EL RIO HEALTH

Quality & Productivity Incentives for Clinical Staff

About Us

History

1970- Opened in October

- Serving patients as El Rio Santa Cruz Neighborhood Health Center

1971- A Federally Qualified Health Center

- Organization that receives a grant under section 330 of the Public Health Service.

1974- A Non-for-Profit

- Managed by a Community Board of Directors – CEO/Executive Director and Senior Staff.

A Nationally Recognized Organization

2010- Joint Commission

- El Rio was accredited for both Clinical and Diagnostic Laboratory Services

2010- National Committee for Quality Assurance (NCQA)

- El Rio was granted a Level-3 Patient Centered Medical Home (PCMH)

2015-2019- Healthcare Equality Index (HEI)

- El Rio was recognized as (Gold Status) leaders in LGBTQ Healthcare Equality Index- 100% score for 3 years

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What Do We Really Want?

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Beware of False Prophets

- Medicaid PPS
- Value Based Payments
- Alternative Payment Models
- Accountable Care Organizations
- Bundled Payments
- Comprehensive Payment for Primary Care
- CMMI Innovations

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Sylvia Burwell Secretary of HHS (2014- 2017)

"90% of traditional Medicare payments transformed into value-based reimbursement by 2018."

Future of Value-Based Payment: A Road Map to 2030

(Penn LDI 2/2021)

Table 2. Share of Payments Made, by Payer and Payment Category (2018)

	Fee-for-service, not linked to quality or value	Fee-for-service, linked to quality or value	APMs built on fee-for-service architecture	APMs using population-based payment
Overall	39.1%	25.1%	30.7%	5.1%
Medicare	10.2%	48.9%	36.5%	4.4%
Medicare Advantage	39.5%	6.9%	36.4%	17.2%
Medicaid	66.1%	10.6%	17.4%	5.9%
Commercial	55.7%	14.2%	27.6%	2.5%

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Present Truths

- Encounters have been trending down in recent years as RVUs have been increasing (El Rio & national trend)
- Quality Measures becoming an increasingly larger component of revenue
- Majority of El Rio revenue is still driven by Encounters

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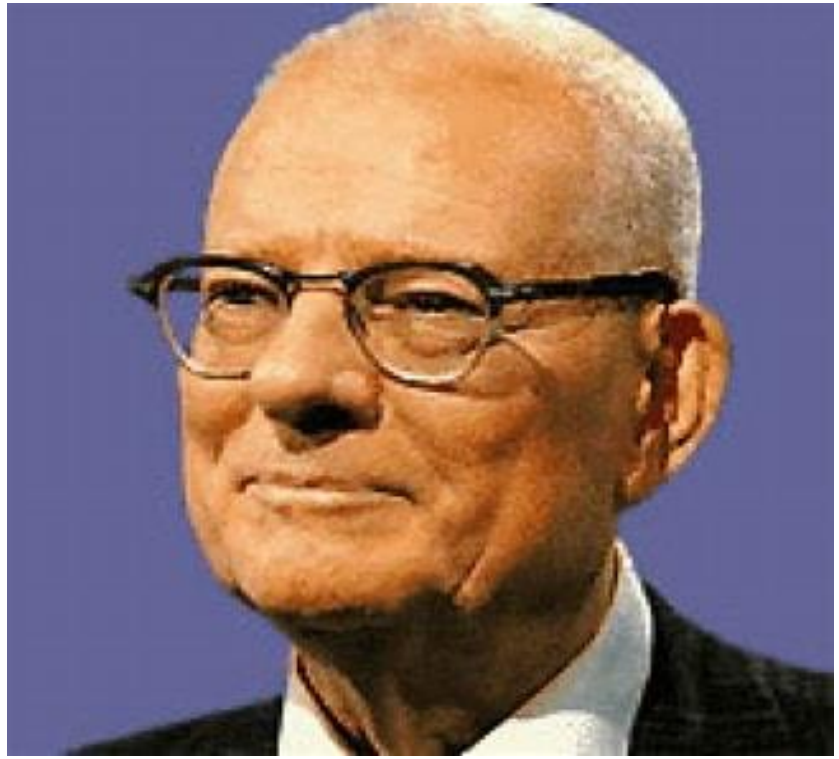
W. Edwards Deming
1900-1993



- "It is not necessary to change. Survival is not mandatory."
- "A bad system will beat a good person every time."
- *"Every system is perfectly designed to get the results it gets"*

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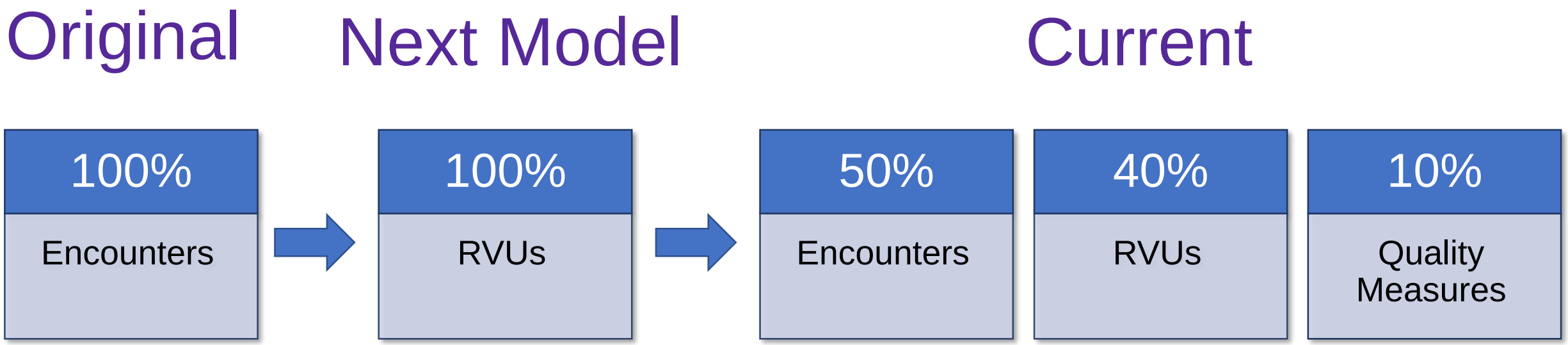
Historical Journey



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Lessons of Our Current Situation

- Attribution is a killer
- Exceptions lurk around every corner
- Vetting data is critical
- Complicated systems consume large administrative resources
- Have not really incentivized much/ needle not moving
- Perfectly designed to annoy clinicians
- KISS

Financial Elements of Our Incentive Plan

- Encounters Bonus Program:
  - All providers are eligible for the “Encounters Bonus Program” which will be based on a provider’s increase in annual encounters versus the previous calendar year.
  - This program is separate and in addition to the quarterly incentive program. The bonus program is adjusted for change in sessions and/or full time equivalent from one year to the next. To be eligible providers must have completed one full year of qualified baseline productivity.

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Financial Elements of Our Incentive Plan

- Encounters Bonus Program:
  - Bonus amounts are:
    - Increase of 1-199 encounters will pay: $10 per encounter
    - Increase of 200-299 encounters will pay: $20 per encounter
    - Increase of 300-399 encounters will pay: $30 per encounter
    - Increase of 400+ encounters will pay: $40 per encounter
  - Payment is made in one lump sum on or before March 31st of the following year.

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Financial Elements of Our Incentive Plan

- Productivity Incentive Pay:
  - El Rio Health uses productivity incentive pay for those physicians surpassing the baselines for encounters, RVUs and quality measures.
  - Payments are given quarterly based on data from the rolling 12-month period.
  - Payments are made within 60 days of the end of the previous quarter.
  - Productivity is reported in a way that is fully transparent, easily understood, and corresponding to the period reported (for example, the October report will be for encounters from October 1-31).

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Financial Elements of Our Incentive Plan

- Productivity Incentive Pay (Physician Example):

Productivity Incentive weightings have changed yearly:

2021	2022	2023
40% Encounters	50% Encounters	50% Encounters
50% RVUs	40% RVUs	40% RVUs
10% Quality Measures	10% Quality Measures	10% Quality Measures

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Financial Elements of Our Incentive Plan

- Productivity Incentive Pay (Physician Example):

Encounter Baselines to be reached prior to productivity incentive pay:

2021	2022	2023
2,400	2,500	2,600

- For physicians who reach these encounter baselines, the dollar value per encounter will continue to be $65.65.

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Financial Elements of Our Incentive Plan

- Productivity Incentive Pay (Physician Example):

RVU Baselines to be reached prior to productivity incentive pay:

2021	2022	2023
3,059	3,192	3,331

- For physicians who reach their RVU baseline, the dollar value per RVU will continue to be $44.

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Financial Elements of Our Incentive Plan

- Productivity Incentive Pay (Physician Example):
  - Incentive Caps:
    - There are no cap for productivity incentive pay for encounters or RVUs.
    - The Quality Measures cap is standardized for all primary care physicians to $10,000 (i.e., $100,000 cap * 10% weighting) and be proportionally prorated for those physicians working less than 32 clinical hours per week.

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Financial Elements of Our Incentive Plan

- Providers not on a defined incentive program can qualify for the greater of the annual key results incentive or any amounts earned through the supplemental productivity incentive programs (e.g. encounters bonus program).
- Addendum contracts for teaching hours are created for core faculty and associate core faculty on an annual basis, with any RVU/encounters from resident work also credited to core/associate faculty.
- Currently, the use of scribes incurs an extra appointment slot per session and an RVU adjustment to incentives to keep the cost budget neutral.

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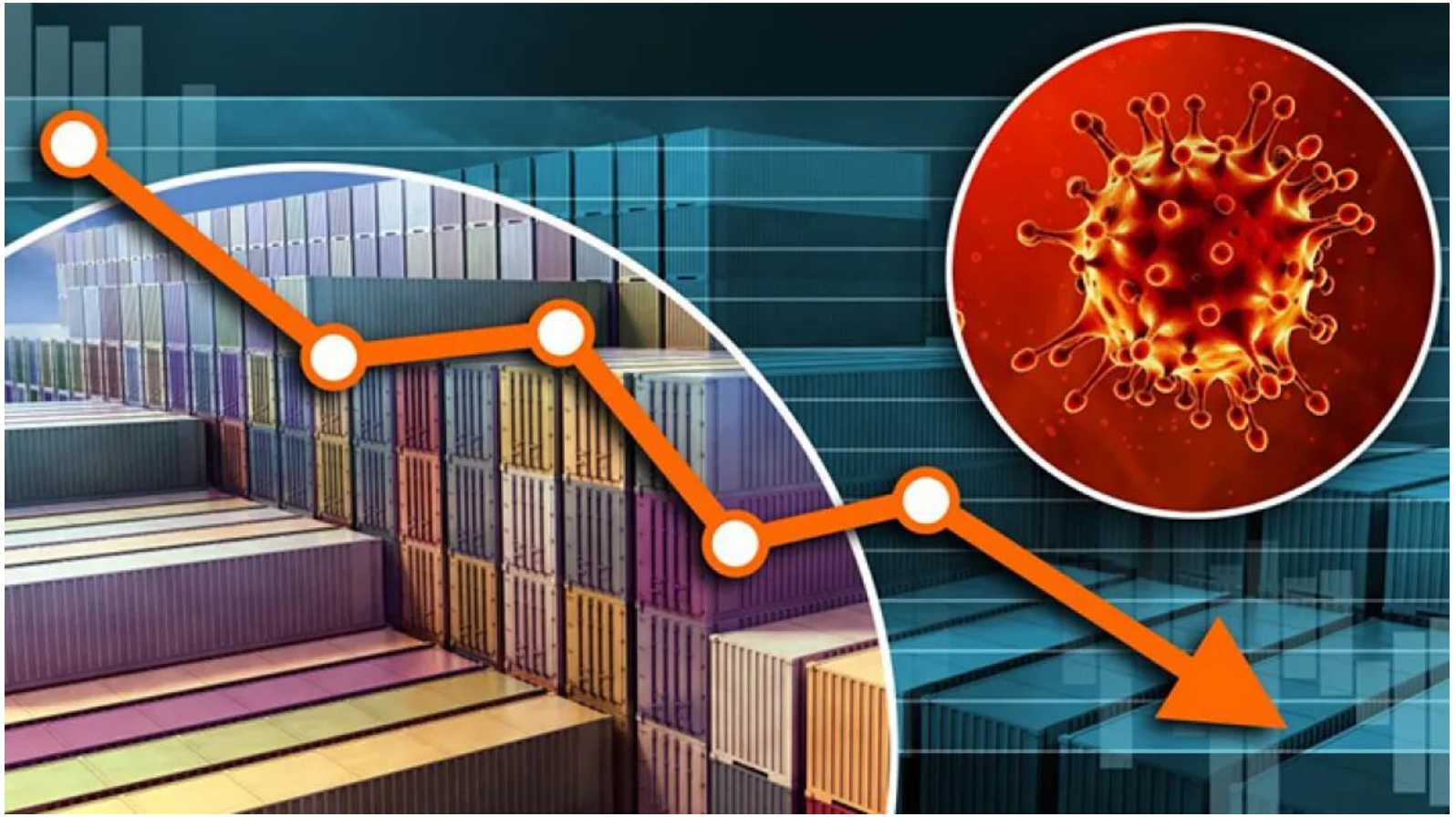
The COVID (and Epic) Disruption



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Have Incentives Moved The Needle

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Where Do We Go From Here

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What Challenges Exist

- Most revenue is still tied to encounters
- Complex systems are difficult to administer
- Should incentives models be the same for everyone, or should there be some variability for factors like productivity, tenure, base salary differences, or other factors?

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Best Practices

- The 2022 MGMA Practice Operations Survey found that health systems see approximately $31,000 in value-based revenue per FTE physician
- While still small, we need to build quality systems, incentive systems, and overall compensation models that move our organizations and clinicians in this direction

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Thank You

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