The Future is Almost Here:
Is Your Physician Group Ready to Transition From Volume to Value?

March 27, 2012

John Behn
Mike Fleischman
Susan Stowell

STROUDWATER ASSOCIATES

Presentation Agenda

STROUDWATER ASSOCIATES

- Defining value
- Imperative to change
- Working from a stable platform
- Preparing for value based medicine

Defining Value

What is patient value?

STROUDWATER ASSOCIATES

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}$$

Who Determines Patient Value?

STROUDWATER ASSOCIATES

- Whoever spends the money gets to define value.
- Currently, that is CMS and large employers.
- Increasingly, it will become the patient.

Who Determines Patient Value?

- The Accountable Care Act does not define “Value”
- National Committee for Quality Assurance (NCQA) is stepping into the void.
- NCQA released its standards and guidelines for Accountable Care Organization (ACO) Accreditation in November 2011.
  - Roadmap for provider-led organizations to demonstrate their ability to reach the triple aim: reduce cost, improve quality and enhance the patient experience
  - Builds on patient-centered medical homes
  - Provides an independent evaluation of organizations' ability to coordinate the high-quality, efficient, patient-centered care expected of ACOs

What is “Quality”?

- Quality = Fitness to satisfy a defined need
- Not an undefined intangible
- Objective measurement of processes and outcomes
- Includes everything that affects patient value …
- Including customer service, which, ironically has inherent elements of subjectivity

How Do Medical Providers Produce Value?

STROUDWATER ASSOCIATES

- Provide consistent, high quality medical care …
- That adheres to best practices …
- Minimizing variation …
- At lower total cost …
- Without providing unnecessary care …
- With superior customer service …
- All delivered to demanding patients who increasingly control the money.

Imperative to change

Measuring and paying for “quality” has already started…

STROUDWATER ASSOCIATES

- Centers for Medicare and Medicaid Services (CMS) instituted several significant reimbursement initiatives
  - Pay for performance initiatives started over 7 years ago
  - Core measures tracking and benchmarking
  - Medicare Group Practice Demonstration Program
  - Never events
  - Physician Quality Reporting Initiative (PQRI)
- Commercially
  - NCQA
  - Variations of the quality theme being developed by private insurers and medical specialty associations

More CMS “quality” focused reimbursement programs are planned

STROUDWATER ASSOCIATES

- Value Based Purchasing Program
- Hospital readmission reduction program
- Payment reductions for health care acquired conditions
- Shared Savings Program (ACOs)

While these programs target hospital reimbursement, they require provider engagement and involvement to ensure performance

Commercial insurers moving away from strictly paying for volume

STROUDWATER ASSOCIATES

- Patient centered medical home
  - Primary care
  - Specialty based
  - ➢ *Care coordination fees*

- Accountable Care Organizations
  - Providers at risk for cost savings and quality
  - ➢ *Bonus paid in lieu of increase in FFS payment, and payable only if certain criteria are met*

Commercial insurers moving away from strictly paying for volume, contd.

STROUDWATER ASSOCIATES

- Payment methodologies
  - FFS + Performance Bonus that represent achievement of quality outcomes
  - FFS + Care Management Fee – PCMH concept
  - FFS + Shared Savings that represent achievement of quality and outcomes and a measured reduction in costs
  - Withholds
  - Risk pools
  - Capitation
  - Bundled payments

- Structural innovations
  - Provider – insurer partnerships

Employers shift from defined benefit to defined contribution

STROUDWATER ASSOCIATES

- Continuing struggle with high employee healthcare costs forcing employers of all sizes to shift from defined benefit to defined contribution plans
  - Creates a dramatically different market for commercial insurers
  - Places significant downward pressure on reimbursement across providers

- Employees are instantly engaged as active consumers and a new level of price awareness is created

- Added element of demonstrable value in provider panels will enable commercial carriers and individual providers to gain larger market shares

Consumers are engaged but frustrated

STROUDWATER ASSOCIATES

- High deductible health plans with a savings component
  - Continue to be the major area of growth in commercial insurance
  - However, consumers may still chose hospitals and physicians the old-fashioned way (based on perception and insurance network coverage)

- Growth in patient "education" regarding hospital and provider quality via the Internet
  - Majority of the consumers end up more confused than when they started

- Enormous communication gap
  - Average hospital and physician communication is targeted to a 12th grade education
  - 25% of US citizens are functionally illiterate
  - Another 25% read at less than a 12th grade level

Market place example

STROUDWATER ASSOCIATES

- National healthcare insurer is recognizing the value of care coordination as a way of saving costs using a number of different contractual approaches.

- One model will partition a portion of a provider's payment in the form of a bonus. Among the measures that are being considered for tying to payments are:
  - Hospital readmission rates;
  - Use of radiology services;
  - Mortality rates for certain conditions;
  - Hospital-acquired infection rates; and
  - Patient satisfaction.

Market place example continued

STROUDWATER ASSOCIATES

- On the physician side, UHC considering goals that would involve:
  - Rates of inpatient admissions;
  - Emergency-room use;
  - Total cost of patient care; and
  - Quality measures such as use rates for recommended screenings.
- Under pilot programs, insurer is benchmarking bonuses at $1 to $3 per member per month for primary-care physicians
- For accountable care organizations, the bonuses could range from $1 to $5 per member per month.

When the payers start moving into the "new ideas" space, you know there's a trend in the works.

Working from a stable platform

Moving from volume to value will require a stable platform yet…

STROUDWATER ASSOCIATES

- Reimbursement is declining
  - Physician expectations that compensation will increase all while:
    - Older physicians are “slowing” down
    - Younger physicians have lifestyle demands very different than the older generation
    - Part time physicians must be accommodated

- Increased administrative challenges
  - Implementing and maintaining an IT platform
  - Development of new physician leadership
  - Shifting attention from production to quality

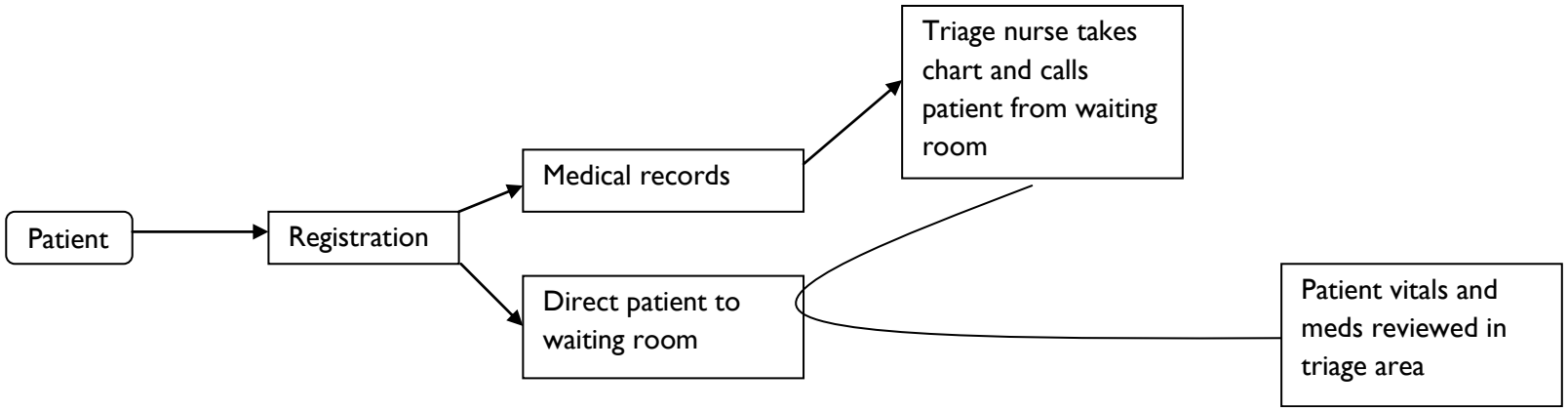
Operations must be efficient

STROUDWATER ASSOCIATES

- Revenue cycle
  - Ability to manage documentation, billing, and collections is critical to short and long term survival
  - Now is the time to prepare
    - Be honest and realistic in your assessment
  - Does the practice have a commitment to quality in all areas?
    - Clinical Interactions
    - Documentation
    - Revenue Recognition
    - Employee Satisfaction
    - Patient Satisfaction
  - Does your practice have effective policies and procedures to govern:
    - Systematic, compliant and total revenue capture
    - Adjudication of denials, contractuals and bad debt
    - Effective internal and external communication platforms

Operations must be efficient

- Patient flow and processes
  - Is your practice physician or patient centric?
    - Look at your flow and processes from a patient's vantage point
    - Re-examine flow and processes to ensure that the practice is optimally using its resources



Operations must be efficient

STROUDWATER ASSOCIATES

- Support staff
  - Does everyone within the practice understand their role and their importance to the overall performance of the practice?

Example: Schedulers
People in the scheduling role hold your practice's productivity and throughput at their finger tips yet in many practices , they don't have the education or training to place patients in the right appointments and sometimes they can hold back productivity by selectively scheduling patients.

  - Are roles and responsibilities clearly defined?
  - Are you maximizing the time of your physicians?
    - Use of mid-levels
    - Identifying opportunities to leverage other care providers

Operations must be efficient

- Support staff
  - Is your staffing adequate to support operations?
    - Do you have the right people in the right jobs?
    - Have you given each position the appropriate decision-rights?
    - Are they cross-trained?

Staffing Analysis - Support Staff per Provider FTE

	XYZ OB/GYN			
	Acutal		MGMA	
Support Staffing	FTEs	Ratio	Ratio	% Diff
Provider FTEs	5.0			
Registered Nurse	-	-	0.45	-100%
LPN/Desk Nurse/Tech	9.0	1.80	1.50	20%
Front office support staff	6.0	1.20	2.46	-51%
Ancillary Support Staff	-	-	0.35	-100%
Business office	4.0	0.80	0.97	-18%
Total FTE support staff	19.0	3.80	3.99	-5%

Based on 59th percentile FOR OB/GYN PRACTICES. For practice where the average number of patients per physician is 2,248 and average Work RVUs produced by a physician is 7,738

Staffing benchmarks can help identify where a practice may be overstaffed but it does not tell the entire story

Operations must be efficient

- Information technology platform
  - A robust IT system will allow for efficient and coordinated care
  - Increased need to extract data in order to maximize reimbursement and demonstrate "value"
  - Data out is only as good as data in
  - If you don't have an IT solution, have you started a selection process?
  - If you do have an IT solution, prior to implementation, did you:
    - Examine and streamline your processes so that the IT solution complements and supports your care givers?
    - Work with the providers to customize the templates?

Beware of the early effects of the coming storm of "Big Data"

STROUDWATER ASSOCIATES

- Many providers are still today challenged to simply manage and utilize their own internal data sets
- Data as likely to tranquilize providers as it is to transform the care they deliver in the near term
  - Will play a transformative role in ensuring that new payment models achieve their ultimate goal of value-based purchasing
  - Ultimately will improve care quality and lower costs
- "Big Data" alone will not make the new collaborative organizations successful
  - Must be integrated, analyzed and transformed into simple clear evidence
  - Need to demonstrate to all stake holders that the new payment models incentives produce improved clinical outcomes, higher patient satisfaction and lower costs

Operations must be efficient

STROUDWATER ASSOCIATES

- Ancillary utilization
  - Payers will be closely watching utilization of ancillary services, especially those contained within the practice.
  - Denials of pre-certification requests may become more common or the payers may suggest less expensive alternatives.

- Pharmacy utilization
  - Close monitoring of formulary use will increase
  - Patients will be closely involved in this area of care since it again focuses on their level of co-pays
  - To improve value, payers may recommend alterative treatments, pill splitting, etc.

All providers must be engaged

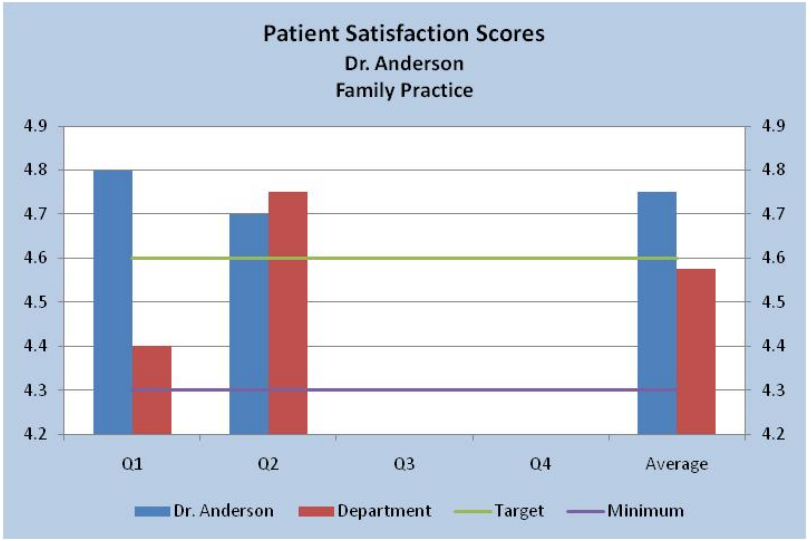
STROUDWATER ASSOCIATES

- Practice structure
  - Challenge:
    - Many providers seek hospital employment to minimize their administrative duties
    - This should not mean removing all responsibility from the providers for the practice's performance!
    - They hold the key to utilization, reimbursement, and costs!!
  - It is critical to:
    - Engage providers through a leadership team
    - The team's composition and charge will be organization-dependent
      - Should include representation from all major components of the practice

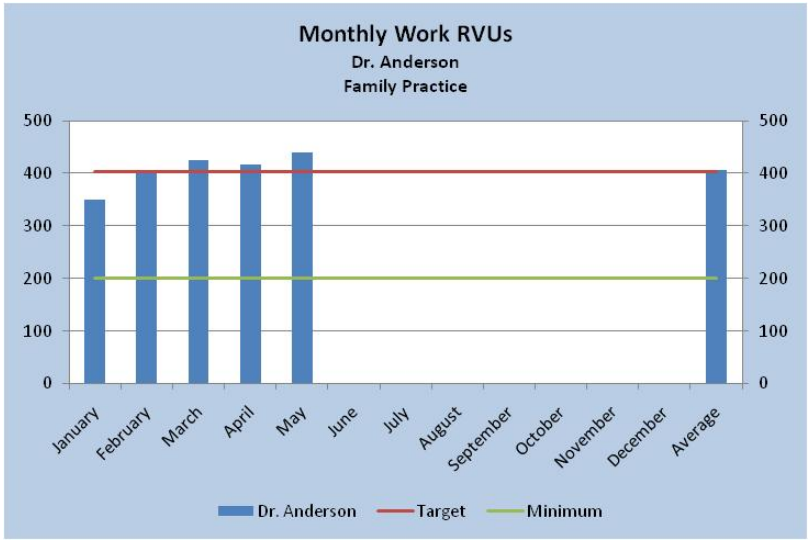
Engaging providers through data

STROUDWATER ASSOCIATES

- Publishing information on key metrics will drive performance
  - Quality
  - Patient satisfaction
  - Productivity
  - Financial performance of the practice



Give straightforward, accurate, and timely feedback on performance



	2007 Budget	2007 Actual	Varience
Total Net Collections	$ 8,263,795	$ 8,938,587	$ 674,792
			$ -
Other Income			$ -
Rental Income	212,194	216,283	$ 4,089
Interest Income	8,750	10,500	$ 1,750
Total Income	**$ 8,484,739**	**$ 9,165,371**	$ 680,632
Expenses			
Salaries to Physician Primary	1,604,302	1,669,895	$ 65,593
Salaries- Other Physicians and Medical Providers	1,860,934	2,101,577	$ 240,643
Salaries and Wages-Administrative staff	1,617,387	1,750,128	$ 132,741
Payroll Taxes	311,868	333,329	$ 21,461
Payroll Expense	12,000	12,360	$ 360
Purchases-Drugs	36,000	37,080	$ 1,080
Purchases-Supplies	110,000	113,300	$ 3,300
Purchases- Supplies- GI Suite	210,000	216,300	$ 6,300

© 2011 Stroudwater Associates

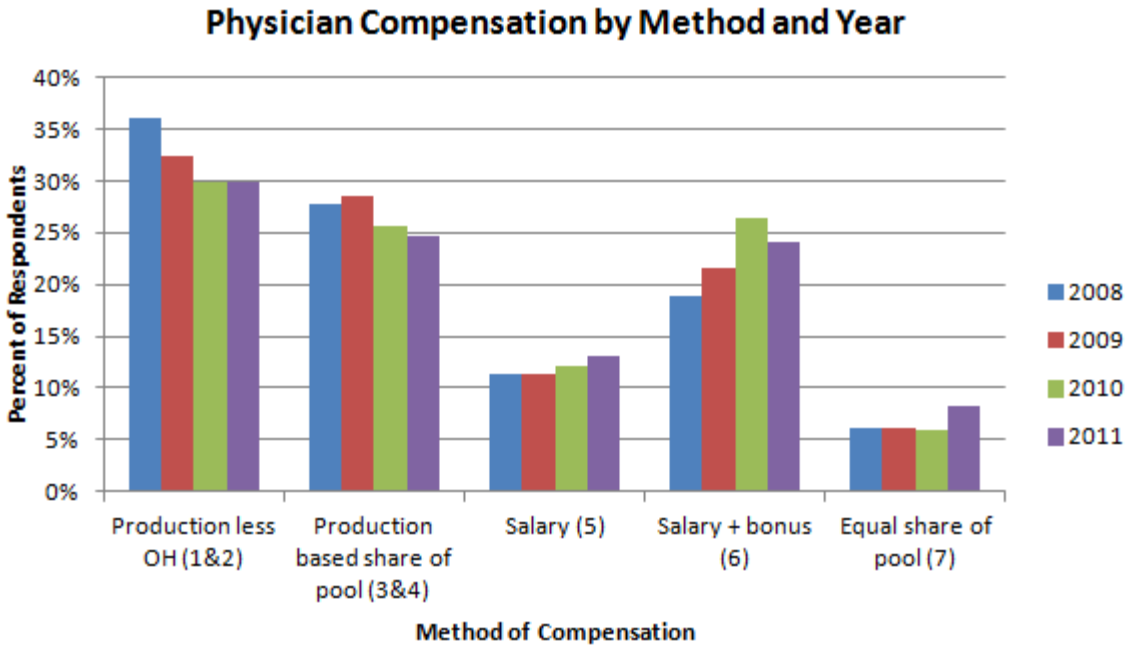
Compensation structures must be flexible

STROUDWATER ASSOCIATES

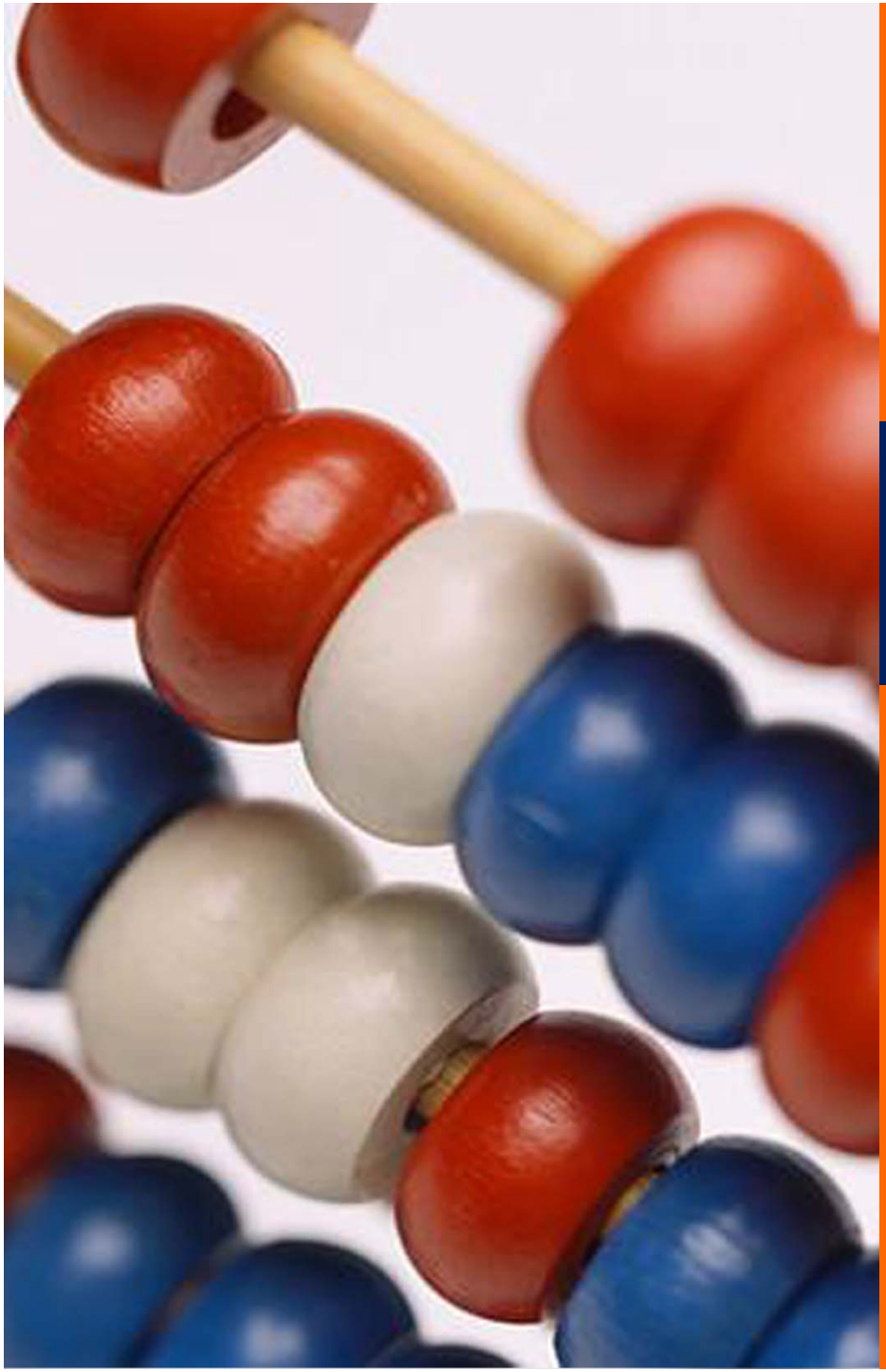
- Requires a measured approach to compensation design
  - Organizations should begin introducing topics and metrics *NOW* that will need to be addressed in the future
  - Goal:
    - Prepare physicians for focus on quality rather than on volume and devise the appropriate compensation plans to reward them for their achievements.

Many organizations are looking at incentives in the compensation structure to drive performance

- Use of incentive compensation (as a percentage of all types of comp) is growing
  - Quality
  - Patient satisfaction
  - Financial measures
  - Team based care



Source: MGMA Physician Compensation and Production Surveys, 2008 - 2011



Preparing for value-based medicine

- Educate the support staff on what is happening in market place and why it is important to the future of your practice
  - Discuss impact of quality, cost, and patient satisfaction metrics on all aspects of operations
  - Determine the requirements and how your group will meet them
  - Acknowledge that this is incremental work for all
- Employees must understand:
  - Their role and contributions to whole
  - Consequences for poor performance

Team goal:

"We know we're the best. Now we have to prove it to others!"

Clinical staff preparation

STROUDWATER ASSOCIATES

- Supporting team based care
  - Enabling providers to meet and discuss quality care
  - Identify physician leader
  - Reiterate the importance of quality, cost, and patient satisfaction – discuss requirements to achieve targets

Practice structure preparation

STROUDWATER ASSOCIATES

- Running a physician group is very different than running a hospital
- Practice needs a clearly defined leadership structure
- Practice must have a cohesive, well communicated message and mission centered on quality clinical outcomes, patient satisfaction and employee satisfaction

Steps to prepare your physician group

STROUDWATER ASSOCIATES

1. Assess the stability of the existing group

Structure	IT platform	Revenue cycle	Leadership
Support staff	Compensation plan	Team based care capabilities	

2. Establish your baseline costs
3. Research marketplace to determine what types of programs insurers in your marketplace are interested in
   - How do the commercial programs match up with CMS initiatives?
   - How well is your organization doing in meeting CMS Meaningful Use and other guidelines?

Steps to prepare your physician group

STROUDWATER ASSOCIATES

4. Determine which type of innovative program would best suit your practice/organization
   - If your organization is not ready yet, identify the gaps in capability and develop a plan to get there
5. Prepare “your story”
6. Negotiations with insurers

Questions

Contact for more information:

Susan Stowell
Principal
Hospital-Physician Alignment, Practice Leader
207.221.8263
sstowell@stroudwater.com

Mike Fleischman
Principal
770.235.4977
mfleischman@stroudwater.com

John Behn
Senior Consultant
Revenue Cycle, Practice Leader
603.801.2027
jbehn@stroudwater.com

William E. Simon School, University of Rochester, MBA

Princeton University, BA

SUSAN R. STOWELL, MBA, AVA, FACMPE

Principal and Director

Hospital-Physician Alignment, Practice Leader

Ms. Stowell joined Stroudwater Associates in 2002. Her professional focus is hospital-physician relations, facilities planning, and medical staff planning. She has experience working with physician practices as well as hospitals of all sizes ranging from critical access hospitals to academic medical centers.

Susan's recent work has included the development and implementation of the Community Service Plan, a deferred compensation plan for ED Call, at a large community hospital; hospital employment offers and arrangements for physicians; assessment of physician practices for process improvement purposes and sales; Strategic Master Facility Planning for a number of different clients including two academic medical centers in the South Atlantic area and a large community hospital in the south; and affiliations, acquisitions, joint ventures, and divestitures work with acute care hospitals and long-term care facilities in several regions of the United States

University of Missouri - Columbia, BA

L. MICHAEL FLEISCHMAN, FAAHC

Principal

Mr. Fleischman brings more than 35 years of experience in the healthcare industry to each client engagement. As a consultant, Mike's focus over the past 25 years has been on helping providers develop more integrated clinical systems, including physician-hospital relations, medical group strategic planning, group governance, medical staff development plans and community needs analysis, operational assessments and compliance including HIPAA.

Early in his career, Mike worked as an Educational Specialist and Clinic Director for the Centers for Disease Control and Prevention, and served as Project Officer for Section 330 Primary Care and Certificate of Need programs for the U.S. Public Health Service during which time he received the US Surgeon General's Special Recognition Award for Meritorious Service.

Suffolk University, MPH

Boston University, BA

JOHN E. BEHN, III, MPA
Senior Consultant
Revenue Cycle, Practice Leader

Mr. Behn has over 15 years experience in healthcare financial management and consulting. His focus has been on chargemaster auditing, revenue cycle initiatives as well as hospital and physician practice management. He has extensive experience with solo practitioners, large group practices, small community hospitals and large academic institutions. John has led initiatives to increase physician and departmental productivity, implement physician specific and hospital wide revenue cycle protocols and develop chargemaster maintenance policies and procedures. He has had success in growing gross revenue and net reimbursement through combining operational improvements, chargemaster effectiveness and efficient business office protocols.

Prior to joining Stroudwater, John was Associate Director of Revenue Control and Payment Systems for Lahey Clinic in Burlington, Massachusetts. In this capacity he had responsibility for total revenue capture for multiple hospital locations totaling over $1 billion per year. He had responsibility for chargemaster creation and maintenance, hospital revenue cycle and quality control initiatives.