

Value-Based Care through Physician Groups

An Actuarial Business Perspective

Subtitle: How some physicians organize themselves to meet buyers' goals

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*Excludes Medicaid programs: Similar principles apply in Medicaid. However, Medicaid has substantive differences in member characteristics, payment system, fees, enrollment instability, participating physicians, and health conditions/illnesses.
Includes a short Pandemic Appendix*

ABSTRACT: Sustainable VBC programs, whether through ACOs (Accountable Care Organizations), Medicare Advantage, or commercial networks need strong provider performance. One type of provider-based care is physician groups. Some groups sustain better performance (higher quality and much lower spending for buyers). Others do not. This paper offers real world insights into the business approaches used by the better groups. This is how some physicians organize themselves to meet buyers' goals.

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To the review panel

A group of senior actuaries with experience in provider-based care volunteered time beyond their regular jobs to offer insights, deepen content, improve, clarify, and create a structure to discuss these important and complex real-world programs.

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To responsible physician group executives

Some of us have the opportunity to see physician group executives in action and occasionally collaborate with them. Some do not just support their physicians; they take responsibility for care, health, and spending in their communities. They turn these concepts into organizations and real-world actions. We hope that this summary of their work offers useful ideas for other communities.

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Section 1 – Executive Summary

Buyers of healthcare need “better care, smarter spending, and healthier members”.¹ However, the goal of lower spending remains a massive challenge in the United States. Actions to create more affordable healthcare and reduce wasted services² are not done consistently. Costs and trends are high for the primary buyers of healthcare – individuals with low subsidies, employers and governments that pay most of the costs.

This paper is written for anyone working to improve health system performance (both care and spending) - whether hospital, physician group, carrier, buyer, consultant, or vendor. It may be particularly useful to those working with aligned physicians in their community.

Recent years have seen a vast expansion of concepts, expertise, payment alternatives, analytic tools, decision support systems, and working techniques to deliver more affordable, high quality care. More health providers and insurance carriers have come to the aid of people who manage the costs of health programs for buyers. Increasingly, organizations are preparing to accept responsibility for total cost – and take a broad business role as manager of the local health system to deliver more efficient and effective programs.

Provider organizations, such as hospitals, physicians, and staff models, have essential expertise and capabilities to build potentially strong, useful provider-based programs. This paper focuses on one of many useful versions of provider-based care – physician groups who already take responsibility for both care and spending in their local communities. Physician groups may be created by the physicians themselves, or developed by hospitals, staff models, and supported by some carriers or states. We focus on physician groups for several reasons:

1. **Physician support, engagement, and management is essential whether you are a hospital, carrier, buyer, or vendor.** Physician groups offer a perspective on how some physicians voluntarily organize themselves and meet buyer goals.
2. **Some physician groups sustain higher performance and savings.** Physician groups have delivered results, in some cases with significantly positive outcomes including:

¹<https://www.cms.gov/newsroom/fact-sheets/better-care-smarter-spending-healthier-people-improving-quality-and-paying-what-works> offers a concise six-word phrase for federal goals.

² Definition: Various phrases are often used about actions that create affordability, such as efficiency, reducing trend, responsible financial management, smart spending, etc. However, these phrases do not quite capture the thoughtful balance between cost and quality when providers who are responsible for cost and care decide on action. So, the report uses the provider-centric phrase “reduce wasted services” and their related costs.

- ✓ **Sustained measurable quality improvement** in most populations and programs
- ✓ **Financial gains that vary widely by population, program, and location.**
Commercial programs rates can only have a minimal impact or be 10% better. Medicare ACOs average a few percent savings. Medicare Advantage products add pharmacy and better medical benefit coverage.

3. **Physician groups have grown – more members in many communities.**

Membership in physician groups is growing rapidly given the expansion of value-based care (VBC) for many Medicare beneficiaries beyond their existing products in other lines of business. Another sign of the growing importance of physician groups are more joint ventures, their acquisition by hospitals and jumbo healthcare companies, and attraction of investments from venture capital to remain independent.

4. **As existing businesses, higher performing physician groups offer real world insights about how to improve a local health system.** Providers who have sustained higher performance find responsible initiatives to reduce wasted services and improve affordability. In some communities, the groups are a long-standing presence with sustained higher performance, including less expensive products in Medicare Advantage, HMOs, ACOs, Exchanges, and Medicaid.

5. **Knowledge on responsible ways physicians manage waste and spending is hard to find.** Changes in the physician business environment and unique business approaches of physician groups are complicated and not readily visible to outsiders for various reasons. Groups often work behind-the-scenes. In some states, regulations discourage alternative networks. Or, physician group performance may not be distinct (it just matches the market).

Given the importance of physicians, growth of groups, range of potential value, and uneven knowledge, a group of leading healthcare actuaries has created this white paper. We are committed to quality care, improved health, and lower spending. We have had the opportunity to see strong, collaborative physician groups in action. This paper reflects our extensive, real world experience to create better care, smarter spending and healthier members through working relationships with aligned physicians and groups. This comes from many sources, including public and private sector projects, research, and ongoing discussions with key leaders (both physician executives and national thought leaders).

Our expertise is finance and spending, so this is a business briefing. This paper will:

- Offer real-world insights into existing “best practice” approaches to support, organize, and manage physician performance.

- Present a consolidated source on business approaches used by physician groups. It pulls various important and complex topics in the same place – physicians, affordable healthcare, business, finance, outpatient health system management, and responsible ways to reduce waste and lower spending
- Outline the fundamental concept of physician-based care, the physician environment and goals, how reducing wasted services can drive lower spending, and measurement
- Describe the important role of an intermediary that supports physicians, drives better system performance and supports buyer spending goals
- Illustrate how these business approaches are applied in real world programs done by one type of intermediary - physician groups
- Present a framework to assess business practices of intermediaries and create ongoing improvement
- Describe modern buyer approaches to monitor and measure these programs

Section 2 - Fundamental concept and structure of report

Traditional fee-for-service payment within the current US cottage industry approach to healthcare often does not support nor reward responsibility and good decisions. Physicians, who direct much of healthcare spending, often have a limited support system and information. As a result, there is wide variation in the overall performance of underlying providers (primary care, specialist, hospitals, business goals, geography, training, etc.) and the local communities they support.

Some value-based care programs directly address these two major problems. These work at different levels:

- Overall level (responsible for total care, health, and cost). This can be done by a hospital system or hospital-owned insurer, a carrier with an alternative network of individual physicians selected based on existing quality and efficiency, or physicians' groups that take broad responsibility for health system performance.
- Supported through action at a detailed, tactical level such as initiatives that target one specific specialty or illness/condition. This can be done within a provider organization or through an external program such as a Patient Centered Medical Home focused on primary care physicians, or a Bundled Payments program where specialists or hospitals take broad responsibility for a certain set of illnesses.

Some of the better programs work together to utilize the unique strengths of each part of the industry. Hospitals own physician groups. Carriers support physician groups. Physician groups and hospitals work as strong allies.

One summary of the fundamental concept comes from Lessons from Higher Performing Networks from the Pacific Business Group on Health.³ It states, "a critical mass of responsible providers with the right support, authority, and aligned financial incentives will perform significantly better than the typical health program. These experts take actions that health plans, employers, and members cannot".

Physicians are in a unique position to improve performance given their essential role in the health system. Better care and healthier people are intuitive for physicians. Information and resources are already available to support performance improvement on these two goals. Resources are also available to help increase revenue or reduce the physician's own operating expenses (and increase net income). More physicians are working for hospitals or consolidating into larger practices.

³ http://www.pbgh.org/storage/documents/commentary/HiPerfNetworkBrief_Final3.pdf Note: this public paper was co-written by one of the authors of this paper.

Engaged and responsible physicians bring an entirely new package of people, tools and solutions that offer major opportunities for improvement. Physicians are highly educated and typically motivated professionals. Physicians direct treatment and have the opportunity to reduce wasted services and related costs. They work in real time. With proper tools and information, they can take action earlier on multiple illness-specific initiatives. Decisions are made with better up-front information, so there is less need for re-work and fewer retrospective disagreements with carriers.

For example, primary care physicians want patients to stay healthy, comply with treatment, avoid complications, plus avoid high fees and unneeded services. However, they often work in an uncoordinated health system and rarely have the information or support to accomplish this. Physicians are often willing to take on more responsibility and financial risk if given support, different payment incentive arrangements, and/or lower administrative burden.

However, resources and support for the right financial action are often not recorded. There are few sources about how physicians can reduce waste and payments across the health system and create more affordable programs.

This paper is organized around major business components. The first seven components within the health system are summarized in the table below. The last two components are important external connections, but these vary widely so are not covered in this paper.

Major business components

Who? (Physicians and leadership model)

	<u>Overview</u>	<u>Detail</u>
1. A critical mass of responsible physicians with a commitment and authority to manage care and resources in their community	Section 3 and 5	Section 6A
2. Strong leadership that has a deep business commitment to support physicians, reduce wasted services, and meet buyer goals	All sections	

What actions are needed?

3. Action on specific initiatives through physicians – to reduce wasted services and spending	Section 4	Section 6B
4. Action on specific initiatives through physicians – for better care and healthier members	---	6C

How is this organized?

	Overview	Detail
5. An intermediary with infrastructure to support, improve, organize, and manage physician performance	Section 5	Section 6D
6. A financial structure that supports and reinforces the overall organization	---	Section 6E
7. A financial structure that supports and reinforces individual physicians	---	Section 6F

Key external connections (only lightly covered in this paper)

8. Support and engage members across a wide range of illnesses
9. An aligned carrier partnership to deliver certain services like insurance, regulations, membership, systems, analysis, etc.

The report highlights the Physician Environment and Goals in Section 3. The next two sections cover two essential topics: Reducing Wasted Services and the Role of an Intermediary for Physicians.

Section 6, the longest section, offers a detailed review of the business components above integrated within Higher Performing Physician Groups (HPPGs). This can be used as a starting framework to assess existing business practices and create ongoing improvement.

The final Section 7 summarizes Measurement and analysis for buyers.

These last two sections can work in combination. Section 6 offers the framework for a business assessment. Section 7 describes modern analytics to measure past results and direct future improvement.

Section 3 – Physician environment and goals

As discussed in the overall concept, the commitment of physicians and their leaders is an essential starting place. Some have been taking broad responsibility for a while. For many others, this is a major change in business direction.

Most physicians and buyers of healthcare already have two common goals. They share a commitment to; 1) better care and; 2) healthier members and recovery from the current illness/condition.

The third goal, more affordable costs to primary buyers and members, is more challenging. The buyer's interest in more affordable care does not directly match the business of running a physician practice.

In a fee-for-service environment, there is a strong incentive to increase services, particularly if fees are high. More services equate to more revenue and higher net income. However, revenue growth is becoming more challenging given the very high and increasing costs of healthcare to buyers. As a result, more providers are considering a business model focused on net income – balancing revenue growth and expense management - especially if supported by incentive payments.

Closer alignment of buyer and provider goals often starts with:

- Providers who are willing to reduce wasted services, address variations in resource use, and address high fees across the system
- A business focus on net income⁴ growth rather than revenue growth, and
- Physicians' and buyers' agreement on a better payment arrangement, customized to each particular product and the physicians' business situation

Alignment has become more common for many reasons: Physician revenue is a relatively small part of overall spending. Physician decisions impact costs throughout the full health system; many physician decisions impact "other people's money" while having only a limited impact on the physician's own revenue and net income. Physicians do not have massive overhead and capital requirements that challenge other providers.

⁴ Net income is a core financial measure, but is very complex and beyond the scope of this paper. As highlights:

- Physician operating expenses are a very high percentage of fee revenue. So, net income for two physicians with identical fees and revenue can be very different.
- A revenue growth goal for a provider conflicts with lower spending for buyers.
- Claims savings for the buyer are not equal to the "net income loss for the provider" – net provider income is often far lower. Agreement on net income is often easier than agreement on revenue.

Business situation - physicians

Although many physicians are moving to salaried employment or larger groups, many physicians still run their own business with high expenses and workloads. They are committed to support their patients, but also have significant business and financial goals. As with any business, they seek to:

1. Maintain and/or grow their members, services, fees, and/or revenue
2. Manage or reduce their operating expenses (internal efficiency, consolidation, etc.)
3. Control their time and workload
4. Maintain and/or grow their net income (earnings) – which is their primary financial goal, and
5. Reduce wasted services across the entire system (optional - for the subset of physicians with aligned financial incentives beyond the physician’s own services)

Some physicians already work to reduce waste and are potential allies. Other physicians focus extensively on revenue growth – seeking to maximize services and net income.

Balancing all goals is complex and time-consuming. Unless the physician has very high management skills and sources, external support is needed. In addition, under fee-for-service payment, physician efforts to reduce waste can be counterproductive – it can drain time and may lower the physician’s own revenue.

One source of support for physicians is intermediaries (such as hospitals or physician groups). Intermediaries can address the five business goals for their panel of physicians. Key elements reinforce each other. For example, the intermediary can help physicians grow revenue through payment for the added work needed to reduce wasted services across the system. The effect on workload is mixed - better payment alignment may decrease⁵ or increase⁶ workloads. For example, the Health Affairs article in the footnote below says, “shifting to capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care . . .”. This can reduce the physician’s own workload and keep comparable revenue.

This connection of individual physician payment to business goals is complex. Section 6F offers additional material on Individual Physician Compensation.

⁵ For example, a Health Affairs article models capitation of primary care with more nurse engagement and less physician time <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0367>

⁶ For example, unpaid time spent managing an illness or even refilling a prescription without an office visit.

Business goals – intermediaries for physicians

The business goals of any intermediary organization are also very important.

Currently, there are many types of organizations and programs to support physicians. Some physicians have formal connections with other parts of the health system through a staff model or hospital (perhaps alongside a hospital-owned insurer). Some are associations for a single specialty in the local community (such as emergency physicians, cardiologists, or primary care). Others are multi-specialty Independent Practice Associations (IPAs). Some intermediaries focus on a health improvement initiative, often for one particular illness or chronic disease. Others deal with many illnesses.

Almost all intermediaries offer some support to their physicians on three topics: better care, revenue growth, and/or internal efficiency.

However, only some intermediaries work to reduce waste and spending. They take additional financial responsibility in exchange for higher volume and/or alternative payment. Often they build a more coordinated local health system for their physicians and members. This can be done for all products or for a certain carrier or product such as Medicare Advantage.

Section 4 – Reduce wasted services

Commitment and authority to manage care and resources in their community

Some providers have taken responsibility for more affordable care for a while. For many others, this is a major change in business direction.

This paper uses a provider-centric phrase for lower spending: “Reduce wasted services”. This fundamental phrase comes directly from some major provider executives as they communicate with their physicians, staff, and allies.

- The founding Chief Medical Officer (CMO) of one of the most successful physician groups – (over 500,000 at-risk members) – had an ongoing message for physicians, staff, and allies about one of their major goals – “reduce waste”. This was not just a slogan or general observation about the health industry; it was a call to action in the community for their physicians, staff, and hospitals that were close allies.
- The leader of a major hospital/health system and hospital-owned insurer tells staff quality is essential. Waste is viewed as another type of bad quality. The health system implemented more than a hundred quality improvement initiatives. These initiatives also often reduced waste and related expenses. However, financial results were challenging; often better quality will reduce revenue under the fee-for-service system. The hospital system saw small losses on many quality initiatives in the short term (lost revenue was slightly more than expense savings). However, they took action anyway. The hospital system eventually opened their own insurance carrier and shifted to a Medicare Advantage program to align their quality and financial goals.

These fundamental messages match the experiences and perspective of the authors. Reducing wasted services is essential for affordable programs. As buyers continue to face cost pressures and move toward value-based care, providers with a commitment to reduce wasted services and improve affordability can become allies and perhaps gain members.

More affordable care requires action on spending, not just better care and health. Reducing wasted services is essential for many reasons. It drives more affordable care. It receives less attention than health or quality initiatives. Providers (hospitals, physicians, physician groups, or staff) can have a positive impact in real-time. Affordable care is not just keeping people healthy. It is about managing the resources used when a person becomes sick.

Various public and private analyses and conversations have shown a wide variation in resource use and cost for many illnesses/conditions. While most physicians are similar,

a small percentage are large outliers and use far more resources. Some of these outliers have unique expertise and/or demonstrate higher quality. Others do not.

The authors also see large variation in the number and depth of initiatives on wasted services. Some provider and their organizations do many initiatives; others do few. This gap offers many opportunities for improvement.

Targeted initiatives have a broad scope (across all spending)

There are hundreds of useful initiatives; each targeted to a particular problem.

Some initiatives are small and practical, such as a conversation between medical director and very cautious physician -- “You want another test? Will this test make a difference in your recommended treatment?” Other initiatives may be substantive, collaborative, and happen over many years such as the ongoing project between a major physician group and their main hospital ally. Each year they reduce wasted inpatient services for a different hospital department (see overview in Appendix A).

For some potentially wasted services, real-time physician engagement is essential. A patient cannot decide if they to spend another day in the ICU or need a longer observation stay to extend an emergency visit. Yet, an individual physician may not have the clout to have an impact. A physician group or other intermediary can help.

The leaders mentioned earlier have a comprehensive definition of waste. All types of waste are addressed if the problem is big or frequent enough. Yet this is managed through a business process so it does not become overwhelming. Staff identifies clinical and business problems, estimates impact, sets priorities, designs initiatives, gathers feedback, and makes changes over time to adapt. There is ongoing improvement on all expenses.

The scope includes:

- Claims cost for buyers/carriers (paid and allowed charges)
- Claims cost for members (plan design, deductibles, etc.)
- High contractual fees (particularly in the commercial sector)
- Internal provider expenses (unpaid by buyers)
- Unneeded Services (whether or not visible to members)
- Over-utilization and under-utilization
- Across all parts of the industry, including hospital, physicians, carriers, and others (if the provider accepts responsibility)
- Small, easy actions and major substantive, powerful efforts

- Clear or unclear clinical direction (consensus metrics, clinical path, evidence-based medicine)⁷
- High cost claimants, emergencies, complicated care are included (subject to negotiations as discussed below)

Provider decisions to reduce waste are often limited by contracting disagreements or payment systems. For example, for commercial programs, many hospitals are paid per-day, while some are paid per-admission (with many other variations including stop-loss arrangements). If paid per-day, the length of stay is a major ongoing argument between experts for the buyer and hospital. Under a per-admission payment, the hospital has both clinical and financial responsibility for resources, days, ICU, and other internal expenses.

Similar business disconnects also impact high cost claimants, emergency care, and complication rates. These are unmanageable risks for buyers, yet partly manageable for hospitals and physicians. Management principles would assign this management role to the provider; however, contract negotiations might leave responsibility with the carrier.

Progress to reduce waste has lagged for many reasons. One is limited financial information. As a comparison, there is substantial information on quality metrics: extensive websites with deep information, formal studies, and extensive implementation plans. Comparable information on initiatives to reduce waste is not readily visible.

Analysis uses data and tools from all industry segments

Action requires analysis. Identify potential waste, measure the possible impact, and selectively change payment to align with individual physicians. Analytic tools are now much better, with deeper analysis for a specific community delivered with shorter turnaround times.

Each section of the industry has unique data sources, analytic resources, and powerful business techniques. Carriers may do extensive claims analysis such as cost drivers or pharmacy use. Hospitals do extensive acute management, supply chain consolidation, staff evaluations, major management initiatives such as Six Sigma, and they own resources in the community. Physicians have their own decision support tools, personal interactions, lab data, clinical flags, disease registries, referral review, or analysis of resource use variation. We have seen strong collaborative efforts using all available resources.

⁷ Unclear clinical direction often leads to wide variation in resource use and opportunities to reduce waste.

Reduce waste with aligned overall payment

Reducing waste also ties directly to the payment system. Provider organizations prefer fixed payments (such as capitation or upside and strong versions of risk sharing). If they fix their payments at a reasonable level based on existing services, then the organization gains by reducing future waste. In effect, this is a return to the original concept of pre-paid medicine.

As examples, both the organizations mentioned at the opening of this section use fixed payments for many major products. The physician group takes capitation for hospital and physician services on commercial and Medicare Advantage products. The hospital-owned insurer is paid a fixed fee by their insured members and runs a Medicare Advantage program.

A deeper discussion of payments to organizations is in Section 6E. Payment to individual providers is in Section 6F.

Different provider and buyer perspective on payment

A provider's goal to reduce wasted services and the buyer's goal for more affordable care are not identical, but they can become closely aligned. Overall, buyers benefit from thoughtful provider efforts to reduce wasted services.

Yet, there are some challenging differences in perspective.

- The identical word can mean different things. Claims are costs to buyers. Claims are gross revenue to providers, but the actual impact on the provider is net income. Net income is often much smaller, but not visible to the buyer. Understanding the large distinction between provider revenue and net income can be very important in negotiations.
- Reducing waste can create conflicting goals, particular for some providers. Lowering surgical complication rates improves quality and lowers the provider's expenses, but means less revenue for the surgeon and hospital. This loss of revenue can slow or stop key initiatives to reduce waste.
- From an operational perspective, providers want the same process for all buyers - physician and hospital action on a patient with similar health status should follow the same path for Medicare, commercial, or Medicaid. They prefer expense management to happen on all lines of business and all carriers. Action across all

product lines is not intuitive for an employer or carrier who requests immediate action to reduce their own claims.⁸

- Even if the provider reduces wasted services and improves efficiency, buyers may only see part of these gains. For example, large providers have significant market presence and negotiating power. They choose how much savings to pass to buyers.

New payment arrangements offer ways to work past these issues if designed to be at least “win/neutral”. For example, to improve health and reduce emergency visits over time, the carrier might fund a chronic care nurse at the physician office. This is a direct expense (and possible gain) to buyers, but cost neutral to providers. As another example, a hospital can ask a major employer to give verbal support in physician meetings for consolidating surgical devices – moving from four devices to one. No immediate financial impact on the buyer, but expense reduction for the hospital over time across all lines of business (not just this particular buyer).

Section 6B (Initiatives on Wasted Services) expands this discussion.

⁸ Most provider executives have ongoing internal conversations about how to avoid “standing with a foot in two canoes”. Or, even worse, stand in many canoes (i.e. a different process for Medicare and each major carrier). This often creates a complex business discussion between providers and buyers/carriers.

Section 5 – Role of intermediary for physician

An infrastructure to support, improve, organize, and manage physician performance

Strong leadership that has a deep business commitment to support physicians, reduce wasted services, and meet buyer goals

Healthcare expenditures are more than one-sixth of the US economy. It is a very complex system to understand, organize and manage. There is a large information gap between buyers of care and physicians. Physicians already have a demanding and complex job. Added responsibilities for care and spending adds a new role.

An intermediary can be very useful, if not essential.

By using an intermediary, physicians, buyers, and carriers do not need a deep understanding of each other's situation. A physician does not need to become a manager and expert in claims, analysis, staff development, technology, and physician support systems. The better intermediaries bridge across multiple perspectives and perform many management functions. They coordinate and manage the local health system for their patients and physicians. Their leadership team creates an infrastructure to bring this together.

Various organizations operate as an intermediary between physicians and buyers/carriers. This includes hospitals, hospital-owned insurers, staff models, physician groups, clinics, stand-alone management teams, and a few states and carriers. Deloitte Consulting describes the powerful role of hospital systems as “general contractor”.⁹ Even a staff model may have a dedicated intermediary for their physicians (such as Kaiser's Permanente Medical Group).

Each type of organization has unique strengths, expertise, data sources, and infrastructure. Hospitals have extensive expertise and data on acute care, access to capital, and they own parts of many local health systems (including physician groups and/or hospital-owned insurers). Carriers have expertise in insurance, claims analysis, and often have complete databases on payment. Physicians are expert professionals that direct care, understand the outpatient delivery system, and guide resource use in their communities.

⁹<https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-hcp-health-system-as-general-contractor-012915.pdf>

An intermediary will bridge different perspectives:

- Buyers see healthcare as an unmanageable risk and a series of random events. Providers see a mix of manageable and unmanageable risks. Buyers do not just “transfer risk” to providers. They transfer “risk and responsibility” – a bigger role to motivated and experienced experts who are effective managers of manageable risks over time.
- Physicians work at a very detailed patient-level. Buyers/carriers work at a broad population-level. Intermediaries let physicians work at the detailed patient-level while bringing population-level support and scale.
- Physicians, particularly patient-centric specialties such as primary care, build working relationships across the outpatient system. Buyers/carriers do not see the underlying working relationships but see all claim payments across the system for each patient. The better intermediaries leverage the physician’s role as navigator of the local outpatient care system. The better intermediaries become health system managers on quality, working relationships, wasted services, and costs.
- Physicians’ fundamental mindset is treatment for illnesses/conditions applied to each individual patient. Large buyers/carriers manage overall total spending and a few illnesses. Intermediaries can create intuitive illness-specific initiatives to reduce waste and practice pattern variation.
- Buyers/carriers and physician group leaders often use scorecard metrics (like total cost or days/units per thousand). However, a statement that “days per thousand are high” gives no practical guidance to the physician. Intermediaries translate overall metrics into specific actions for the physician and their staff.
- Physicians see only their own income. Fees from other providers are rarely known to individual physicians. Buyers see the full fees from all providers. The better intermediaries can validate and use buyers’ fee data or create their own reporting. This lets them manage most costs across the entire system.
- Physicians are typically paid only for direct personal patient contact. This leaves many unpaid services and operating expenses that dilute their income and drive future fee increases. Carriers or buyers do not see these expenses. Intermediaries offer large economies of scale through infrastructure and shared management.
- An individual physician is a small part of the local health system and has little impact. An individual buyer may also have a limited perspective on the health system - their own experience as a patient (office visits or an admission under high stress). Stronger intermediaries offer a larger physician presence. Management works behind the scenes to improve the health system.

Most intermediaries have several major responsibilities: support physicians, create initiatives for “health improvement”, and act as an intermediary/negotiator to carriers/buyers.

A subset of intermediaries takes additional responsibilities. They work to improve service, grow membership, reduce waste, and/or create a more affordable and effective health system in their communities. The better intermediaries often see themselves as manager of the local health system for physicians and their members.

Although each different type of provider-based intermediary has strong examples, the next section focuses on one type of intermediary - physician groups. Particularly, the subset of physician groups that sustain higher performance over time, called Higher Performing Physician Groups (HPPGs) for this paper. A detailed discussion of these groups offers real world examples of how some physicians choose to manage themselves. These examples can be used to assess physician group performance.

Section 6 – Business Assessment (illustrated by higher performing physician groups)

As a reminder, each type of provider organization, hospitals, physicians, staff models, etc. has unique expertise and capabilities. Each has their success stories - high performance organizations with a major positive impact on their community. This section offers an illustrative example of one type of provider organization – a “physician group”.

The earlier sections identify major approaches that lead to higher performance in value-based care programs. But results depend on real-world implementation, not just concepts. This extended section offers a deeper discussion of real-world organizations.

These examples offer insights into physician approaches to improve health performance. This business assessment is offered for many purposes: As a guide for internal discussion on ongoing improvement, a structure for a joint collaboration, to develop executive interview questions, or as a framework for an extensive on-site review of capabilities.

Physician groups come in various sizes, capabilities, operating approaches, initiatives, and business goals. They can be hospital-owned or standalone, just starting or long-standing local presences, and multi- or single-specialty. Management teams may cover a single location or be shared across multiple states. In some states, carriers or the state government offer major assistance.

This section offers business observations about a subset of physician groups, the Higher Performing Physician Groups that have demonstrated higher performance over multiple years.

HPPGs are existing groups that meets four criteria:¹⁰

- Produce distinctly lower premiums and lower medical spending (and/or higher benefits) than the typical network
- Deliver better measurable quality metrics than other programs,
- Operate for multiple populations and products (such as commercial, Medicare Advantage, ACO, Exchanges), and
- Demonstrate unique capabilities and infrastructure that create their higher performance.

¹⁰ Modified from the criteria in “Provider Networks – Actuarial Perspective on Performance In and Out of Exchanges (page 38) at <https://www.soa.org/research-reports/2018/provider-networks-performance/>

Each HPPG takes broad responsibility for “better care, smarter spending, and healthier members” in their communities. They indirectly run a healthcare system. They take financial responsibility, often paid by fixed monthly fees for many members. Most of these organizations started small but have grown over time, although there are some newer, smaller operations. For example, some small primary-care-only physician groups or clinics have alliances with some carriers.

The unique business approaches of existing HPPGs offer an instructive practical business example of one type of value-based care program. This offers a real-world example of how to engage, support, and organize key physician experts who are willing to support buyer goals. Differences in their approaches also helps explain the wide differences in financial results.

The following material expands upon several key elements from the “Lessons from Higher Performing Networks” paper mentioned earlier (Appendix B¹¹ shows the one-page Executive Summary).

The following subsections 6A to 6F describe characteristics of Higher Performing Physician groups.

- | | |
|-----------|--|
| 6A | Aligned physicians - selection and improvement |
| 6B | Initiatives - reduce waste and related expenses |
| 6C | Initiatives – care and health |
| 6D | Business structure |
| 6E | Overall payment to physician groups |
| 6F | Compensation and payments to individual physicians |

¹¹ http://www.pbgh.org/storage/documents/commentary/HiPerfNetworkBrief_ExecSummary.pdf

6A – Aligned physicians - selection and improvement

A critical mass of responsible physicians with a commitment and authority to manage care and resources in their community

Many physicians are willing to take more responsibility for cost as well as care when offered reasonable support, payment incentives, and a better working environment. Some join provider organizations with strong leadership and aligned goals (such as a hospital, multi-specialty group, or primary care group). In some cases, the physicians own the group and voluntarily invest their own money and time to create this ongoing business.

When a physician group starts, there is special outreach to certain specialties and the physicians with unique local roles, for example, physicians who see referrals for the most complex cases.

The founding physician for one group tells the story of an important physician who was not ready to join the group. The physician had a deep personal professional commitment to care and health, but did not see the need to support or manage other physicians. The founder invited the physician to join the peer review committee and review actual cases. Over time, the independent physician became convinced that the physician support, organization, and management was needed and helpful. Eventually, this physician joined the board of directors.

After the group is running, there is typically a screening process for new physicians including formal credentialing and review of their professional reputation. The group also determines whether it needs more physicians with their particular expertise.

Assuming the group communicates its mission and responsibilities accurately, the result of this process is a self-selected group of doctors. Most are solid to very good performers. Other physicians remain independent. However, physicians who see themselves as outliers are less likely to apply – such as those who consistently use far more resources than their peers do. So, although there is no initial financial screening, there is a financial impact to the self-selection that is not widely known. If fewer financial outliers join the group, physician groups often start with a small but clear cost advantage. This advantage reflects existing behavior before any management or performance improvement.

Physician groups, particularly HPPGs, also offer the physician multiple advantages such as more members or an alternative payment structure. Solid performing physicians often get additional revenue for existing practice patterns - more money for the same

work. This encourages them to continue their existing quality and cost-effective behavior.

Ongoing improvement

One unique strength of HPPGs is ongoing improvement: for their physicians, the physicians' staffs, their direct allies, and for the local health system.

The typical group understands the physician, their environment and supports their goals: membership, revenue, net income, internal expenses, and workloads. HPPGs offer additional support on efforts to reduce waste and create economies of scale. They respect the time of the physician and their staff: Old administrative tasks are reduced when new ones are added. Reports are redesigned to be more intuitive and actionable.

HPPGs educate the physicians before services are done to avoid after-the-fact disagreements. For example, an automated referral screening system will schedule appointments, tracks requests, records ordering physician, and manages compliance. So, added monitoring in exchange for less work for scheduling, automated reporting, and fewer after-the-fact disagreements. As another example, pharmacy medication management approaches such as generic drugs, formulary, mail order, or step therapy are embedded into the physician's regular process. A Pharmacy Benefit Manager is not needed for utilization management, so outside administrative fees are lower.

Groups deal with the diverse set of specialties, personal working styles, and business models. Many groups support independent physicians, although there is a growing push towards salaried programs. HPPGs take an active role to simplify connections across the outpatient system, such as standardizing processes among physicians or with key suppliers.

HPPGs encourage ongoing performance improvement.

- Build relationships with high performers, expand their membership, and continue to support ongoing improvement in their techniques.
- Support physicians with solid performance and offer them continuing education and training (both professional and practical) if they want to improve.

Different HPPGs use a wide range of approaches to manage their poorer performers, difficult specialties, or oversupply, including coaching, peer reporting, training, targeted bonuses, physician selection, and internal channeling. Action happens internally behind the scenes rather than in an all-or-nothing contracting approach inherent in typical network insurance contracting.

HPPGs also build internal staff, from basic support to deep resources on complicated situations: medical directors, staff support for chronic care or other illnesses, extended disease registries, or pre-screened web links to detailed clinical information.

Physician groups that take responsibility for spending must continually balance between physician support and change. Be a trusted partner, yet improve the system. In the early years, this comes from executive leadership, staff support, and often formal workgroups for complicated clinical and resource use topics. This evolves over time.

6B – Initiatives - reduce waste and related expenses

Action on specific initiatives through physicians - on spending (reduce wasted services)

Better care may increase or decrease costs for buyers so, better care, by itself, does not create sustainable lower spending by buyers. Real-time actions and specific initiatives by physicians are needed to identify and reduce waste (unneeded tests, complications, high fees, etc.).

Given large dollars spent in healthcare, there are hundreds of physician-level initiatives to reduce wasted services across the industry. The number and depth of initiatives vary widely by physician group. All groups focus on certain clinical quality initiatives that also lower costs, such as readmissions and chronic illnesses support. They also handle the common carrier initiatives: pre-admission review, fees, place of treatment, duplicated services, etc. Some groups focus primarily on these actions.

However, High Performing Physician Groups implement far more financial initiatives than other groups. These are targeted by product, population and payment arrangement. For example:

- Address more illnesses
- Identify at-risk patients using multiple data sources
- Develop support programs for these high-risk patients
- Refer to higher performing specialists and facilities
- Build ongoing working relationships for better coordination and easier workloads
- Use advanced pharmacy management approaches
- Use hospitalists for acute care management
- Supply chain management of basic lab tests
- Practical decisions to find lower fees for comparable services
- Reduce fraud
- Work with allies on wasted services

Some action is small and targeted - action does not always require high technology. As a practical example from a decade ago, physicians were having problems with formulary compliance. In response, the association of physician groups produced a small laminated card for physicians and their staffs that listed key formulary drugs for each major carrier. This card was distributed to physicians and office staff.

Other initiatives are substantive, for example, the hospital/physician collaboration mentioned earlier and in Appendix A¹². This major physician group has worked for more than a decade to reduce waste, including an ongoing joint initiative with their major hospital ally.

As another example, the Health Affairs article from page 8 covers “team- and non-visit-based primary care”. The article offers a model to quantify some of the business questions groups ask themselves:

- How is the choice of services impacted by payment?
- What services are needed? When?
- When does the patient need to visit the office? When can other methods of communication be used?
- Who is the right person to act (such as physician, physician staff, or central staff)?
- What support does this person need?
- Is action easier given new technology?

Physician-centric initiatives

HPPGs address waste in real time, if possible, using the physician, staff, or the delivery system. They leverage physician staff. Staff work at the “top of their license”. Initiatives are assigned to the right part of the health system (i.e. the organization and person most likely to have an impact). This includes physicians, nurses, physician group staff, hospitals, nursing homes, etc. Plus, there is a growing use of volunteer community resources.

Actions, particularly major initiatives, are physician-centric, intuitive, and build on their expertise and capabilities. These are reinforced by education, training, and/or selective incentive payments, or even a simple reminder phone call to a particular physician.

There is often a formal process to prioritize major initiatives often with physician input. A few initiatives are pursued the first year; the next year, new initiatives are implemented. This can become self-sustaining – as part of the normal process as the group works toward better working relationships, particularly for outpatient care. This rolling process has implications for start-up organizations. The breadth of long-standing HPPGs can seem overwhelming, but programs are built over time.

Major initiatives depend on the local business environment (number of hospitals, fees, resources, rural/urban, etc.). They are also customized to the payment system, specific

¹² “Provider Networks – Actuarial Perspective on Performance In and Out of Exchanges (page 77) at <https://www.soa.org/research-reports/2018/provider-networks-performance/>

cost drivers, and population (Medicare, commercial, exchange, and Medicaid). For example, fees are a major challenge and opportunity for commercial populations and Exchanges. Complex patients with multiple health problems are a major focus for Medicare. The table below shows Key Levers by Population.

Lever	Medicare	Commercial	Medicaid
Admissions	Yes	Yes	Yes
Length of Stay *	--	Yes	--
Pharmacy	--	Yes	Yes
Leakage	Yes	Yes	--
Price	--	Yes	--
Provider variation	Yes	Yes	Yes
Ambulatory care	Yes	Yes	Yes
Quality	Mixed	Mixed	Yes
Emergency	Yes	Yes	Yes
Post-acute Care	Yes	--	--
Behavioral Health	--	Yes	Yes
Fraud	Yes	Yes	Yes

* When paid per-diem or as a percentage of billed fees

There is also a “sentinel” effect. Physicians within HPPGs avoid actions that waste resources (if payments are aligned). An independent physician, outside of the group, paid on fee-for-service, may open his own on-site lab – more expense, more effort, but much higher revenue. An allied physician, such as a joint owner of an HPPG, uses the lab selected by his physician group.

A lot can be done. Implementing more useful initiatives means better results. This starts with an executive with responsibility and authority over wasted services and expense management, infrastructure, and dedicated staff with a mix of business and clinical expertise.

6C – Initiatives – care and health

Action on specific initiatives through physicians and/or imbedded within the health system - on care and health

Intermediaries, such as physician groups support members and physicians by integrating physician expertise and capabilities with modern resources. This builds on the physicians working relationships and knowledge about the patient. The intermediary then brings structure, staffing and modern tools to develop better support at the right time and place. As examples:

- A support system – such as nurses, phone, telemedicine, and educational material specific to their condition
- After the physician flags potential problems, the group helps handle next steps from staffing to direct patient support. Key patient information is collected and assignments made, key information is sent to other staff, etc.
- Pre-screened health information is consistent across the health system (not piecemeal or contradictory). For example, two extensive health websites are offered: one for professionals with aligned content on a basic site written for laypeople.
- Support for at-risk members continues even if an office visit is not required for immediate health reasons
- Identify best patient approaches to support and engage members
- Physician training, patient satisfaction survey, and bonuses improve direct contact.
- Track compliance, understand patient-specific challenges, and engage members

Higher performing groups bring depth: centralized support, research, and economies of scale beyond what a small physician practice can do on their own. They also go beyond the core chronic illnesses. Over time, they have built support systems for most other illnesses, address outpatient and post-acute care, and offer specialized support for at-risk patients.

This paper only does an overview on care and health topics. There are many excellent papers, resources, and extensive training material on quality improvement, care coordination, member engagement, and chronic care support - both in general and through physician groups. Also, carriers often do deep on-site assessments before they officially “delegate” clinical services to a physician group.

A few highlights on care and health initiatives that are more closely related to spending.

Highlights related to spending

1. Health improvement does not automatically mean lower short-term costs.
2. HPPGs do not just work common initiatives such as readmissions and chronic conditions. They develop and manage programs for many other health conditions/illnesses as well.
3. If responsible for inpatient care, HPPGs use traditional techniques, plus hospitalists or intensivists since resource use for acute care is a very technical decision.
4. The common initiatives and consensus metrics (readmissions, Evidence Based Care, etc.) are done. But HPPGs review all costs even if no consensus metrics exist. In fact, if there is not a consensus metric or clear clinical pathway, there is often wide variation in resource use.
5. Initiatives include outpatient care, not just acute admissions. The groups build better working relationships, lower workloads, and less duplication for physicians. This leads to better support with less confusion and wasted effort for members.
6. Minor health improvement initiatives are implemented selectively with a centralized search for the right vendor while managing administrative expenses.
7. Identify and support potential future “high-risk” (very expensive) members.

This final topic, future high-risk members, is particularly important since a small set of people generate most health spending in the next year¹³. Yet, spending is only known after-the-fact, usually too late for action. It is not possible to identify many of the specific individuals with serious health problems in advance. Many of last year’s patients have recovered or are already in treatment, so their costs drop substantially the next year (often stated as “regression to the mean”). Many expensive patients are new. The challenge is to identify those likely to have problems next year.

HPPGs work to improve identification of future high-risk patients and develop action plans:

- Identify future at-risk members – investigate, develop and/or test various data sources and methods to identify future high-risk members such as predictive models or risk stratification.

¹³ The “80/20” Pareto rule-of-thumb often discussed in public literature is highly approximate – with major variations by population.

- Develop initiatives – targeted population health programs to assist members once identified – customized to each condition/illness and sometimes to the specific individual’s clinical and/or social situation.
- There are targeted analyses for particular illnesses or moderate risk patients, such as non-compliance with treatment protocols or gaps in care.

Measurement of results for “high-risk” members is particularly challenging. This is a small population. Regression to the mean can greatly exaggerate the apparent savings or clinical impact if only a basic year-over-year comparison is done. A classic example is low back pain programs where the triggering event is the high cost surgery. Costs normally drop the year after the surgery is done, so a large claim is unlikely the next year. So, claims are lower even with no additional management.

6D - Business structure

An infrastructure to support, improve, organize, and manage physician performance

As discussed earlier, the financial performance of intermediaries such as physician groups varies. Some are consistently high performers; others produce results that are similar to broad network fee-for-service systems. Results depend on implementation and infrastructure.

Some physician groups see their primary roles as quality improvement and contracting agent for physicians; others also act as financial manager of the health system and resource use. Roles also change when financial arrangements offer incentives for financial results. For example, a risk pool or incentive payment targeted at a particular problem gives specific funding for needed management resources.

This paper reflects formal and organized physician groups. Various attempts to transport key elements to other locations and products are underway, such as Medicare ACOs. We will see how these different levels of infrastructure perform over time.

A physician group changes the role of physicians in the community – the stronger ones become an active presence in the community. For example, efforts to improve outpatient services coordination and expense become easier as their volume and presence grows. Hospitals own some physician groups and become strong allies to work on major quality and cost initiatives.

As an overview, the basic business structure and payment model for many HPPGs fund a formal legal organization and staff.¹⁴ Historically, payment was often through full or partial capitation and risk pools. Common characteristics of the business structure are:

- Stand-alone businesses – run by physicians and often owned by physicians.
- Led by physicians with strong personal skills and practical experience with outpatient medicine. If the group takes financial risk such as partial capitation (outpatient), there is active management of outpatient costs, fees, resources, etc.
- Executive team (often supported a Management Service Organization (MSO). For HPPGs, the CMO or CFO has responsibility and authority to reduce wasted services and related expenses across the health system.

¹⁴ This varies substantially by state.

- Physicians treated as valuable staff with ongoing compensation, not just contracted suppliers with a new fee adjustment every few years. Physicians may be owners. Long-term relationships and trust are built to allow ongoing performance improvement. Section 6F expands this discussion.
- Education and feedback – through ongoing education, training, and social reinforcement.
- Support for physician workloads, their staff, and their internal expenses – physician service is central to their business mission and frames all decisions.
- Member connection to physicians – preferably based on member choice at time of enrollment. If not, attribution¹⁵ or other less visible methods are used. Some HPPGs also track the ordering physician to understand who is responsible for each service.
- Regulation – HPPGs can bring a balanced physician voice to state laws and regulations given their overall responsibility for both healthcare delivery and cost.
- Systems and reporting – reports deliver useful information at the right time in an easy format to the right individual. This is not the traditional top-down push for more data. Data requests respect the time of physicians and staff. Report formats are intuitive and useful.¹⁶
- Claim payment – physician groups may pay claims themselves particularly under capitation contracts. This can be a major budget item with the expense included within the capitation.
- Analysis – targeted, but extensive, financial analysis is done. Multiple data sources are used (sometimes with proxy financial estimates). Or, analysis is split with carriers or buyers. Illness-specific and provider-level information is used for retrospective results and future opportunities.

The internal time and effort applied to reduce wasted services is a very pragmatic business decision. Under a capitated contract, each dollar saved comes to the group, so the group adds an infrastructure and staff to reduce wasted services. Infrastructure varies widely under other payment arrangements.

¹⁵ Physician views on prospective and retrospective attribution are complex and vary by type of product (Medicare, Medicaid, commercial, Exchanges).

¹⁶ Physician-level data collection and reporting can be much different from the historical carrier/buyer process. Multiple data sources are used. Data collection is made easier. Some traditional reports are discarded. New physician-centric reports are created.

Groups have pragmatic business reactions to different payment structures. For example:

- Staffing varies based on the hospital payment system. More staff is needed if hospitals are paid per-diem than if paid per-admission since the group needs to manage length of stay or ICU days.
- A carrier and group did not reach agreement to fund the previous risk pool, so the pool payment stopped. For the group, staff to manage this waste became an expense without offsetting income. Staffing declined significantly over time.
- A federal ACO projected it would not meet its gainsharing target by year-end. Some initiatives, such as outreach to avoid emergency use, were discontinued for the remainder of the year.

While much of the structure is common, there are still important differences among HPPG groups. Some work on many products; others specialize. All HPPG groups have some electronic data feeds, customized reporting, and extensive disease registries that have been built over time. But many different vendors are used for outpatient EMR systems that need to be customized to each office. Rural organizations involve local physicians in management oversight but also bring outside management services, off-site specialists, and telehealth.

Large and medium-sized physician groups use different approaches to improve performance. Medium and small groups tend to rely on working relationships and visible hands-on leaders, while larger groups also build infrastructure.

The structure also continues to evolve, especially as physician groups expand and modify their structure and initiatives in other locations and other products. For example, some MSOs expand into new communities. Some have been bought by consulting firms. This greatly speeds the pace of change to new locations.

Carrier relationships may be limited or be aligned depending on the specific project. A few states and carriers are a driving force for physician group improvement, and fund multiple projects. In another state, an association of physician groups may fill a similar role.

Management of administrative costs and creation of economies of scale is a continuing challenge for physician groups. However, their deep understanding of outpatient care and extensive working relationships offer offsetting strengths. Other challenges vary by size, physician experience, expertise of the management team/MSO, and resources that are available from allies.

6E - Overall payment to physician groups

A financial structure that supports and reinforces the overall organization

An overall payment arrangement between the physician group and carriers/buyers is needed to fund and support financial performance. Given new options, this is not just the traditional version of capitation. A range of value-based payment arrangements and specific incentives bring targeted accountability to provider organizations.

Strong arrangements are needed; lower levels of financial responsibility (such as weak one-sided gainsharing) do not work. The exception is multi-year contracts where the targets become more aggressive over time. Weaker arrangements are used in the private sector as transition arrangements for a few years. Future agreements depend on making measurable progress in the first few years.

Subject to state law, many HPPGs prefer a payment connected to overall costs (such as capitation or strong gainsharing). This has several advantages to the higher performing groups. It aligns incentives. They keep some gains for reinvestment and pass some to aligned physicians. It encourages reduction of wasted services, since the related expenses reduce net income for the physician group. The physician group manages its own dollars (not the carrier's budget).

Capitation allows the executive team group to build an organization, staff, and build hands-on experience running a business. The organization has income. It has expenses. There is a large budget to fund operations and use for capital and investments. Physicians spend less time to recreate the wheel.

Historically, formal organizations under capitation were more likely to sustain lower spending, while loose affiliations rarely worked. Formal organizations are also easier for carriers and regulators to assess and monitor. This may be changing given vast improvements in technology and physician support, as well as the new payment approaches being created and tested.

A formal organization with substantial financial risk¹⁷ changes the mindset of individual physicians toward waste (particularly if they own the physician group). Providers become aware of waste in the system. It is no longer an industry problem; it is a direct expense to them. They begin to apply their expertise to resource management.

¹⁷ Capitation or high gainsharing that cover administrative expenses and offer a potential increase in net income.

Current payment framework for many physician groups

Many physician groups are built using the “full” or “partial” capitation/bonus framework. Other groups do not use capitation, but rely on bonuses, gainsharing, or other risk-sharing based arrangements. Pharmacy, large claims, and behavioral costs may be excluded or included. Regardless of the payment system, the physician group needs ongoing reporting of total costs and reports that identify cost drivers.

Almost all arrangements have core quality metrics. Usually, these must be met before any bonus payment for the physician group is available. For HPPGs, most, if not all, of any quality bonus paid to the organization is usually distributed back to the physicians.

The level of payment reflects the responsibility that the organization accepts. The following table shows three common options.

Typical capitation agreement between carrier and physician groups

See notes below

	Population	Responsibility	Financial arrangement
“Full Risk”	Commercial / Medicare Advantage	Almost all services	Inpatient and outpatient capitation
“Partial Risk”	Commercial / Medicare Advantage	Outpatient (and all physician)	Outpatient capitation Risk pools (such as inpatient and pharmacy performance)
Pathways to Success	Medicare ACO	Almost all services	Gainsharing with capped loss sharing Quality adjustment for gainsharing

Notes:

1. The term “full risk” capitation is often used to distinguish between full and partial risk. However, it is not quite accurate. Pharmacy and behavioral health are often excluded. In-network large claims may also be excluded depending on extensive negotiation that balances the value of physician involvement against the challenges to negotiate a practical measurement approach.
2. Many articles about capitation discuss “full risk” capitation. “Partial risk” is less visible, but often used, particularly for smaller physician groups. It creates a more manageable business role tied directly to their unique outpatient expertise. It aligns their authority with financial risk. It also partly addresses the challenge of small size rate credibility.

3. *Risk pools or targeted initiatives are long-standing options in certain circumstances. The carrier identifies a specific major problem and offers funding for performance. The physician group then develops initiatives. Use of risk pools varies with local market conditions.*
4. *Many other revised approaches are being used in the private sector.*

Details are often defined through a DOFR (Division of Financial Responsibility).¹⁸ This splits the financial claims responsibility between physician, carrier, and/or hospital.

For capitation or global payment, an absolute per member per month (PMPM) is negotiated. Extensive analysis and negotiation are done to measure, develop, and monitor these programs over time. The payment varies with existing performance, competitors, market condition, working relationships, duplication of services, new treatments, member support, quality, etc.

Financial agreements must be clear and achievable - problems that the physician group can directly impact. Expected incentive amounts must be large enough to get the attention of the physician group and fund the administrative work needed to change behavior. Providers assess the potential for additional revenue and net income against possible losses.

Agreement is not necessarily a zero-sum game. Carriers have potential savings from lower claims. But lower claims may have a much smaller impact on the provider's net income. This comes from potential expense savings from lower internal waste (although this is not directly visible to buyers/carriers).

Contract terms are highly sophisticated, customized business agreements between each different carrier and physician group. Details vary widely across the country depending on local presence, existing performance, state regulation, etc. While the negotiations on capitation or targets are quite complex, some physician groups prefer relatively simple financial targets in the final contract.

Some group/carrier working relationships remain poor. Others are much better with targeted joint work on key financial problems, health improvement, streamlining operations, and/or reducing duplication. Some carriers ask strong physician groups to expand into new locations. Carrier reporting of total-cost cost and drivers is becoming more common, particularly on ACO/PPO contracts where claims are paid by the carrier.

¹⁸ Overview at: <http://www.iha.org/sites/default/files/resources/fact-sheet-dofr-2015.pdf>

Future payment arrangements and business structure

Historically, full financial responsibility such as capitation offered strong alignment and allowed a formal business, staff expertise, infrastructure, and data. Virtual management was rare. Newer versions of capitation or global payment (with bonuses, quality requirements, and risk pools) are still the strong choice of many experienced HPPGs.

The combination of new technology, higher provider expertise, plus new payment options opens many opportunities to revise and test business and financial approaches.

More “virtual” management is possible given modern technology, analytics, and new initiatives to improve care and health, and reduce waste. For example, reporting and analytic systems are much faster, and deeper reports are possible. This allows targeted incentive payments to work alongside overall payment arrangements like capitation, global payment, and strong versions of shared savings. Weak versions have only a small connection to overall costs and provide far less incentive to change behavior.

Active providers, Center for Medicare and Medicaid (CMS), states, and carriers are testing many different combinations of structure and financial support through alternative payment model incentives. There are also many different payment structures (from shared savings to targeted arrangements like staffing support, sophisticated efficiency metrics, payments for certain initiatives, on-site staff, joint research, etc.). Some carriers’ contracts fund on-site staff, specific improvement initiatives, practical research, or tool development.

Public versions¹⁹ of new payment arrangements are a starting point – a common framework and terminology to begin discussions. However, carrier approaches are quite different - even if the title of the program is identical. Approaches also vary widely by state or municipality. Some states have significant experience in provider-based care and physician networks over many years. Others are just starting.

The industry still seeks the right balance of responsibility and payment for providers. There are many challenges: Full capitation creates an all-or-nothing arrangement. Claims are much larger than administrative costs or net provider income. So, a small percentage gain in claims is a large windfall and much higher than management expenses. Losses are magnified and cause severe pressure. Renewals that use claims reporting effectively continue the weaknesses of a fee-for-service payment system. The absolute level of health costs varies widely by location and illness so an absolute dollar

¹⁹ For example, the federal ACO approach is widely known. But it is constrained by the Medicare law (such as fixed fees for most services, member can use any provider, contract terms are public, provider participation is optional, attribution, the same structure is used in all states). This is quite different from the private sector. As another example, some primary care physicians already accept more responsibility than an official PCMH program in exchange for higher compensation.

rate is hard to determine. There are also technical challenges for capitation of small groups or new populations.

The ultimate measure of a successful contract for the buyer is sustained results: better measurable health, distinctly lower total spending and trends. But, complete responsibility for everything is too large for many provider organizations, so the industry is testing a mix of strong overall cost targets with other targeted financial incentives.

As a final reminder, a strong financial arrangement with an organization is an important starting point, but overall payment alone is not enough to produce sustained results. Sustained high performance requires the other business components described previously.

6F – Compensation and payments to individual physicians

A financial structure that supports and reinforces individual physicians

Both carriers and provider-based health systems such as hospitals and physician groups have worked with physicians for decades. But their working relationships and payment systems with physicians are different. Carriers use a traditional supplier contracting approach to fees. Most provider organizations have ongoing relationships both with salaried and allied physicians.

Long-standing provider approaches to physician payment offer insight about building physician relationships. Physicians are treated as important and sophisticated staff members, even if they are independent contractors. Yet, they are expensive resources – they must have support so their time is used wisely. Payment arrangements are similar to the “total compensation” model used by other industries to pay their key staff. Payment should reinforce behavior and actions. Versions of this model are used for both salaried employees and independent physicians contracted with the group.

In effect, there is a large toolkit of physician payment arrangements. Each tool is applied to address a specific problem, such as a bundled payment to reduce supplier expenses or complications for one particular specialty. Incentive payments reward higher performance.

Historically, the toolkit included a mix of base pay, salaries, capitation, performance bonuses, on-site staff, case rates, initiative-based incentives for quality and efficiency, training, etc. Now, the toolkit is even larger given newer payment arrangements such as bundled payments, fees for Patient Centered Medical Homes (PCMH) and other targeted bonuses.

In general, arrangements use base pay alongside small to medium-sized incentive bonuses. Bonus payments to an individual physician are typically upside-only. Withholds are rare; instead no bonus is paid. Management of low performance happens behind-the-scenes, such as fewer referrals for poorer performing specialists.

Compensation discussions intuitively reflect the fact that many physicians run their own businesses. Compensation is not just gross revenue (i.e. fees), but workloads, internal expenses, taxes, and the resulting net income. Intermediaries, such as physician groups, offer support to reduce workloads, increase membership, improve the working environment, reduce operating expenses, and offer economies of scale.

Payment methods and levels are diverse, highly targeted to local market conditions and specialty. More physicians are now employed, with a salary as base pay. If not salaried, the following types of base and incentive pay are common.²⁰

- Bonus payments for quality for most or all physicians
- For primary care physicians, base pay is often capitation
- For specialists, base pay is often fee-for-service or case rates
- Both primary care and specialist physicians have upside bonuses based on their own performance. For example, up to 7% bonus for high performance on quality, efficiency, and member satisfaction.

The criteria for Incentive payments varies widely and use of incentives is growing:

- Physicians often own the physician group.²¹ Ongoing profits for the overall organization typically come to the owners each year given tax implications.
- The savings from capitated and shared savings arrangements typically reflect total healthcare system costs. This is far greater than physician income and the physician component of total spend. Even a small percent savings on overall system costs is a relatively large and significant percentage of physician revenue and net income.
- The financial impact of a bonus is not the same as the value of a fee. Fee-for-service revenue comes with overhead that may be half of gross revenue for a typical doctor. For example, if the bonus is paid for existing strong performance it does not add new expenses. So, the bonus has a magnified impact on net income.
- If overall bonus pools are funded by carriers, part of the carrier's payment is often allocated to contributing physicians. For example, the full carrier payment for quality may be allocated to physicians with higher measurable quality.
- Behavior (such as good internal citizenship or collaboration with other physicians) may impact bonuses.

²⁰ There are geographic differences based on state law, ownership, and management preferences. For instance, many physician groups pay bonuses quarterly or annually (just after performance is measured). However, some groups allocate bonus payments as fee increases in the following year.

²¹ The physician's ownership decision is complex and based on extensive analysis and discussion. Investment results vary widely, but if the group delivers distinctly less expensive products and high membership, physician equity typically grows. However, equity growth or declines can change depending on market conditions.

HPPG approach to incentives

HPPGs build upon the criteria above. There is a different emphasis and new criteria are added. These include:²²

- Incentive payouts may be frequent so that the performance stays “top of mind.”
- Bonuses typically are paid for both consistent and excellent performance. This discourages physicians with weak performance. Solid physicians do not need to pursue other aggressive approaches to supplement their revenue. To repeat a previous example, a solid or high performing physician is less likely to open an expensive on-site lab and lose their bonus.
- Bonuses for individual performance are a higher percent of total compensation. At the high end, half of any bonus may reflect efficiency or efforts to reduce waste. Other groups put little weight on financial criteria (i.e. cost of care, reducing waste, etc.)
- Physician-specific efficiency may be measured based on claim-based episode analysis.
- Some physician groups make personal performance visible and create competition among physicians. Others prefer to handle individual performance behind-the scenes.
- Compliance with utilization and referral guidelines.
- Panel size and composition.

They also support individual improvement for physicians who want higher bonuses through detailing, education, and training. Consistently low performers may eventually lose volume over time.

Payment to suppliers and non-network physicians

A wide mix of payment arrangements is used with suppliers and non-network physicians. Most HPPG physician groups are very active. The physician group has a very strong negotiating position, since they know the volume of services needed, can direct patient referrals, guide inpatient and outpatient treatment, and channel patients for each specific illness. For example, the group may ask for bids on ambulatory surgery centers or basic lab testing. Or, the group may build its own urgent care center.

²² This comes from unpublished projects. Internal working of compensation and bonus decisions are proprietary.

Most HPPGs manage utilization, avoid unnecessary referrals, track resource use, create smaller physician networks to develop deep working relationships, and take action by illness.

Physician groups also develop widely different working relationships with hospitals. Some are owned by the hospital. Others build deep alliances and full risk capitation with a few hospitals and direct most care to these facilities while using tertiary hospitals for the specific illnesses where they deliver unique services and quality.

Section 7 – Measurement and analysis for buyers

Industry approaches to identify the better programs prioritize specific initiatives, monitor results, and give feedback for ongoing improvement

Buyers seek healthcare financial solutions as rising spending on health continues to limit salaries or pressure non-medical budgets for governments. They seek:

- Relationships with physicians who can be long term allies;
- Sustainable total cost increases - near the increases in employee salaries or the general cost of living;
- Programs with lower total costs than other programs in the market, and;
- Ongoing physician-level initiatives to create healthier members, better care, and reduce wasted services with their related costs.

The overall financial results are easily visible for buyers. Individuals and small employers see their own premiums. Governments and large self-funded employers track their costs per member.

This section covers the deeper analysis used by buyers: analytic resources, scorecard metrics, and lists specific analytic techniques. These help carriers and buyers measure which provider-based programs reduce waste, manage health systems, guide ongoing improvement, and sustain lower trends. In general, the approaches below apply to commercial and self-funded products. These approaches need adjustment when used for Medicare or Medicaid. For example, pharmacy data may not be available for Medicare programs.²³ This section does not address the extensive technical analysis that is done in contract negotiations between commercial carriers and providers.

Improved analytic resources

One historic limitation facing buyers was the limited analytic resources and data. These resources have substantially improved:

- Ongoing analysis rather than an annual event
- Review at the local community level rather than the overall population

²³ This paper covers lower spending (reduce waste, efficiency, etc.). Although important, it does not cover analysis aimed at more revenue. For example, Medicare Advantage risk adjustment and STARS are not covered.

- Review each specific illness/condition rather than an overall grand total for all illness (such as episode analysis, bundled payments, etc.) although many technical challenges such as comorbidities continue
- Evaluate every service rather than totals with a broad type-of-service
- Use unique data sources and analytic tools developed by hospitals and physicians
- Provider quicker analysis given more powerful and faster computing systems

Many data sources are used for these analyses. When available, financial analysis starts with claims data, since claims record the actual dollars paid by buyers and seen by providers as revenue.

However, the starting total claims dollars for the provider and carrier/buyer are different and reconciliation can be needed. Reporting dates rarely match. Duplicate or disputed charges are handled differently. Carriers often have multiple products and benefit designs. Providers see only their own allowed contractual fees and paid claims while buyers analyze claims from all providers. Carriers often adjust for outliers. Pharmacy data may be available, but sometimes this important source is not available.

When providers are managers, many other sources of data are used such as lab results, disease stage, or feedback from physicians and clinical staff. Data from multiple EMR vendors may be available, but need to be integrated. A growing trend is the use of more patient reported outcomes. As one example, some HPPGs track the disease stage of certain cancers and monitor injectable drug resource use to identify new opportunities to support and pay their physicians.

Payment arrangements and data sources vary widely by type of population (Medicare, Medicaid, commercial, and employer), so, while some analyses are common, many need to be customized to each population.

All members' claims are rolled up by the accountable physician. Results may be tracked by ordering physician. Claims and other payments are tracked against overall contract and results.

Analysis can be done by the buyers/carriers, providers, or both. For example, one major carrier ran an analysis for one of their ACOs. They found patients in one local office had much higher emergency department utilization than normal. They met with the local staff and found that the receptionist had automatically forwarded incoming calls to the emergency department when the line was busy. Once this was changed, emergency use dropped to normal levels.

Fundamental (scorecard) metrics

Several fundamental **metrics** are used on overall scorecards: days/units per thousand, inpatient admissions, complications, readmission rates, and emergency room visits. These may be tracked monthly by the executives with seasonal adjustments.

More sophisticated versions of scorecard metrics are used for other purposes. They can be adjusted for seasonality, case mix, age, and type of product. Planned and unplanned readmissions can be tracked. Metrics are compared to benchmarks (typical performance) or targets (high-level performance).

However, overall metrics are just a starting point for financial analysis, since they only address broad results. Buyers are responsible for all spending, not just scorecard measures of admissions and emergency visits. Much deeper analysis is needed to evaluate performance, determine cost drivers, and manage the program.

Scorecard metrics are useful to management but are often not actionable for physicians. Providers need information organized by patient or illness rather than grand totals, such as flags as reminders of patient specific challenges. For example, Dr. Z's patients use more emergency visits than his peers for the same illnesses. Or, the group finds high days per thousand for a certain illness and develops a specialist initiative.

Advanced analytics

Given the massive dollars and complexity of healthcare, there are many methods to analyze health data to manage and improve performance. Key methods to measure the performance of physicians and groups of physicians include:

1. Illness-specific measurement of group and individual physician performance – Information organized by illness is more intuitive and actionable for physicians. Analytic methods include episode-based analytics, bundled payment, ambulatory sensitive care, preference sensitive care, and many specific quality metrics, etc. For example, the episode-based analytics and structure used in bundled payment programs connect costs to particular illnesses, and attribute those system-wide costs to a specific physician or physician group. These techniques can be used for initial selection of networks, physician incentive payments, individual physicians, or rolled up for each physician groups.
2. Comparison of groups across carriers and/or locations – the overall cost for a buyer can be compared across locations or carriers. Adjustments for age and gender are common. Pharmacy-based risk adjustment is done when data is

available to avoid coding problems. Both actual fees and standard fees can be evaluated to flag the impact of providers with very high fees.

3. Cost driver identification and analysis – claims analysis can identify historic waste. If expected to continue, this offers a starting place for potentially reducing future waste. Any analysis must be actionable for physicians or others within the provider organization (identify certain conditions, certain physicians, or flag higher risk patients).
4. All spending/all conditions – as mentioned earlier, buyers pay all claims. So, the analysis and management approaches must address all spending, not just a few “scorecard metrics”. While metrics such as Never Events, Ambulatory Sensitive Care, Evidence-Based Medicine, are clinically important, they only address a small percentage of the total spend. For example, buyers are responsible for both jumbo and non-jumbo claims. One example is mentioned earlier in Section 6C - some HPPGs take responsibility for future “large claimants” if they reach financial agreement with the buyer/carrier.
5. Major decisions based on claims and net income – as mentioned in section 3 and 6E, providers focus on both revenue and net income. Yet buyers only see the physician’s revenue - a different financial impact from the same event. Understanding the magnitude of this difference can lead to more informed and different decisions. For example, a bonus has a different impact than a fee on net income.
6. Gap compared to best practice – more targets are becoming available. Some are broad measures like admissions or days per thousand. Some are condition-specific such as gaps in care or complication rates. For example, episode analysis systems are used to identify high performing physicians, examine their practice patterns, send them members, and apply their approach more widely.
7. Gaming and loopholes – new initiatives and payment methods offer opportunities to find loopholes and game the system. Although this remains an ongoing challenge, improvements in computer systems and analytic resources make this easier to track. Analysis can track total costs for each patient by illness, then unusual utilization patterns can be flagged for review. Or, if cumulative changes in aggregate risk scores continue to grow over several years, this can be detected and investigated.
8. Monitor actual results of proposed initiatives – The number and depth of initiatives offers a starting measure of the potential of a provider organization. Deeper reviews can also be done of the process to identify cost drivers, prioritize, and then develop physician-level actions to address the problem. Once initiatives are developed, actions and results can be monitored.

9. Joint financial committees – ongoing joint financial committees can be formed across multiple decision makers. These committees identify cost drivers, set priorities, and take action. Hospitals, physician groups, and/or carriers bring their tools, data sources and analytic tools. This committee is especially important in ACO/PPO contracts or when the carrier pays claims (not the physician group).
10. Renewals – the renewal discussion moves from an “accept high ongoing trends” to a “performance improvement” mindset. Providers identify “manageable risks” and take responsibility for initiatives to improve the system over time. Continued high trends result in an “improvement plan” and specific actions rather than continued acceptance.
11. Reporting to providers for their total population is disconnected from specific and credible reporting to buyers for their particular members. Although this remains an ongoing challenge, at a minimum, buyers are shown summaries of the overall performance reporting done for the provider organizations.
12. Adjust for selection when applicable. Simple measurement techniques can misstate results. A common example comes when patients are attributed to the ACO using historic claims since selection can overstate savings. Sometimes a comparison group of potentially attributed members in other communities is used instead.²⁴
13. Improved spending becomes much harder after early visible problems (“low hanging fruit”) are fixed. So, the providers build additional expertise over the years to create continuing improvement. New growing problems are addressed. Multiple techniques are used (analysis, external master list of potential initiatives, carrier identification of problems, and outliers, etc.) These are analyzed and prioritized.
14. Social factors - social and economic challenges are major problems for some people. Many analytic approaches are used including formal analytic systems such as Social Determinants of Health approaches that are under development. Many unique approaches for patient support and compliance are used and customized to different populations.²⁵

²⁴ As a brief highlight of a very complex topic, some attribution methods are based on members that had services in the prior year. It does not attribute members with no claims. This creates selection, since those with no services in one year have normal claims in the following year.

²⁵ Physicians and physician groups understand their patients’ environment, languages, ability to adhere to treatment regimens (or even will split pills given fees), transportation problems, behavioral health issues, stress, poverty, etc.

Overall impact (business assessment and analytics)

Physician-based programs have the potential to improve care, health, and spending over time. Ongoing improvement requires a combination of business and analytic approaches.

Section 6 offers the business discussion – examples and a framework to assess the business capabilities of intermediaries that support physicians using examples from the practices of existing high-performance physician groups. This can be used to assess the management team, review current operations, and offer ideas to drive ongoing improvement.

Section 7 describes various modern analytic techniques to measure physician-based performance on care, health, and spending. These results are driven by the business capabilities and actions discussed in Section 6.

Appendices

Appendix A – Hospital / physician group collaboration

From: “Provider Networks – Actuarial Perspective on Performance In and Out of Exchanges (page 77) at <https://www.soa.org/research-reports/2018/provider-networks-performance/>



A5 Reduction of Wasted Services: Example

Sustainable financial performance and lower Exchange premiums require an ongoing commitment to the reduction of waste services. The following real, but simplified, example helps understand how reducing waste and expenses can work. This example comes from an alliance of a hospital and unaffiliated physician organization that do not own a carrier. This work began before the advent of Exchanges.

For various business reasons, executives at a hospital and an affiliated physician group wanted to reduce waste and control their expenses for certain Medicare admissions. As a side effect, this reduced the length of stay. Since the new approach for controlling expenses applied for all patients, it had a different impact on different lines-of-business. The lower length of stay reduced revenue from insurance programs that paid on a percentage of charge or per-diem fee basis. It had no impact on Medicare given payments per admission. It had a mixed impact on Medicaid. Lost revenue meant lost margin (income less expenses). So they reviewed results across all lines of business:

- Total revenue was down. Expenses were down. The net impact on overall margin was breakeven: the loss from regular insured business was just below the gain from Medicare and Medicaid.
- Margins continued to improve over time (since commercial insurance contracts could be renegotiated, and capitation in Medicare Advantage and commercial programs was possible).
- The hospital and physician organization appeared likely to pick up enrollment from commercial business.

The net impact was a gain on margin although a loss of revenue. As a result, they implemented the initial program and continued to add new illnesses to the program every year. They also modified their commercial contracts over time to capitation.

Several major financial lessons can be seen from this example. A reduction in wasted resources (and related expenses) was clearly the right thing to do. Losses almost blocked the implementation (revenue was clearly lower in the early years). However, the analysis focused on margin, instead of revenue, and a useful solution was discovered. This higher financial performance had enabled substantial growth in enrollment over the last decade.

Appendix B – Executive summary from Lessons paper

From http://www.pbgh.org/storage/documents/commentary/HiPerfNetworkBrief_ExecSummary.pdf



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Lessons from Higher Performing Networks

KEY ELEMENTS FOR FINANCIAL PERFORMANCE

GREGGER VIGEN, FSA MBA AND EMMA HOO

Many essential elements of provider-based care are already well known in the industry. Executive leadership, quality improvement, as well as actions to reduce readmissions and support for members with chronic diseases are widespread. However, financial performance for employers requires additional actions that often work behind-the-scenes. As we examined what Higher Performing Networks did differently, the following twelve elements stood out:

Pilots and Initiatives

1. Implement multiple initiatives aimed at financial results (supported by new payment systems). Initiatives extend beyond quality improvement and are targeted to the line of business (such as Medicare, Medicaid, employer, or individual).

Care Coordination & Quality Measurement

2. Improve care coordination and member engagement.
3. Manage future high-risk members - not past illnesses.
4. Use outcomes-focused and value-differentiating measures.

Alternative Payment Models

5. Develop strong ongoing financial agreements on overall costs (with purchasers).
6. Implement selective "aligned incentives" over time (with individual providers).

Management, Roles and Responsibilities

7. Use the full resources and unique capabilities of responsible, informed providers - from the executives to individual providers.
8. Reduce waste and related internal operating expenses across the system - demonstrated by multiple initiatives and a responsible executive.
9. Communicate with allies in deep blunt discussions (cost drivers, responsibilities, duplicate tasks, etc.).

Infrastructure

10. Use multiple data sources to create useful reports to prioritize, create initiatives, and support the individual taking action.
11. Develop infrastructure to support informed action at the right time by the right individual.
12. Monitor economies of scale - particularly for smaller organizations (as they buy, rent, collaborate with other providers, or use allies).

Each of these elements is very important and reinforce each other. Initiatives (1) must be done by responsible providers (7). Misaligned incentives (6) inhibit efforts to reduce waste (8). And, so on.

ISSUE BRIEF

Appendix C – Pandemic supplement

How some physician groups manage the Coronavirus

Sources: This appendix provides a short snapshot of a very complex environment that varies over time. The situation differs widely by local virus status, physician specialty, age of physician/staff, type of members, funding source, laws/regulations, and payment arrangement. Local results also depend on the capabilities of each intermediary to bring support and implement solutions during a crisis.²⁶ So, one article outlines massive problems. Another article has a positive tone and describe their improved practical solution – while understanding that the problem is still there, it is just smaller.

This supplement is based on information obtained through July 2020 and is based primarily on self-reported material. It comes from physicians and the various intermediaries who support them (such as large hospital systems, independent physician groups, clinics, consultants, etc.). It outlines various practical business approaches that are widely reported by physician groups, but a public article does not mean results. Results depend on implementation.

The focus here is not on acute inpatient treatment. Hospitals and their staff have made extraordinary efforts to address the major problems for very ill patients while protecting their staff and still serving non-virus patients. Major efforts (such as intensive care, ventilators, supplies, infection control, construction, etc.) are widely documented in other sources so they will not be covered here.

The virus and related social and financial impact are challenging for everyone. It is particularly difficult for physicians and other health workers who are still expected to deliver better care, healthier members, and the right level of services while protecting themselves and their patients from the virus.

This appendix highlights ideas based on real-world actions about how active intermediaries (physician groups) deal with the virus. It focuses on groups who have taken broad responsibility to support physicians, improve care, and coordinate local delivery of care.

Current Environment

The personal and business situation is vastly different among physicians, health workers, members, and communities. Massive risk exists for older, vulnerable populations including older physicians and staff in face-to-face contact. Urgent problems come in a surge location. Smaller physician practices have few resources and no time. Physician support varies widely.

²⁶ Widely different physician situations are reported in multiple surveys done by organizations such as the California Health Care Foundation (www.chcf.org) and American Medical Group Association (www.amga.org)

The virus makes a disorganized delivery system even more complex. Physicians working under fee-for-service payment models have ongoing financial pressures for revenue. The cumulative impact can be overwhelming.

The working environment can be much different for physicians affiliated with a medium or a strong physician-focused intermediary. As highlights:

- Operating a healthcare business remains very challenging given widely varying impact on patients and staff as well as infection control. On a personal level, patients and health workers face enormous pressure and stress. Physician groups help with many practical challenges.
- A physician connected to an established, solid group has support to address many new and complex problems during a time of crisis. There is an existing infrastructure that offers economies of scale, shared support staff, operational support, technology, and other resources. Often, they work within a smaller, more coordinated delivery system. This lets physician and their staff focus on patient care and health.
- Physicians need ways to reduce face-to-face contact and risk of infection for members, physicians, and staff. There is a major expansion of technology to find alternate ways to communicate. One major change is very visible - wide use of “telehealth” between physician and patient along with increased usage of mail order drugs. Yet, as discussed below, the technology changes within the system are far broader than replacing a patient office visit with a web call.
- After a large early drop in services, providers are now in a transition period on revenue and net income. The financial situation for any particular provider varies widely depending on the payment arrangement and member decisions on missed services. Providers paid by fee-for-service report services are working to restore historic service levels and report mixed results. Providers and physician groups paid via stronger versions of Value-Based Payment saw less or no impact²⁷.

Initiatives and infrastructure

Physician groups, or other intermediaries, bring business practices and economies of scale to help physicians run their businesses. Their existing infrastructure and resources have been redirected to reduce infection risk, address physician business problems, support patients, and lessen the serious personal pressures on the physician and their staff.

²⁷ For example, physicians paid on salary or capitation saw little impact depending on layoffs. Physicians’ bonus were sometimes paid in advance. Physician group revenue depends on the specific contract and line-of-business.

Major Initiatives include:

1. Personal protective equipment (PPE) and all supplies – Groups leverage their size to create more purchasing power, handle supply chain problems, ensure delivery, and arrange supplies exchanges with physician groups in communities with lower virus problems. Groups provide compliance training for staff, operational support, and ongoing vendor management. Surveys report physicians connected to larger practices have far less problems than other physicians. Surveys show an improving supply situation for most physicians although PPE is still a very serious problem in locations fighting surges.
2. Practical operational support. Physician groups support many changes in the work environment required by the virus. Restructured offices, hours, and workloads to reduce in-person contacts and lessen infection risk to vulnerable physicians and nurses (sometimes a dedicated center for virus patients has been created). They monitor the status of other parts of the local health system and find new preferred vendors if needed. Management of new testing and lab requirements is also a focus. Physician groups evaluate virus-specific clinical research and distribute the implications to each specialty. They redirect existing care management staff to address virus problems. They also inventory resources, and in some cases, arrange for shared resources. This can become quite complicated as some staff or physicians consider far less hours or retirement. Some groups have enough staff to handle both urgent operational issues like infection control and workloads, while still developing their ongoing planning.
3. Telehealth for physicians and members – Telehealth (either visual face-to-face or audio only) is widely implemented. However, web contact requires technology for both physician and member. Physicians and their staff need effective internal connections within the health system. Groups pull internal technology experts, modify services from existing technology vendors, evaluate technical and confidentiality of potential platforms, run pilot programs, and select a vendor. Physician implementation issues like home hardware, access to historic patient information, and internet speed may be addressed.

Member connectivity remains a challenge, particularly for low-income patients (or those losing jobs). In some cases, hardware support is offered members. One creative anecdote describes sterilized computers made available for patients while sitting in their cars outside the doctor's office. These computers were linked to the office website.

4. Other technology and connections – Telehealth is just one part of the technology improvements underway since physician groups are also responsible to find and implement technology within the physician work environment. This includes technology for disease registry reporting, electronic medical records, automated

information flow between physicians, automated referral scheduling, remote hospital or home monitoring, at-risk patient priority lists, automated pharmacy, emergency room notification systems, and phone apps. **In many cases, this pandemic accelerated the transition to support systems that was already underway.** Vendors were being screened, pilot projects were completed, and programs implemented at least for many physicians. The pandemic is driving a much faster and extensive rollout of technology support.

5. At-risk patients – Many groups already know most of their at-risk members through a formal tracking system such as disease registries or electronic medical record, and may have ongoing contact information. This allowed extensive early outreach to at-risk patients about their health and personal situation with suggestions to avoid infection. Almost all vulnerable members were contacted, not just those with a cancelled appointment.
6. Personal behavioral health (for workers and patients) – There is no simple answer to these challenges, but many personal behavioral health initiatives are underway to assist workers and patients. This starts with core material on stress, resilience, and virus education supported by multiple communication tools and personal help techniques. Business support for the physician and staff is highlighted above. Support can be highly customized to the person, health condition, business role, and personal situation. High risk member in isolation may be selectively linked to local volunteer organizations for meal delivery or errands. Pharmacy and treatment compliance for ongoing illness is monitored. And so on.

Physician groups use other business initiatives that build on their clinical expertise across all illnesses. The group offers a central source of information on vaccines, inpatient treatment, palliative care, etc. The Chief Medical Officer, hospitalists, and internal staff collect approaches and validate to each condition with key specialists. Priorities are set. Telehealth triage systems are developed and each specific treatment is examined to see what can be done virtually (phone, visual call, emergency department, and home monitoring). There are also continuous improvement initiatives underway including. For example, the approach to first identify unique problems (kidney dialysis for an infected patient) becomes the starting place across the system for the next similar problem.

Services, payment, and spending

The impact on services and the virus has come in three phases. It has had major impacts on services, revenue, and net physician income that have changed over time. Expenses were much higher including infection control. There was some additional funding from governments or carriers for some providers to partially offset these initial cost increases.

In the first financial phase, the early widespread shutdown created massive drops in services and major declines in revenue for providers paid under fee-for-service. The second phase, partial reopening had two changes happening at the same time: there was some pickup of the backlog of missed services mixed with new problems. During the second phase there was more personal contact and services, but still below normal levels.

We are now in a third transition phase on services and payment. All providers are working to support clients and catchup on missed services. However, the level of services and financial situation is very different depending on specialty, payment, intermediary, normal level of patient contact, ability to use technology, and other factors. There is a very high need for infectious disease experts. Vast decline in emergency room use continues. Most physicians still report lower paid services although the range of decline varies widely²⁸. Some still see severe problems. Others report utilization at close to normal levels.

The financial impact on each physician reflects the payment arrangement. Physicians paid primarily through fee-for service who experience a reduction in service volume see lower revenue. Yet, there is little impact on a physician paid by salary or capitation unless there are layoffs or other adjustments.

Given this wide variation during this transition phase, this leaves some major decisions for providers as they develop their ongoing plan.

Ongoing planning

Delivery of better care, healthier people, and the right level of services and spending during the virus is a very complex topic. Physicians and physician groups have made many practical changes in the short term. However, this is the physician's ongoing job thus they need an ongoing plan. Some physicians are considering major changes: retirement, consolidation, affiliation with local intermediaries, and/or change in payment system.

Let's highlight how this plan might address the major business components from the body of the report.

Member connections and support (with modern technology)

Member connection is an important starting point. One survey reports that physician groups are "anticipating approximately 25% of primary care visits and 10%-20% of specialty

²⁸ <https://www.commonwealthfund.org/publications/2020/aug/impact-covid-19-pandemic-outpatient-visits-changing-patterns-care-newest>

visits would remain as telehealth services.”²⁹ This is an average over multiple specialties, each with its unique mix of services, patient contact, and viable technology options.

This survey just addresses office visits that move to telehealth. Many other changes are underway:

- Changes in place of treatment, such as lower emergency room or replacing facility care with home care
- Member choices on elective surgery, pregnancy, etc.
- Type of staff, such as nurse support rather than a physician
- Internal impact of technology changes within the system
- Workload changes for physicians and staff.

Initiatives and infrastructure

The initiatives and infrastructure described earlier in the Appendix continue to be refined and expanded.

Intermediaries (Consolidation or alignment)

Various approaches are being considered. Some physicians are directly requesting more funding and support from the government or buyers. Others are considering mergers, consolidation or informal alignment with strong intermediaries to get more support, infrastructure, and resources.

Physician payment

The change in direct patient contact impacts physician payment. While many physicians will continue their current payment arrangements, others are reconsidering their choice of payment arrangement. The implications vary widely by specialty

Any change in payment arrangement is probably not a stand-alone decision. It can be directly connected to other business decisions. Joining a hospital system often means a salaried position. A new intermediary may offer bonuses or access to existing payment agreements. Or, if a major technology shift occurs and use of nurses is being considered, a

²⁹ <https://www.amga.org/performance-improvement/covid-19/pulse-surveys/status-updates/> Similar observations made during APG webcast at <https://www.apg.org/wp-content/uploads/2020/04/COVID-19-Case-Studies-in-Excellence.pdf>

change to alternative payment may produce more net income than a fee-for-service payment.

This is a snapshot of a challenging time for physicians and offers real-world examples of approaches used to offer support and address the difficult situation. These examples can be used engage physicians in practical discussions, build relationships, develop ongoing collaboration, or work with intermediaries such as physician groups to assess and improve their existing efforts.