Survey of Risk-Based Contracting and Physician Compensation in Organized Delivery Systems

Conducted by
Brandeis University, Heller School of Social Policy and Management
Council of Accountable Physician Practices
Participating CAPP Groups – Summer/Fall 2011

Atrius Health
Austin Regional Clinic
Billings Clinic
Dean Health System
The Everett Clinic
Fallon Clinic
Geisinger Health System

Group Health Physicians
Health Care Partners
HealthPartners Medical Group
Henry Ford Medical Group
Intermountain Medical Group
Kaiser Permanente Medical Group
Marshfield Clinic

Mayo Clinic
Oschner Health System
Palo Alto Medical Foundation
Scott & White Healthcare
Sharp Rees-Stealy Med Group
Virginia Mason Medical Group
Wenatchee Valley Med Center
Health System Characteristics:
Number and Type of Clinicians

Note: Kaiser-Permanente Group not pictured (n=15,000+)
Health System Characteristics:
Clinician Mix

Ratio of PCPs to All Physicians

Ratio of NP/PAs to Primary Care Physicians
Types of Contracts

**Frequency of Contracts: Number of CAPP Groups (out of 21)**

- Fee-for-Service: 18
- FFS with Pay-for-Performance: 5
- Episode Payments: 1
- Shared Savings: 4
- Shared Risk: 3
- Partial Capitation: 5
- Global Capitation: 10
- Other Revenue: 2

**Average Size of Contracts as a Percent of Total Patient Revenue**

- Fee-For-Service, 53.9%
- FFS from affiliated health plan, 7.8%
- FFS with P4P, 3.2%
- Global Capitation, 24.6%
- Shared Risk, 3.0%
- Shared Savings, 1.7%

Calculated as a simple (unweighted) average (n= 21).
2010 Patient Revenue by Contract Type

FFS-based

Risk-based

FFS  Affiliated Health Plan  Risk
Organization and Market Characteristics

Facility Ownership

- Hospital: 45% Risk Groups, 80% FFS Groups
- Skilled Nursing Facility: 36% Risk Groups, 50% FFS Groups
- Ambulatory Surgical Center: 64% Risk Groups, 80% FFS Groups
- Health Plan: 73% Risk Groups, 40% FFS Groups

State HMO Penetration 2010

Percent Risk

Risk Groups
FFS Groups
2010 PCP Compensation Method

FFS-based

Risk-based

Production  Salary  Performance  Other
Risk Contracting and Primary Care Physician Compensation

PCP Compensation, Percent Production vs. Percent of Group’s Contracts at Risk
Medical Group Data Management

Percent of Groups Reporting “Fully Implemented”

- Shared electronic health record
- Results management
- Data warehouse & analytic software
- Patient disease registries
- Physician and patient reminders
- Practice-based variation analysis

Risk-Based (N=11) vs FFS - Based (N=10)
Medical Group Patient Management

Percent of Groups Reporting They are “Far Along”

- Reduce avoidable admissions & readmissions
- Reduce network leakage
- Establish preferred relationships with efficient hospitals & specialists
- Mgmt. Programs for high-risk patients
- Patient engagement initiatives

Risk-Based (N=11)  FFS - Based (N=10)
Future Predictions

In a survey addendum (n=15):
- 11 groups were seeking new risk contracts: 6 risk-based, 5 FFS-based
- 3 others were actively preparing for new contracts

- FFS groups predict a more rapid decline in FFS payments (-26%), replaced primarily by shared savings (+14%)

- More than half (56%) predict they will change physician compensation structures in the next two years
What are the largest challenges to increasing your revenue from alternative payment contracts? (n=14)

- Need to improve care management capabilities
  - Very Important: 57%
  - Somewhat Important: 43%

- Need to improve data management and information systems
  - Very Important: 43%
  - Somewhat Important: 50%

- Large local PPO market not appropriate for risk contracting
  - Very Important: 29%
  - Somewhat Important: 43%

- Payer willingness to offer risk contracts
  - Very Important: 36%
  - Somewhat Important: 21%

- Physician and staff resistance
  - Very Important: 29%
Implications

○ “Many large medical groups will need to acquire new skills and tools to be ready for payment reform”, *Health Affairs* Sept 2012
  ● Developing and implementing information systems that track performance
  ● Aligning physician-level reward systems
  ● Fostering physician leadership
  ● Supporting continuous performance improvement

○ Recognize the difficulties, cost, and time to implement these changes nationally
  ● Smaller groups lack the culture/history of managed care
  ● Many areas lack the insurance partners (and their data) to gain experience with alternative contracts

○ What state and federal policies are needed to support this transition?
○ What further research will help groups and policymakers?