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ID Compensation Conversations Webinar Series

Introducing the Value-Based Arrangements Guide (for ID physicians employed by academic medical centers)

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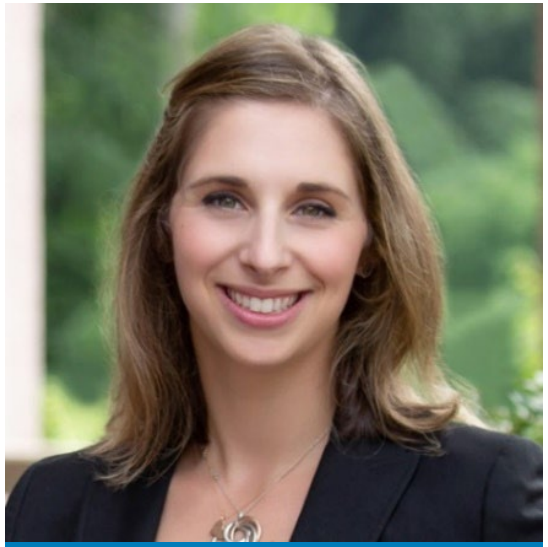
Today's Learning Objectives

- Review options to incorporate value-based arrangements (VBA) within specific practice settings, i.e., ambulatory, inpatient, outpatient, telehealth.
- Consider goals and opportunities to begin to develop ID-centric value or quality metrics for future consideration by hospital administrators, medical school leadership, and/or payers.
- Evaluate the process to begin negotiations with administrators to tie compensation to additive revenue realized by the AMC or faculty group practice from high performance in ID-influenced value-based metrics.

SPEAKERS



Amy Strauss

Trish Perl, MD, MSc
UT Southwestern – Professor, Chair in Internal Medicine

Jeanne Marrazzo, MD, MPH
UAB Medicine – Professor, Director of Division of ID

Moderator

Stuart McClure

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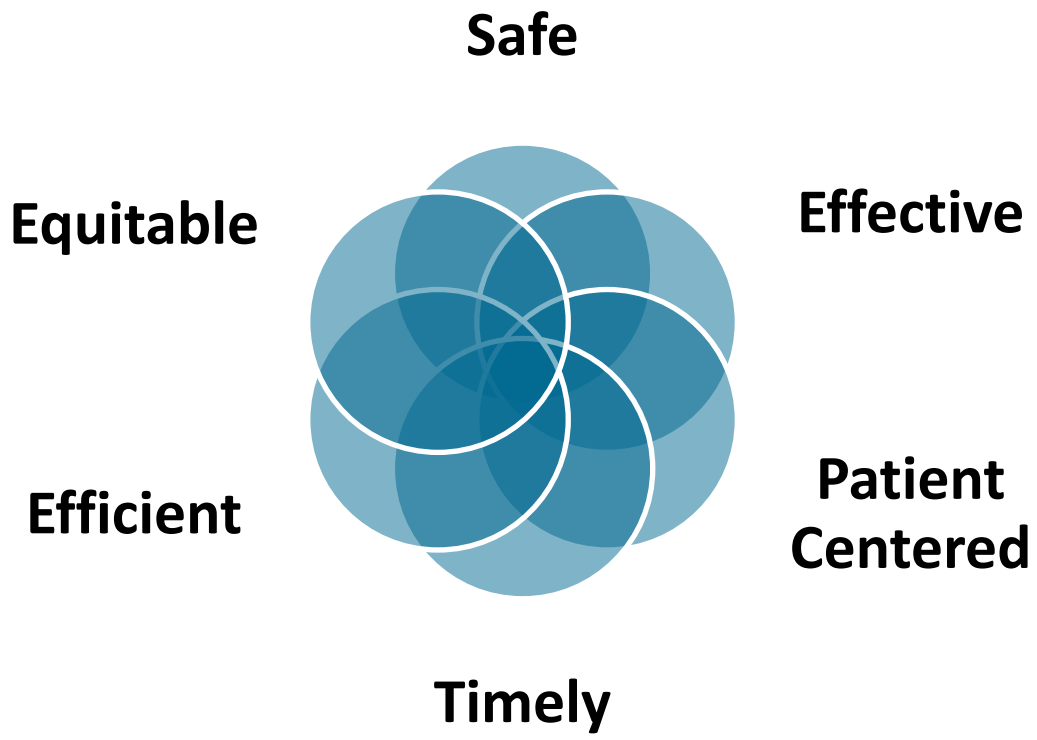
Trends in Value-Based Compensation

WHAT IS VALUE-BASED CONTRACTING?

- Value-based contracting is the driver from **volume to value**.
- Created by **improving the quality of care and/or reducing the cost** of care.
- It involves rewarding providers and **sharing risk for providing** high quality, **coordinated care at the population level**.
- There are **six aligned key domains of healthcare quality** that can be influenced by ID.
- The following five initial value-based programs were created to initiate value-based contracting:
  - End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
  - Hospital Value-Based Purchasing (VBP) Program
  - Hospital Readmissions Reduction Program (HRRP)
  - Value Modifier (VM) Program (also called the Physician Value-Based Modifier [PVBM])
  - Hospital-Acquired Condition (HAC) Reduction Program



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NATIONALLY, MOST HEALTHCARE ORGANIZATIONS RECOGNIZE THE ROLE OF ID AS A FUNDAMENTAL ENABLER OF POPULATION HEALTH.

Access Constraints

Physician Workforce Shortage

Reimbursement Tied to Covered Lives

Evolving Practice Preferences

Team-Based Care Models

Aging Populations

"There's various studies that have been published that say if patients with an infection in a hospital are **treated by a specialist**, *infectious diseases, that they have* **much better outcomes**. *The cure is better, the length of stay is less, the cost is much less, readmission rate is less and mortality is less."*

— Thomas File Jr., MD, former President of IDSA

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Value-Based Contracting Approaches

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

CMS instituted MACRA to bring new incentive programs that use value-based payment models to provide high-quality and cost-efficient care.

Merit-based Incentive Payment System (MIPS): This is one of the incentive programs under MACRA that determines Medicare payment adjustments based on a composite of four performance scores that improve quality, interoperability, and cost.

- ***ID efforts to improve care coordination lead to immediate ROI in population health.***
- ***Capitalizing on infection protocols can reduce HAI and readmission rates.***
- ***Efforts directly drive the success of value-based contracting arrangements.***
- ***Existing measures within the 2021 MIPS in which ID physician activities can be attributable include the following*:**
  - Preventive care and screening: influenza
  - Documentation of current medications in the health record
  - Pneumococcal vaccination status for older adults
  - HIV/AIDS: sexually transmitted disease screening for chlamydia, gonorrhea, and syphilis
  - HIV viral load suppression
  - HIV medical visit frequency

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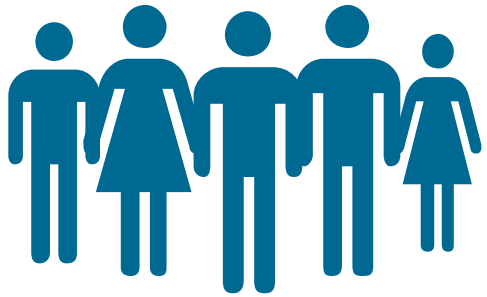
GROUP AND INDIVIDUAL COMPENSATION

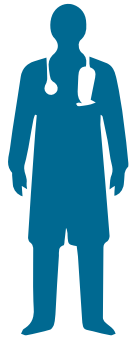
When differentiating compensation, key design concepts include group versus individual units of measure and the definition of mechanisms that should create variation in compensation.

Group Performance



- It is important to recognize team-based care approaches and subspecialization.
- Mitigates internal competition.
- Creates positive peer pressure.
- May be applied to both volume- and value-based incentives.

Individual Performance



- It is important to align compensation with individual efforts.
- Recognizes individual contributions and emphasizes personal control.
- Mitigates the “free rider” effect.

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QUALITY-TO-VALUE SPECTRUM

On the left are introductory quality measures and on the right are more complex population health measures. The adoption of quality- and/or value-based metrics is generally dependent on the convergence of organizational and/or payer appetite for contributing funding to a compensation or reimbursement program.

Quality Measures Continuum of Complexity

Patient satisfaction	HAI rate reduction	Engagement and follow-up with new Medicaid patients	Population health management
Infection reporting and protocols	Readmission rates	Methicillin-resistant Staphylococcus aureus (MRSA) measures set	Infection management
Referring provider satisfaction	Documentation improvement	72-hour review of antibiotic therapy for sepsis	Comanagement opportunities
Vaccination status confirmation	Communication of test results in a timely manner	Appropriate use of anti-MRSA antibiotics	Cross-specialty participation in team-based care or bundled payment programs
Drug allergy management and documentation	Medical visit frequency	Guideline-recommended treatment of C. diff infection	Reduction in HAIs coupled with cross-organizational protocols on infection management

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INCORPORATING VALUE-BASED CONTRACTS INTO COMPENSATION

Identification and Engagement of Decision-Makers for Value-Based Contracts

- Identify relevant decision-makers who should be involved in negotiating and implementing value-based contracting.
- **Example:** An ID physician can align with a chief medical officer and chief operating officer regarding value-based contract performance and associated compensation.

Impact to Other Specialties

- Awareness of the potential value-based contracts that are active among other specialties and mitigate direct competition for funding.
- **Example:** Partner with orthopedics, and prevent and treat prosthetic joint infections.

Best Practices

- Demonstrate a high performance in value-based arrangements by articulating clearly defined measures that meaningfully impact institutional performance.
- **Example:** Consider negotiating for the management of outbreak responses (e.g., COVID-19), which would include the early identification and control of an outbreak within a hospital.

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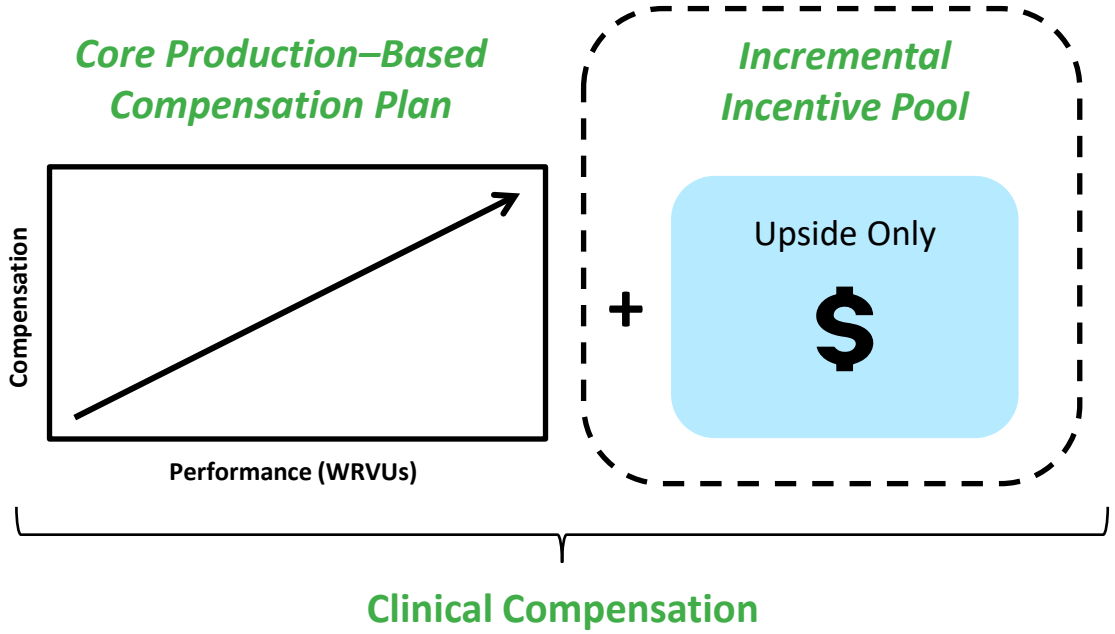
MARKET TRENDS: EMPHASIS ON VALUE-BASED COMPENSATION

A common innovation for compensation is to introduce an incentive pool and make distributions available to physicians based on their performance in risk contracts.



- In this approach, the existing core compensation plan remains intact.
- However, physicians have access to an incentive pool.
  - The incentive pool represents incremental funding.
  - The size of the incentive pool is based on performance in risk contracts.
- The distribution of incentive funds to physicians is often based on:
  - Predefined metrics (either by organizations or by payers).
  - The number of risk-contract patients in each physician panel.
- This approach is an ***upside-only*** reward to physicians.

This is the most common approach because it minimizes change, and its upside-only nature is appealing to most physicians.

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APPROACHES FOR INCENTING ID-SPECIFIC MEASURES

The first approach requires the identification and development of ID-specific measures.

Development of ID-Specific Measures

- To date, there are no broadly applicable value-based programs designed specifically to capture the value of ID physician activities.
- Developing measures may be possible for rare diseases or for care that is managed only by ID physicians.

Areas of Opportunity

- Outpatient parenteral antibiotic therapy
- HIV
- Medication allergies
- Others?

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APPROACHES FOR INCENTING ID-SPECIFIC MEASURES

The second approach is oriented around pre-existing institutional quality and outcomes measures.

Institutional or Group Measures

- Several quality metrics and outcomes measures for which ID physician involvement tends to improve outcomes (examples: CAUTI, CLABSI, sepsis, C. difficile).
- Challenge is convincing hospital/health system leaders that ID attribution to these measures is real and that improvement in these measures adds value to the institution.

Quality Reporting Programs Relevant to ID

Steward	Level of Measurement	Number of Programs
CMS	Clinician	2
CMS	Hospital	7
The Joint Commission	Hospital	2
BCBS of North Carolina	Hospital	1
United Healthcare	Facility	1

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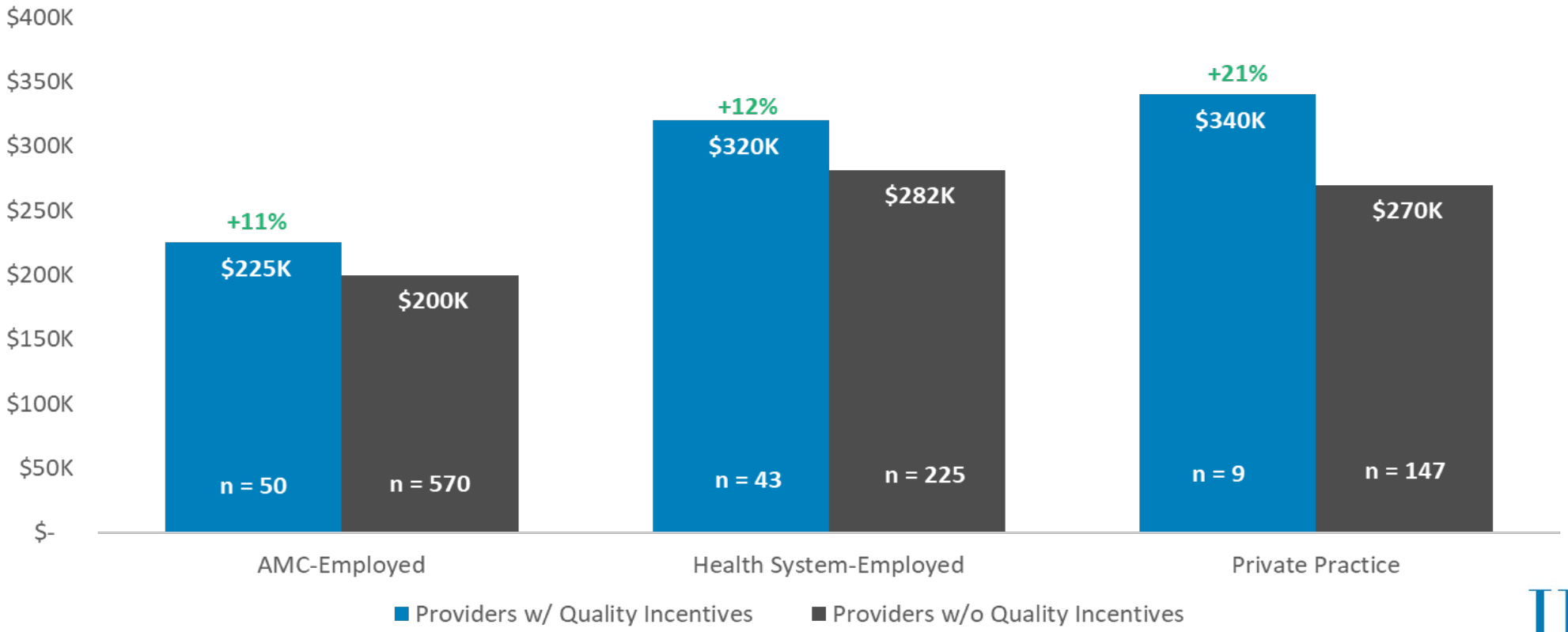
COMPENSATION FOR QUALITY METRICS IN ID

Based on IDSA survey data, we know that ID physicians with a component of compensation tied to their performance in quality metrics earn between 11% and 21% more than ID physicians without any compensation tied to their performance in quality.



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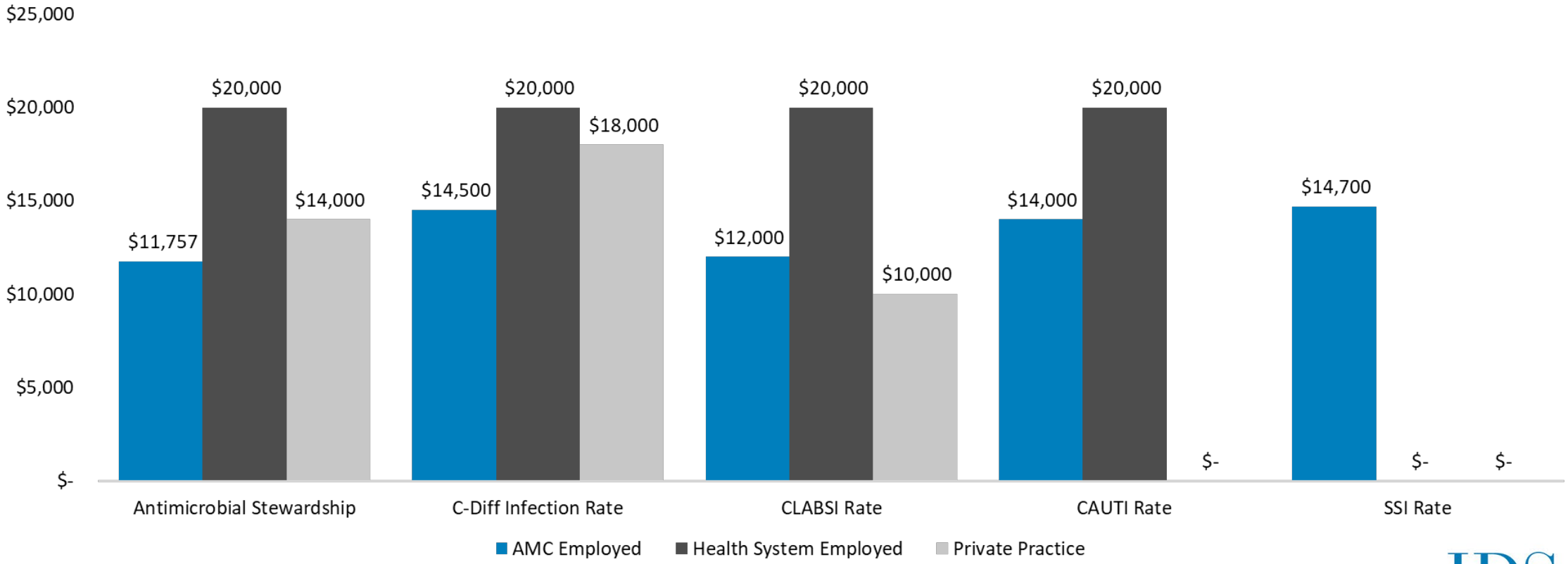
INCREMENTAL QUALITY INCENTIVES EARNED

Depending on the incentive metric and employment setting, ID physicians with a component of compensation tied to their performance in quality metrics tend to earn between $10,000 and $20,000 for meeting or exceeding their targets.



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Negotiation Approaches & Challenges to Implementation

TRANSITION FROM QUALITY TO VALUE

For all physicians, including ID physicians, to thrive in a value-based contract or quality-based compensation incentive, it is important to consider the market in which they operate and the services they provide.

Practice

- Scope of ID services
  - **Comprehensive**: Physician or practice is responsible for all ID-related activities, clinical and administrative.
  - **Individual (not all) ID Services**: Infection control, antimicrobial stewardship, COVID-19/special pathogens, many others.

Market

- Number of beds
- Population within the service area
- Local geography
- Competitors

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QUALITY-TO-VALUE SPECTRUM

Academic medical centers and physicians employed by AMCs tend to gravitate toward metrics with a moderate level of complexity and adoption.

Quality Measures Continuum of Complexity

Patient satisfaction	HAI rate reduction	Engagement and follow-up with new Medicaid patients	Population health management
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PATHWAYS FOR NEGOTIATION

- Understanding of varied payment models to consider for adoption
- Appropriate measurement and transition phase of metrics (i.e. establish trust in the data)
- Impact on collaboration with other specialties
- Identification of the environmental factors impacting adoption of value-based models
- Evaluation of current payer contracts and appetite for at risk measures

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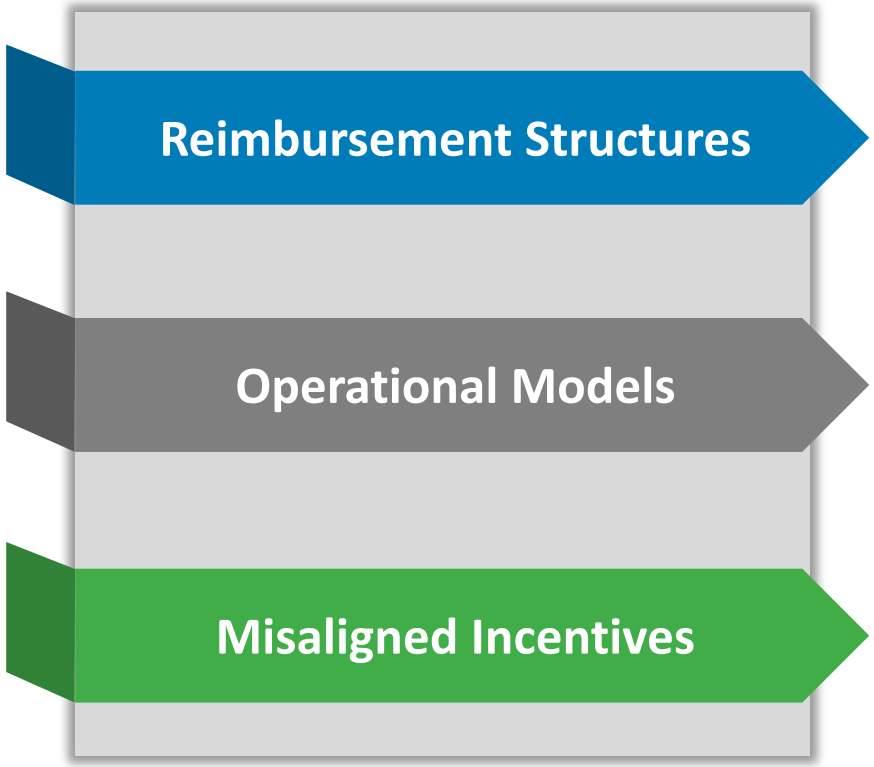
CHALLENGES IN CHANGING STRUCTURAL AND OPERATIONAL BARRIERS

Medical groups have done a superb job in structuring their operations and compensation models to emphasize WRVU production and align with reimbursement contracts.



- FFS reimbursement to reward providers
- Disconnection between WRVUs and care coordination

- Patient effectiveness through coordinated care teams
- Incompatible with a value-based care environment

- Providers are often rewarded in the same way as other specialties.
- WRVUs are used as the predominant measure of work effort.

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Closing

Questions & Discussion

Thank You

To learn more about IDSA's Physician Compensation Initiative, please visit www.idsociety.org/compensation