Physician Engagement for Value-Based Care Success

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The hospital CEO’s most important job is developing and nurturing good medical staff relationships.

Source: Personal conversation with John Sheehan, CPA, MBA
• How we deliver care depends on how we are paid for care
• Healthcare reform is changing both payment and delivery
• Fundamentally, payment reform involves transfer of financial risk from payers to providers
• Volume → Value

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Payment Risk Continuum

High Payer Risk
- Fee-for-Service
- P4P/VBP
- Shared Savings

High Provider Risk
- Bundled Payment
- Global Budget
- Total Cost of Care

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Financial Risk Management

• Definition
  • *The opportunity for revenue gain, and/or the risk for revenue loss, based on non-financial organizational performance.*

• Some current examples
  • Value-Based Purchasing
  • Reduction Programs
  • Reference pricing
  • Shared savings plans (ACOs)
  • Bundled care payments
  • Global hospital budgets
What is Value-Based Payment?

- **Payment** for one or more parts of the Triple Aim
  - Better patient care
  - Smarter spending
  - Improved community health
- Not payment for a unit of delivered service or care
- Not fee-for-service and not cost-based reimbursement
- Coming to your hospital?
  - If so, you’ll need your docs!
Why is Physician Engagement Important?

• Physicians are critical for value-based care (VBC) success
  • Design care processes
  • Interact with patients
  • Follow clinical guidelines
  • Use resources efficiently
  • Must achieve quality/efficiency to realize increased payment

• Rural hospitals and physicians together lead to rural success

• Discuss three VBC initiatives
  • ACOs
  • Bundled payments
  • Global budgets

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• Savings (if any) “shared” with the ACO
• CMS’s largest value-based payment program
• Physicians essential to realize shared savings
  • Outpatient care performance
  • 31 performance measures
  • Primary care visit attribution
  • Patient choice of ACO
  • Local hospital utilization
  • Trustworthy negotiation
Bundled Payment Care Initiatives

- Hospital and physician payments “bundled”
- Episode of care is global payment “light”
- Physicians essential to realize $\textbf{cost < payment}$
  - Efficient care delivery
  - Team development
  - Care coordination
  - Local hospital utilization
  - Trustworthy negotiation

Source: Centers for Medicare & Medicaid Services

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Global Hospital Budgets

• One hospital payment, regardless of care cost
• “If our beds are filled, it means we’ve failed.”
• Physicians essential to realize cost < budget
  • New community care teams
  • Community relationships
  • Care coordination
  • Local hospital utilization
  • Trustworthy negotiation

Solution: Physician Engagement

• A pervasive and persistent challenge
• Now more important than ever due to the transfer of financial risk
• Will discuss “physicians,” but “clinicians” is also appropriate
**Physician Engagement:**

Proactive physician involvement and meaningful physician influence that lead the organization toward a shared vision and a successful future.

- Although a cultural phenomenon, physician engagement is also:
  - Observable
  - Measurable
  - Improvable
Why So Challenging?

• Unrealistic expectations
• Physician ≠ administrator
• No action plan
• No measurement
• No follow-up
• Leadership fatigue!
Managing Expectations

• It’s hard to change others
• It’s easier to change *your approach* to others!
• Leadership – people follow because they **want** to, not because they **have** to
• Consider physicians (and all knowledge workers) as volunteers
• Remember: it’s all about, and always about, relationships built on **trust**
## Never the Twain Shall Meet?

<table>
<thead>
<tr>
<th><strong>Physician</strong></th>
<th><strong>Administrator</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doer</td>
<td>Planner/designer</td>
</tr>
<tr>
<td>Solution-oriented</td>
<td>Process-oriented</td>
</tr>
<tr>
<td>1:1 interaction</td>
<td>1:N interaction</td>
</tr>
<tr>
<td>Always “on”</td>
<td>Some down-time</td>
</tr>
<tr>
<td>Decision-maker</td>
<td>Delegator</td>
</tr>
<tr>
<td>Autonomous</td>
<td>Collaborative</td>
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<tr>
<td>Patient advocate</td>
<td>Organization advocate</td>
</tr>
<tr>
<td>Professional ID</td>
<td>Organizational ID</td>
</tr>
<tr>
<td>Immediate gratification</td>
<td>Delayed gratification</td>
</tr>
</tbody>
</table>

Source: Adapted from “The Dual Role Dilemma,” by Michael E. Kurtz, MS

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Factors Affecting Physician Satisfaction

- Perceptions of quality
- Electronic health records
- Autonomy/control over work
- Practice leadership
- Collegiality and fairness
- Work quantify and pace
- Work content
- Income stability and fairness
- Rules and regs burden

Action Plan for Physician Engagement

• CEO responsibility ("most important job")
• Action Plan
  • Accountability
  • Resources
  • Due dates
  • Measures
• Measures
  • Governance
  • Education
  • Data
  • Compensation
Five Strategies for Success

1. Find mutual interest
2. Reduce meetings
3. Listen intentionally
4. Present data strategically
5. Always follow-up

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We are Important to Our Rural Communities

• Unique rural hospital and physician relationship
  • Historic partnership
  • Face of rural health care
  • Urban alternative
  • Resources + expertise
  • Conveners
  • Community focus
  • Economic engines
  • Provide safety and security
Engage Physicians!

Physicians can be astonishing allies

Starts and ends with relationships built on trust

• Trust – engages the mind
• Truth – engages the heart
• Teamwork – realizes the vision

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Additional Resources


• The Advisory Board. [www.advisory.com/topics/physician-issues/physician-engagement](http://www.advisory.com/topics/physician-issues/physician-engagement)
MACRA is a 2015 bipartisan law, and it replaces:

- Sustainable Growth Rate
- Physician Quality Reporting System
- Value-Based Modifier
- Meaningful Use

MACRA includes the Quality Payment Program (QPP)

- “To improve health outcomes, promote smarter spending, minimize burden of participation, and provide fairness and transparency in operations.”

- Physician pay increase opportunity
Merit-Based Incentive Payment System

- Cost
- Practice improvement
- Quality
- Advancing Care Information

(Percentage of each category is changing.)
MIPS Maximum Bonus/Penalty

Advanced Alternative Payment Model

• Automatic 5% bonus and no risk for penalty
• Must bear financial risk – risk for monetary gain or loss
• A-APMs models
  • Risk-bearing MSSP ACOs
  • Certain bundled payment models
  • Comprehensive Primary Care Plus model (new payment system for medical home)
New QPP Physician Payment Reality

• Minimal FFS payment increase
  • 0.5% x 5 years, then 0% x 5 years
  • Actually a payment decrease (inflation)

• MIPS bonus/penalty
  • Eventually -9% to +27% pay adjustment
  • Plus, up to 10% Exceptional Performance Incentive payment (budget neutral exclusion)
  • Up to 46% payment differential between high and low performers in 2024!

• Or, 5% A-APM bonus
  • Excluded from MIPS performance reporting requirements
2017 QPP Primary Care Participation

• ~10% of PCPs in an A-APM
• <30% PCPs in MIPS
• ~60% PCPs exempt from MIPS and not in an A-APM
• Metro PCPs slightly more likely in A-APM than non-metro
• Metro PCPs slightly less likely in MIPS than non-metro
• Metro and non-metro PCPs exempt from MIPS at approximately same rate
2018/2019 QPP Changes (selected)

- Low-volume threshold – now $90,000 or 200 beneficiaries
- Virtual groups – may include 1-10 MIPS-eligible providers
- Quality category – increased to 45% weight in CY 2019
- Cost category – increased to 15% weight in CY 2019
- Small practice bonus – increased to 6 points, but added to Quality category, not final score
Collaborations to Spread Innovation

✓ Rural Health Value Project
https://ruralhealthvalue.org

✓ Rural Policy Research Institute
https://www.rupri.org

✓ The National Rural Health Resource Center
https://www.ruralcenter.org/

✓ The Rural Health Information Hub
https://www.ruralhealthinfo.org/

✓ The National Rural Health Association
https://www.ruralhealthweb.org/

✓ The American Hospital Association
http://www.aha.org/

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