."

What happens at reappointment?

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Summary Principles:

1. Optimizing value-based payment depends on defining, quantifying and proving superior quality and and financial (total cost) performance
2. Must have accurate and actionable clinical and business analytics to engage stakeholders
3. Improving quality has quantifiable and calculable financial value
4. Developing the business case for improving quality lends advantage among multiple projects competing for scarce(er) resources
5. Physicians must have 'at risk' contracts to be aligned with payer and organizational targeted outcomes
6. Focus on 'vital few' in both your strategic plan and 'at risk' agreements
7. Strategic goals/objectives represent moving targets based upon evolving incentives
8. Play to win; not to be in the middle!

Questions, Discussion, and Wrap Up

Thank You for your Participation!

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