

Searching for Bigfoot on the Front Lines: Strategies to Transforming Faculty Compensation in an Accountable Care World

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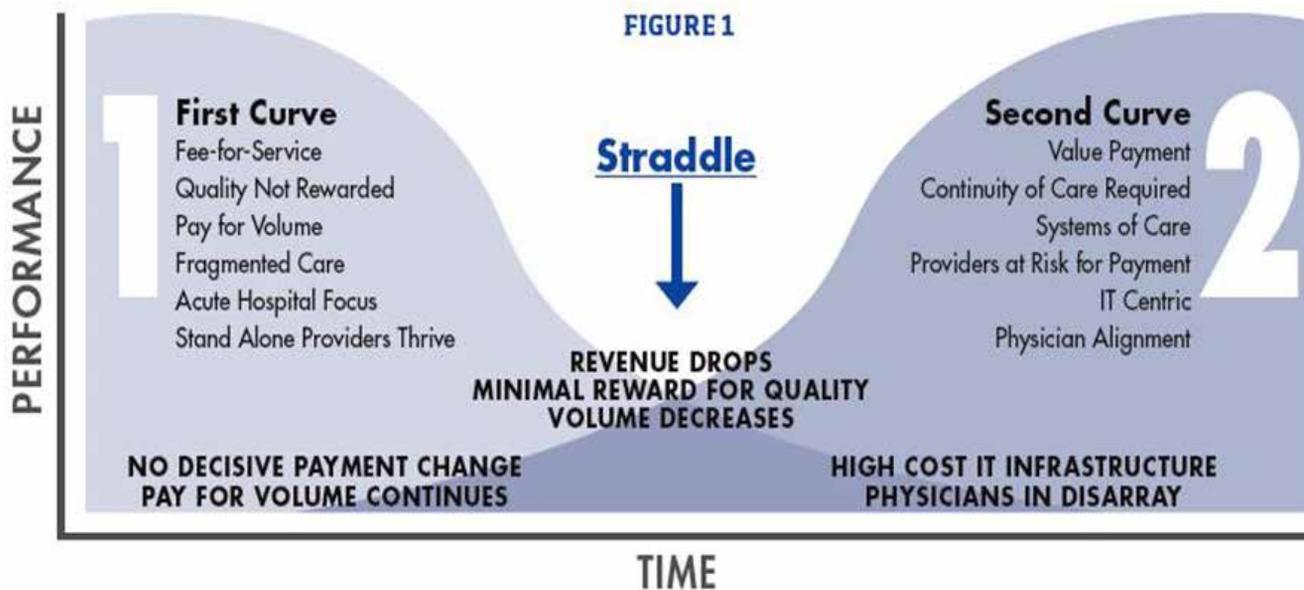
In 2016, academic medical centers (AMCs) and their component entities, teaching hospitals, faculty practice plans and schools of medicine, most likely are searching for Bigfoot. What is Bigfoot? The Bigfoot in non-academic and academic health systems alike is a methodology to transform compensation models from the traditional fee-for-service, productivity-based model (Curve 1) to a quality-based, outcomes model (Curve 2). Yet, finding Bigfoot for AMCs and their component entities is more complicated than for non-academic health systems. AMCs have a mission not only to provide clinical services, but also to educate health professionals and to conduct research.¹

AMCs face financial challenges that exceed those of non-academic hospitals such as fluctuating National Institutes of Health funding² and decreased graduate medical education and indirect medical education funding.³ Moreover, given the tripartite mission of AMCs where there is cross subsidization among clinical, education and research missions, there is institutional vulnerability because “[r]eimbursement changes to one AMC mission can affect all three of an institution’s missions.”⁴ AMCs also are challenged by bureaucratic structures where faculty physicians often work in silos rather than collaborate in interdisciplinary teams.⁵ By sharing how a few AMCs on the front

lines are transitioning to value-based faculty compensation, this article examines in a practical manner some of the themes that emerge in this process, the metrics utilized to incentivize clinical and academic quality and the legal and regulatory considerations associated with value-based compensation.

Moving from Volume-Based to Value-Based Reimbursement

Since the Centers for Medicare & Medicaid Services (CMS) announced its intent to transform its payment programs to incentivize value-based care, AMCs, like all providers, must improve population health, operating costs and the patient experience (the “Triple Aims”), as first described by former CMS Administrator Don Berwick in his 2008 article *The Triple Aims: Care, Health, and Cost*, which he wrote with colleagues when he led the Institute for Healthcare Improvement.⁶ Some of the obstacles to achieving the Triple Aims raised in Dr. Berwick’s article are some of the hurdles that AMCs currently face: physician-centric care, supply-driven demand and physicians creating silos at the expense of the organization. Such hurdles result in AMCs struggling in this period when



hospitals are losing reimbursement because they have not achieved full value-based payments as they transition from volume-based care (the “Straddle”). Figure 1⁷ above illustrates the valley into which AMCs may fall between Curve 1 and Curve 2 and the different activities that create successful reimbursement for each payment model. The traditional AMC model based on volume rewards certain activities while value-based models reward others. While AMCs work to adjust their activities, they can fall into the Straddle. Adjustments such as cultivating patient-centric culture, ensuring an interoperable electronic medical record system, reviewing data on performance with faculty physicians and communicating clear performance goals to faculty physicians may help AMCs to overcome the hurdles that cause reimbursement to decrease in the Straddle.⁸

For example, one measure of CMS’ Value-Based Modifier Program is All Cause Hospital Readmission. CMS explains on its 2015 Measure Information Form, “[s]ome readmissions are unavoidable, but they may also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care [R]educing avoidable readmissions is a key component in the effort to promote more efficient, high quality care.”⁹ Accordingly, CMS applies a modifier for unplanned readmission to an acute care hospital for any cause within 30 days after discharge.

What is needed to achieve this goal of lower unplanned readmissions so that reimbursement does not decrease?

Physician faculty and other hospital staff working together to improve discharge planning and coordinate care are most likely key factors to lowering readmissions.¹⁰ Such coordination is occurring, yet it is not always executed effectively with nearly half of the hospitals in the country recently paying readmission penalties.¹¹ Given physician faculty are in the trenches of care and have an influence on each other, focusing on physician faculty involvement may be a key to improving collaboration. Accordingly, adjusting faculty compensation incentives to align with AMC goals may help AMCs to achieve better value-based reimbursement. However, not only are faculty compensation incentives important, but also the AMC culture and organizational design needs to shift to achieve better value-based reimbursement. As the examination below reveals, organizational change such as creating interdisciplinary committees led by faculty physicians is a big step toward AMCs finding Bigfoot.¹²

Common Themes in the Evolution from Curve 1 to Curve 2

As AMCs work to achieve value-based reimbursement, significant themes emerge from examining the structure and process of the AMC efforts highlighted below by industry experts.¹³ These common themes provide some insights about how these AMCs currently approach aligning faculty compensation to achieve the Triple Aims.

Compensation Committee

To incentivize faculty physicians to improve quality, Greg Anderson of Horne LLP describes how an AMC created a system-wide steering compensation committee in an 18-month effort to implement a value-based compensation strategy. The faculty-represented committee worked across the system to align incentives, break down silos and ensure a transparent process. Mr. Anderson observes, “A physician-led culture is essential to gaining faculty acceptance and engagement.”

The committee recommended providing faculty income security with 80% guaranteed base compensation tied to median market benchmarks. While placing a material portion of salaries at risk is especially challenging in a culture accustomed to guaranteed compensation, the committee determined that attributing 20% of the compensation to personal productivity, quality, and academic performance would be appropriate.

The clinical productivity portion of the incentive is the work Relative Value Unit (wRVU) production for personally performed services of faculty physicians. The achievement of department-level quality metrics such as those below tie the clinical quality measures of individual faculty physicians to others in the department:

Patient and provider satisfaction	20%
Readmission rate reduction	30%
Consultation responsiveness	25%
Transition of care	25%

Faculty physicians receive points based on achievement of the applicable, evidence-based metrics associated with each goal. The department adjusts points for partial achievement of goals and to reflect the full-time equivalent (FTE) status of the faculty physician in clinical practice. The department compares individual faculty physician points to the total department pool and awards clinical quality compensation based on individual scores relative to the department.

The research and teaching components of the incentive are distributed through a discretionary bonus pool in which the department chair can reward faculty for excellence. Each year the AMC establishes the pool and apportions part to each department based on the formula established by the compensation committee, taking into account such factors as departmental financial performance. The department chair establishes

performance criteria for each faculty member, subject to approval by the dean of the school of medicine. Examples are:

- » Scholarly activities, including research, publication, clinical discussions, and participation in educational organizations
- » Achievement of funding goals
- » Excellence in teaching and administration

Quality Leader

Similarly, Andrea Ferrari of Healthcare Appraisers, Inc. observes the benefits of a physician-led environment in transforming an AMC to reward value-based reimbursement behaviors. Some AMCs seize upon their strengths of researching, teaching and leading. Ms Ferrari notes some AMCs engage an academic physician as a “quality leader” to determine what behaviors to reward and how to create and implement a program to which other faculty would respond. Given quality leaders are in the trenches of patient care they may be best able to identify what data to measure for value-based incentives such as reducing inpatient readmission. Moreover, quality leaders may exert a unique peer influence that certain academic physicians may more readily accept from their peers.

Consistent Communication

Like the lengthy implementation process Mr. Anderson describes above, Pershing Yoakley & Associates, PC (PYA) observes at another AMC that a key to transitioning to a value-based model is the deliberate process that took over two and one half years to begin implementation. The AMC had a significant communication plan regarding the new compensation model including surveys, personal interviews and department meetings. Over an eight-month period, a monthly work group defined goals, created preliminary compensation models, evaluated whether models met defined goals and finalized analysis of the impact of the models. After every work group meeting, the work group shared summary talking points with colleagues at department faculty meetings and in other appropriate settings. The work group met with department heads to review and analyze the impact of the compensation model and held open forums with faculty to hear recommendations and departmental feedback.

Over a two-year period, the AMC defined quality metrics for each department and ensured provider education on the compensation model. Quality metrics varied among the

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FIGURE 2

Academic Quality Metrics	Clinical Quality Metrics (PQRS Based)
Grand Rounds	Hospitalization rates for acute conditions (including bacterial pneumonia, urinary tract infection, and dehydration) and chronic conditions (including diabetes, COPD or asthma, and heart failure)
Small-group or one-on-one teaching encounters	Percentage of women age 40–69 who received a mammogram to screen for breast cancer within the past 24 months
Resident/fellow precepting	Hemoglobin A1c control for patients with Diabetes: HbA1c levels should be maintained below 8% for patients age 18–75 with a diagnosis of diabetes
Resident/fellow board exam performance	High blood pressure for patients with Diabetes or Hypertension: Blood pressure should be maintained at less than 140/90mm/Hg
Serve in administration for teaching, clinic, or department	Percentage of women age 40–69 who received a mammogram to screen for breast cancer within the past 24 months

departments; however, each department also followed macro-level compensation parameters in setting its own quality metrics. The total compensation had a 70% base plus a 30% incentive. The incentive included 60% as clinical productivity and 40% as quality measures. PYA also notes that the continued communication throughout the process contributed to having faculty physicians buy into the new model.

One Metric Doesn't Fit All

Definitions of a meaningful metric in improving quality in department and divisions within an AMC can vary greatly. Some AMC departments and divisions are utilizing some of the 33 measures of Medicare's Shared Services Program as metrics in quality-based compensation. Other AMC departments are using standards set forth in their commercial payer contracts. Examples of academic and clinical quality metrics that an AMC may consider in its faculty compensation model include those in Figure 2 above.¹⁴

Returning to the example of the readmission quality measure, the quality leader may pinpoint a prevention strategy for readmission by using interdisciplinary services such as with the extensivist model,¹⁵ where a subset of providers care for a small panel of high-needs patients with intensive services, and

make suggestions for discharge planning. While the extensivist model may be successful at one AMC, it may not work at another AMC. Accordingly, each AMC should adjust measures as most appropriate for its specific institution. Many hospitals continue to have high readmission rates even though they may be using quality metrics already to try to reduce readmission rates. Choosing quality metrics that will have the desired result is not one size fits all and can require adjustment of the metrics at each specific AMC.

Legal and Regulatory Considerations

The transition to value-based physician faculty compensation at an AMC does not exist in isolation from the complexity of health care regulations. As Robert Wade of Krieg Devault stated in his recent presentation at AHLA's Legal Issues Affecting Academic Medical Centers in-person meeting in Washington, DC in March 2016, the regulatory world has not caught up to the new payment philosophy.¹⁶ In other words as AMCs work to adjust their faculty compensation models to transition to Curve 2, which requires more collaboration among physician faculty, they still need to follow current regulations, designed for the fee-for-service world of Curve 1. Faculty physicians and other leaders developing a value-based compensation strategy must continue to

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take into consideration the Stark Law (Stark),¹⁷ the federal Anti-Kickback Statute,¹⁸ state fraud and abuse laws and the Internal Revenue Service tax-exemption laws.¹⁹

While AMCs may not rely always on the academic medical exception to Stark due to the difficulty in meeting all of the exception's requirements, they commonly use the bona fide employment, personal service arrangement and indirect compensation exceptions.²⁰ AMCs also may utilize the personal service and employment safe harbors of the Anti-Kickback Statute.²¹ Whether an AMC directly employs faculty physicians or indirectly utilizes their services through an integrated network, AMCs have routinely determined clinical productivity bonuses based on wRVUs for clinical services personally performed by faculty physicians.²² AMCs need to ensure the compensation is consistent with fair market value, is commercially reasonable and does not take into consideration the volume or value of physician referrals of designated health services as compensation exceptions to Stark require and as a tenet of the Anti-Kickback safe harbors. In addition, documenting the fair market value of compensation should help to protect an AMC from a finding of private inurement.²³

However, compensation pools based in part on the achievement of quality measures add a complication. For instance, how does an AMC value the efforts of a faculty physician to improve quality? Is there enough reliable data to compare the value of a faculty physician's quality activities in a market? How is the partial accomplishment of quality goals to be valued? There may be more questions than definitive answers. One approach may be to base the value of quality efforts on the expertise of the faculty physician.

Although there is no consensus on determining the fair market value of faculty physician efforts on quality activities, the existing approach to base the total aggregate earned compensation (base plus clinical quality plus academic quality) on no more than the 90th percentile of market compensation survey benchmarks continues to be an approach to demonstrate compensation is at fair market value and commercially reasonable. To the extent total aggregate earned compensation exceeds base compensation, the faculty physician will be entitled to a bonus for the difference. Alternatively, AMCs may use a mean plus standard deviation formula to determine the fair market value. While valuing the different portions of the quality compensation may complicate the valuation process, it is especially important to utilize independent valuation professionals and document the valuation methodology.

Have AMCs Found Bigfoot?

AMCs on the front lines do not have the definitive roadmap to find Bigfoot. Unfortunately, at this time there may be more questions than definitive answers on improving quality through value-based compensation. Yet, some themes do emerge from AMCs on the front lines such as: faculty physician-led compensation committees implementing compensation models over a prolonged period giving faculty physicians the opportunity to buy-in to the process; the use of quality leaders who identify which measures may best lead to value-based activities in a particular AMC's culture; the implementation of well-planned communication efforts with faculty physicians; and the use of flexible strategies that change as AMCs determine which measures are most effective with their faculty physicians. These themes inform the process of how AMCs find Bigfoot. Ensuring value-based compensation models meet regulatory requirements adds to the difficulty of removing the barriers to encourage faculty physicians to engage one another. Regardless, the alignment of AMCs and their faculty physicians through compensation models is a path to achieving value-based reimbursement and surviving the Straddle for AMCs even though it can be a sometimes harrowing search. 

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Endnotes

- 1 PricewaterhouseCoopers (PWC), Health Research Institute, *The Future of the Academic Medical Center: Strategies to Avoid a Margin Meltdown* (2012).
- 2 See www.faseb.org/Science-Policy-and-Advocacy/Federal-Funding-Data/NIH-Research-Funding-Trends.aspx.
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- 15 See <http://democracy.blackpool.gov.uk/documents/s3471/Appendix%207a%20Fylde%20Coast%20Extensivist%20Service%20Summary%20Report%20of%20Progress%20171114.pdf>.
- 16 Comments made by Mr. Wade at the Legal Issues Affecting Academic Medical Centers presentation are not attributable to his clients or firm.
- 17 42 U.S.C. § 1395 nn.
- 18 42 U.S.C. § 1320a-7b.
- 19 26 U.S.C. § 501.
- 20 42 C.F.R. § 411.357.
- 21 42 C.F.R. § 1000.952.
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