Implementing Value-based Compensation: Part 2

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Tammy Kritzer and Curtis Mayse do not have any financial conflicts to report at this time.
Learning Objectives

- Diagram transformational operational practices in value-based compensation
- Explain how to implement value-based compensation models
- Examine medical practice’s experience with value-based compensation

Volume to Value Transition

What does this mean for compensation models?

1. Competing interests and priorities will continue
2. Emerging reimbursement frameworks make this messy
3. We need to begin rethinking revenue within the clinic practice; and begin rethinking how we design compensation systems
New Strategic Paradigm: Creating an Operating Framework

Shifting from Volume to Value Based Care

**VOLUME**
- Focused on disease, illness
- Fee for volume
- Increasing demand
- Fragmented providers, payments
- High variation

**VALUE**
- Focus on wellness, prevention
- Optimize outcomes
- Data analytics
- Reduced variation
- Accountable care
- Innovative, integrated, coordinated
- Increased satisfaction, service, safety

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Key Compensation Challenges

- Alignment with reimbursement trends
- Effective incentives to drive care model change and adoption
- Compliance
- Physician engagement and adaptability

Volume to Value Transition

Compensation Trends

1. Most employed compensation models still rely heavily on FFS methodologies
   - WRVU productivity
   - Provider billings or collections
2. Tolerance for financial losses attributed to physician practices is diminishing
   - Not fiscally sustainable
   - Raises compliance concerns and risks
3. More systems incorporating non-production incentives into physician compensation
   - Citizenship
   - Patient satisfaction/experience
   - Quality (limited, but increasingly common)
4. Incentives tied to quality are still an elusive goal
   - IT system requirements
   - Meaningful measures (process, outcomes, efficiency)
   - Physician buy in is necessary for success
   - Most reimbursement still linked to fee for service
Traditional Compensation Structures

**Productivity**
(wRVU, Billing Collections)

**PROS**
- Incentivize hard work
- Pay for what you get
- Allows providers to set their own pace

**CONS**
- Unintended consequences
- Over-utilization
- Not aligned with new reimbursement models

**Salary**
(Base Comp + Incentive)

**PROS**
- Easy to administer
- Predictable income
- May promote teamwork
- No benefit to over-utilize services

**CONS**
- Highly productive docs tend to be unsatisfied
- Limits individual accountability
- Unpredictable profitability

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Physician Compensation Progression

- **Salary Based**
- **Production Based**
- **Production Based with ancillary compensation**
- **Production with Incentives**
Evolving Compensation Structures

The Need for Change

Continued economic pressures driving changes in physician compensation and incentives

Volume to Value
- Hospital based and independent physician groups need to adapt to a payment environment that rewards value over volume.
- Increasing patient to physician ratios and the need to decrease costs per patient will drive the need for new care models.

Physician Alignment with System Goals
- As payment models shift toward and value-based focus, physician organizations will need to drive quality and efficiency.
- Compensation models need to reflect changes in care models and payor reimbursement methodologies.

Value-Based Physician Compensation
- Compensation models will need to reward active physician participation driving desired care model changes.
- Compensation models will need to reflect payment methodologies in transition.
Value-based compensation models will require need to balance competing objectives

Salaried

Recruitment & Retention

Quality & Mission

- Diligence
- Efficiency
- Access
- Population Health
- APM's
- Mission

Hybrid Models

Mission Pop Health

Payer Mix Market Share

Individual

- Speed
- Volume RVUs
- Panel Size
- Profitability
- FFS

Physicians will need to be engaged to develop new comp models and lead the transition from volume to value

Team

Satisfaction

Productivity & Profitability

Competing Objectives & Comp Design

- Value as Percentage of Total Compensation
- Behavioral Change Incentive
  - Incentive must be worth 20 percent or more of total compensation in order to evoke behavioral change in physician
  - Applies to incentives for productivity and other physician behaviors

Recruitment Level
- When incentive is below the 20 percent threshold, physician behavior remains unaffected
- Incentive then acts principally as a tool for recruitment

Twenty Percent the Threshold for Behavior Change

Behavioral Change Threshold

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Medicare Payment Innovations

- Bundled Payments for Care Improvement Initiatives
- Comprehensive Primary Care Initiative
- MACRA / MIPS
- Physician Compensation
- ACO’s
- Medicare Shared Savings Programs
- Comprehensive Care for Joint Replacement Model
- Bundled Payments for Care Improvement Initiatives
- Comprehensive Primary Care Initiative
- MACRA / MIPS
- Physician Compensation
- ACO’s
- Medicare Shared Savings Programs
- Comprehensive Care for Joint Replacement Model
- Health Care Value Equation

Entity Perspective

PROFITABILITY

Outcomes + Experience
Cost

Outcomes + Experience
Operating Expense

Consumer

AFFORDABILITY

Outcomes + Experience
Cost

Outcomes + Experience
Revenue

Outcomes + Experience
Rates * Volume (Visits vs. Lives)

What Problem Are We Trying To Solve?

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## Willingness to Participate in Value-Based Models

<table>
<thead>
<tr>
<th>Variable</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEMOGRAPHICS</strong></td>
<td></td>
</tr>
<tr>
<td>Generation Graduated from Medical School</td>
<td>Millennials are more open to participation in value-based payment models.</td>
</tr>
<tr>
<td>• Boomers (before 1990)</td>
<td></td>
</tr>
<tr>
<td>• Gen X (1990 – 2010)</td>
<td></td>
</tr>
<tr>
<td>• Millennials (after 2010)</td>
<td></td>
</tr>
<tr>
<td><strong>Practice Setting:</strong></td>
<td>Independents are less interested in value-based payment models</td>
</tr>
<tr>
<td>• Employed / Affiliated</td>
<td></td>
</tr>
<tr>
<td>• Independent</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Specialty:</strong></td>
<td>No significant variance</td>
</tr>
<tr>
<td>• PCP</td>
<td></td>
</tr>
<tr>
<td>• Surgical</td>
<td></td>
</tr>
<tr>
<td>• Non-Surgical</td>
<td></td>
</tr>
<tr>
<td><strong>Region:</strong></td>
<td>West Region = higher willingness for participation in value-based models, presumably due to a strong tradition in capitation</td>
</tr>
<tr>
<td>• Northeast</td>
<td></td>
</tr>
<tr>
<td>• South</td>
<td></td>
</tr>
<tr>
<td>• Midwest</td>
<td></td>
</tr>
<tr>
<td>• West</td>
<td>Northeast Region = least willing</td>
</tr>
<tr>
<td><strong>Payer Mix:</strong></td>
<td>High Medicare Advantage = more open to value-based models since Medicare Advantage contracts are often capitated</td>
</tr>
<tr>
<td>• Commercial</td>
<td></td>
</tr>
<tr>
<td>• Medicare</td>
<td></td>
</tr>
<tr>
<td>• Medicare Advantage</td>
<td></td>
</tr>
<tr>
<td>• Medicaid</td>
<td></td>
</tr>
</tbody>
</table>

Source: Deloitte 2016 Survey of US Physicians

## Willingness to Participate in Value-Based Models

<table>
<thead>
<tr>
<th>Variable</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RESOURCE AVAILABILITY</strong></td>
<td></td>
</tr>
<tr>
<td>Care pattern Information</td>
<td>The type and amount of care pattern information matter.</td>
</tr>
<tr>
<td>• Physicians receiving any kind of care pattern information vs. none at all are more willing to participate in value-based payment models.</td>
<td></td>
</tr>
<tr>
<td>• Care pattern information on cost of care is most strongly associated with willingness to participate.</td>
<td></td>
</tr>
<tr>
<td>Clinical Protocols</td>
<td>Having protocols is a strong predictor of willingness to participate in value-based models. How many conditions are covered by protocols is less important.</td>
</tr>
<tr>
<td>EHR</td>
<td>Physicians with EHR at Stage 3 or planning to achieve Stage 3 in the near future are more likely than those at Stage 2 or lower to be interested in value based payment models</td>
</tr>
</tbody>
</table>

Source: Deloitte 2016 Survey of US Physicians
### CMS Announcement

CMS has announced that 30% of Medicare payments to physicians be tied to quality / value by the end of 2016. Will your practice be able to meet this requirement?

<table>
<thead>
<tr>
<th></th>
<th>PC</th>
<th>Specialists</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30.9%</td>
<td>31.9%</td>
<td>31.5%</td>
</tr>
<tr>
<td>No</td>
<td>16.4%</td>
<td>19.3%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Unsure</td>
<td>52.7%</td>
<td>48.8%</td>
<td>50.3%</td>
</tr>
</tbody>
</table>


### Professional Status

<table>
<thead>
<tr>
<th>Current Professional Status</th>
<th>PC</th>
<th>Specialist</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice owner/partner/associate</td>
<td>28.7%</td>
<td>35.2%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Employed by a hospital</td>
<td>63.2%</td>
<td>35.2%</td>
<td>54.9%</td>
</tr>
<tr>
<td>Employed by a medical group</td>
<td>28.0%</td>
<td>20.5%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Other</td>
<td>8.1%</td>
<td>9.9%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

### ACO Feelings

- They are likely to enhance quality / decrease cost: 22.8% (PC), 21.9% (Specialist), 22.3% (All)
- Quality / cost gains will not justify organizational cost / effort: 33.0% (PC), 42.2% (Specialist), 38.7% (All)
- Unlikely to increase quality / decrease cost: 55.8% (PC), 64.1% (Specialist), 64.1% (All)
- Unsure about structure or purpose of ACOs: 29.2% (PC), 27.3% (Specialist), 28.1% (All)

### Practice Description

<table>
<thead>
<tr>
<th>Current Practice Description</th>
<th>PC</th>
<th>Specialist</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am overextended and overworked</td>
<td>81.2%</td>
<td>29.0%</td>
<td>80.3%</td>
</tr>
<tr>
<td>I am at full capacity</td>
<td>52.2%</td>
<td>52.7%</td>
<td>52.4%</td>
</tr>
<tr>
<td>I have time to see more patients and assume more duties</td>
<td>18.8%</td>
<td>19.7%</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

### Physician Foundation Survey

#### 29. To what extent do you have feelings of professional burnout in your medical career?

<table>
<thead>
<tr>
<th></th>
<th>PC</th>
<th>Specialists</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>No such feelings</td>
<td>11.3%</td>
<td>10.4%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Rarely have these feelings</td>
<td>16.2%</td>
<td>14.8%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Sometimes have these feelings</td>
<td>25.0%</td>
<td>25.6%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Often have these feelings</td>
<td>30.6%</td>
<td>31.8%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Always have these feelings (significant burnout)</td>
<td>16.9%</td>
<td>17.4%</td>
<td>17.2%</td>
</tr>
</tbody>
</table>

#### 32. Is any of your compensation tied to quality metrics such as patient satisfaction, following treatment guidelines, compliance, "citizenship", error rates, etc.?

<table>
<thead>
<tr>
<th></th>
<th>PC</th>
<th>Specialists</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>48.80%</td>
<td>39.40%</td>
<td>42.80%</td>
</tr>
<tr>
<td>No</td>
<td>39.80%</td>
<td>48.30%</td>
<td>45.10%</td>
</tr>
<tr>
<td>Unsure</td>
<td>11.40%</td>
<td>12.30%</td>
<td>12.10%</td>
</tr>
</tbody>
</table>

#### 33. What percent of your TOTAL compensation is tied to such metrics?

<table>
<thead>
<tr>
<th></th>
<th>PC</th>
<th>Specialists</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>47.00%</td>
<td>54.50%</td>
<td>51.30%</td>
</tr>
<tr>
<td>11-20</td>
<td>26.70%</td>
<td>25.30%</td>
<td>25.90%</td>
</tr>
<tr>
<td>21-30</td>
<td>11.80%</td>
<td>8.00%</td>
<td>9.70%</td>
</tr>
<tr>
<td>31-40</td>
<td>5.10%</td>
<td>4.90%</td>
<td>5.00%</td>
</tr>
<tr>
<td>41-50</td>
<td>5.10%</td>
<td>3.00%</td>
<td>3.80%</td>
</tr>
<tr>
<td>51 or more</td>
<td>4.30%</td>
<td>4.30%</td>
<td>4.30%</td>
</tr>
</tbody>
</table>


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15. Do you participate in any of the following value/quality reporting systems or practice models?

<table>
<thead>
<tr>
<th></th>
<th>PC</th>
<th>PC2</th>
<th>PC3</th>
<th>Specialist</th>
<th>Specialist2</th>
<th>Specialist3</th>
<th>All</th>
<th>All2</th>
<th>All3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Quality Reporting Systems (PQRS)</td>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>51.2%</td>
<td>30.2%</td>
<td>18.6%</td>
<td>57.9%</td>
<td>27.2%</td>
<td>14.9%</td>
<td>55.3%</td>
<td>28.4%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Patient Satisfaction Surveys</td>
<td>67.8%</td>
<td>24.3%</td>
<td>7.9%</td>
<td>61.3%</td>
<td>26.8%</td>
<td>11.9%</td>
<td>63.5%</td>
<td>26.0%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Patient-Centered Medical Home</td>
<td>76.7%</td>
<td>18.8%</td>
<td>4.5%</td>
<td>73.8%</td>
<td>20.9%</td>
<td>5.3%</td>
<td>74.7%</td>
<td>20.3%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Accountable Care Organization (ACO)</td>
<td>48.2%</td>
<td>42.2%</td>
<td>9.6%</td>
<td>68.3%</td>
<td>16.8%</td>
<td>27.5%</td>
<td>58.3%</td>
<td>14.2%</td>
<td></td>
</tr>
<tr>
<td>Bundled Payments</td>
<td>43.1%</td>
<td>38.9%</td>
<td>18.0%</td>
<td>32.5%</td>
<td>48.5%</td>
<td>19.0%</td>
<td>36.4%</td>
<td>45.0%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Any other Alternative Payment Models (APM’s)</td>
<td>29.2%</td>
<td>40.4%</td>
<td>30.4%</td>
<td>31.9%</td>
<td>44.3%</td>
<td>23.8%</td>
<td>30.8%</td>
<td>42.9%</td>
<td>26.3%</td>
</tr>
</tbody>
</table>

Majority of payments remain FFS


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**Providers Struggling to Keep up with Changes**

**Payment Transformation**

Majority of payments remain FFS

**Care Transformation**

Significant inertia towards Value and Population Management

*Source: The New Yorker*

Trying to keep one foot on the dock while moving to the boat.
New Generation Physician Compensation

Physician productivity is primary incentive.
Usually Tiered to disproportionately reward high producers

Productivity remains a important element of compensation.
“Value” Performance drive larger part of physician compensation.
Base Salary may be included and tied to minimum work standards.

MECHANICS: Distributing Compensation

- Quality
- Margins
- Panel
- Quality
- Disease Management
Compensation Models

- RVU Based
- Net Income Based
- Balanced Score Card - Value Based
- Panel Size Based
- Care Team Value Performance Based

Metric Considerations

- Specialty
- Clinical Indicators
- Adoption of Best Practices
- Service Line Performance
- Developing CME Programming
- Patient Satisfaction
- Access
- Panel Size
- Outreach Services
- EMR Utilization
- APP Usage and Oversight
Engaging Physician Leadership – Transition

Compensation Model Transition to Include Non-Production Performance Metrics

<table>
<thead>
<tr>
<th>Current</th>
<th>2017</th>
<th>2018</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production 100%</td>
<td>Quality Based 5%</td>
<td>Quality Based 10%</td>
<td>Quality (Value Based) Metrics 20%</td>
<td>Quality (Value Based) Metrics 30%</td>
</tr>
<tr>
<td>Panel Size 95%</td>
<td>Panel Size 10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panel Size 20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Production 95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panel Size 20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Production 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panel Size 20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Production 70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panel Size 50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Production 30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panel Size 10%</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Insurance % PMPM 0-5% 5-25% 25-49% ≥ 50%

Primary Care Model – Shadow models allow physicians to plan for compensation model changes

Value-Based Compensation Considerations

Revenues Less Expenses

To account for non-FFS revenue sources, some organizations are reverting back to funds flow models that set physician compensation levels based on calculations of revenues less expenses.
Value-Based Compensation Considerations

**Segregated Funds Flow**

Other organizations are establishing separate compensation plans to account for the differing incentives under risk contracts.

- FFS Payor Contract 1
- FFS Payor Contract 1
- Capitated Payor Contract 3

Criteria may include:
- Panel visitation rate
- Hospital utilization
- HCC coding

**Consistently across multiple payers**

Critically Important

**Payer contracts must coincide with physician compensation models**

Contracts must reward the organization for non-FFS “Value” goals

- Quality and Clinical Outcomes
- Patient Experience
- Total Cost of Care
- Population Management

**Consistent across multiple payers**
Critically Important – Accurate/Understandable Reporting

Compensation plan elements as a tool
- Productivity Planning
- Panel Size
- Quality Metrics

Coherent administrative processes
- Low Error Rate
- Regular Review with Provider
- Initiated with the annual planning process

Graphical
- Visually Appealing
- Reinforcing Strategic Objectives

Compensation Considerations & Factors
- Aligns with organization’s goals
- Consistent with organization’s culture & philosophy
- Physicians & physician leaders have helped develop the plan and the metrics to be used
- Plan is fair, balances the individual’s ability to achieve, & has positive implications for the organization
- Plan is understandable and can be communicated relatively easily to physicians
Compensation Considerations & Factors (cont.)

- Focus on key metrics that are limited and manageable
- There is a funding mechanism for the plan and a method to account for the allocation within the pool
- Data is available, and there is a structure to administer the plan
- Ability to provide regular feedback regarding performance over the course of the year

Considerations & Factors

Plan administration
- Administrative & physician leadership agree & support the components of the plan
- Start 3–6 months before the next year’s plan is developed
- Limit number of metrics to no more than 5–6
- Provide monthly or quarterly results
- Simplify reporting format
- Annual reconciliation and payout of an earned bonus
- Payout should occur within the first quarter of the following fiscal year
Considerations & Factors (cont.)

Critical factors
- Compensation needs to be set in advance
- There needs to be a written agreement
- There should be a consistent approach to determining how compensation is determined, but balanced with knowing one size does not fit all
- Utilize standard agreement template
- Limit/centralize who can draft & sign agreements

Regulatory Realities

1. Medicate and IRS rules governing provider financial relationships
   - Stark / Anti-kick back statutes
   - Civil monetary penalties
   - IRS rules governing tax-exempt organizations

2. Relationships / Compensation must be:
   - Fair Market Value
   - Commercially reasonable

3. Enforcement environment is evolving
   - Individual accountability
   - Financial losses
   - M&A activity creating “mega systems”
**Fair Market Value**

- Prohibits the financial relationship with an entity that provides “designated health services”
- Exceptions for bona fide employment relationships provided compensation is set at fair market value
- Value in an arm’s length transaction & consistent with general market
- Compensation is not determined on volume or value of referrals
- No payment for ancillary services

*Commercial Reasonableness*

- FMV; is a sensible and prudent business arrangement
- The business transactions aid the organization in accomplishing its goals
- The duties performed by the physicians are evaluated on a regular basis
- The physician’s performance is assessed
- There is an ongoing bona fide need for the physicians services
- The services are not duplicated

---

**Why are Regulatory Issues Relevant?**

1. We need to understand the money across the entire continuum of care to truly make a value model work
2. Small and independent physicians groups typically lack the size and influence needed to influence payers
3. Infrastructure and data analytics needed to track “savings” becomes a challenge
4. Requires new collaborations and partnerships to be successful
5. Clinically integrated networks may be an option for those wishing to remain independent
Compensation Models

- Model 1 – Hybrid
- Model 2 – Population health
- Model 3 - Others

Practical Compensation Solutions

**Model 1 - Phased Hybrid**

<table>
<thead>
<tr>
<th>Overview</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incrementally shift compensation from volume to value</td>
<td></td>
</tr>
<tr>
<td>• Phase 1 – Limited incentives for quality/citizenship (up to 15%)</td>
<td></td>
</tr>
<tr>
<td>• Phase 2 – Individual and group quality performance measures</td>
<td></td>
</tr>
<tr>
<td>(up to 25%)</td>
<td></td>
</tr>
<tr>
<td>• Phase 3 – Combination of PMPM and other incentives (50% plus)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advantages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Allows physicians time to adjust</td>
<td></td>
</tr>
<tr>
<td>• More time to develop management and information system capacity</td>
<td></td>
</tr>
<tr>
<td>• Permits flexibility to accommodate both fee for service and value</td>
<td></td>
</tr>
<tr>
<td>reimbursement</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t require new funding to support quality goals</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disadvantages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• May be too slow</td>
<td></td>
</tr>
<tr>
<td>• May reduce productivity and fee-for-service revenue</td>
<td></td>
</tr>
<tr>
<td>• Greater administrative demands</td>
<td></td>
</tr>
<tr>
<td>• Setting meaningful quality metrics</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal/Regulatory</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fair market value/commercial reasonableness</td>
<td></td>
</tr>
</tbody>
</table>
### Model 1 – Hybrid

<table>
<thead>
<tr>
<th>Total Compensation</th>
<th>Base (up or down)</th>
<th>May be tied to benchmark or percent of prior year compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Base may increase or decrease as a percent of total compensation in advanced phases</td>
<td></td>
</tr>
<tr>
<td>Production Incentive</td>
<td>(down)</td>
<td>WRVUs or portion of Professional Collections</td>
</tr>
<tr>
<td></td>
<td>Reliance on production incentives decreases in advanced phases</td>
<td></td>
</tr>
<tr>
<td>Quality Incentive</td>
<td>(up)</td>
<td>Initially may be based on non-clinical measures such as patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>Advanced phases require the performance of specific quality outcomes and care coordination</td>
<td></td>
</tr>
</tbody>
</table>

### Actual Hybrid Model – Adaptable

**Lever 1**:
- **Base Salary**: $650,000
- **Total Compensation**: $662,000

**Lever 2**:  
- **Total Compensation**: $817,808
  - **Base Salary**: $650,000
  - **Total Compensation**: $662,000

**Lever 3**:  
- **Total Compensation**: $817,808
  - **Base Salary**: $650,000
  - **Total Compensation**: $662,000

**Lever 4**:  
- **Total Compensation**: $817,808
  - **Base Salary**: $650,000
  - **Total Compensation**: $662,000
# Model 2 – Population Health

## Overview
- Combination of base compensation, fee-for-service production and PMPM
- Similar to a hybrid model

## Advantages
- Physicians incentivized to manage a specific population’s care or overall individual panel size
- Permits flexibility to accommodate both fee for service and value reimbursement

## Disadvantages
- May be difficult to apply to some specialties
- May reduce productivity and fee-for-service revenue
- Greater administrative demands
- Ideally aligned with specific payer contracts—may require additional funding

## Legal/regulatory
- Fair market value/commercial reasonableness
- Civil monetary penalties – stunting on care concerns
- Can new bonus programs be stacked on existing compensation without fair market value concerns?

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## Model 2 – Population Health

<table>
<thead>
<tr>
<th>Total Compensation</th>
<th>Base</th>
<th>Production Incentive</th>
<th>PMPM – Withhold Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>WRVUs or portion of professional collections</td>
<td>Tied to specific patient population(s) or overall panel size</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low rate per WRVU tied to all WRVUs or higher amount above threshold</td>
<td>Require the performance of specific quality outcomes and care coordination</td>
</tr>
</tbody>
</table>

May be tied to benchmark or percent of prior year compensation
INTERACTIVE MODEL

Continuing Education

ACMPE credit for medical practice executives.............. 1
ACHE credit for medical practice executives............... 1
CME *AMA PRA Category 1 Credits™*..................... 1
*CPE* credit for certified public accountants (CPAs).......... 1.2
CEU credit for generic continuing education............... 1

*CPE CODE:

Let the speakers know what you thought!
Evaluations will be emailed to you daily.
Thank You.

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