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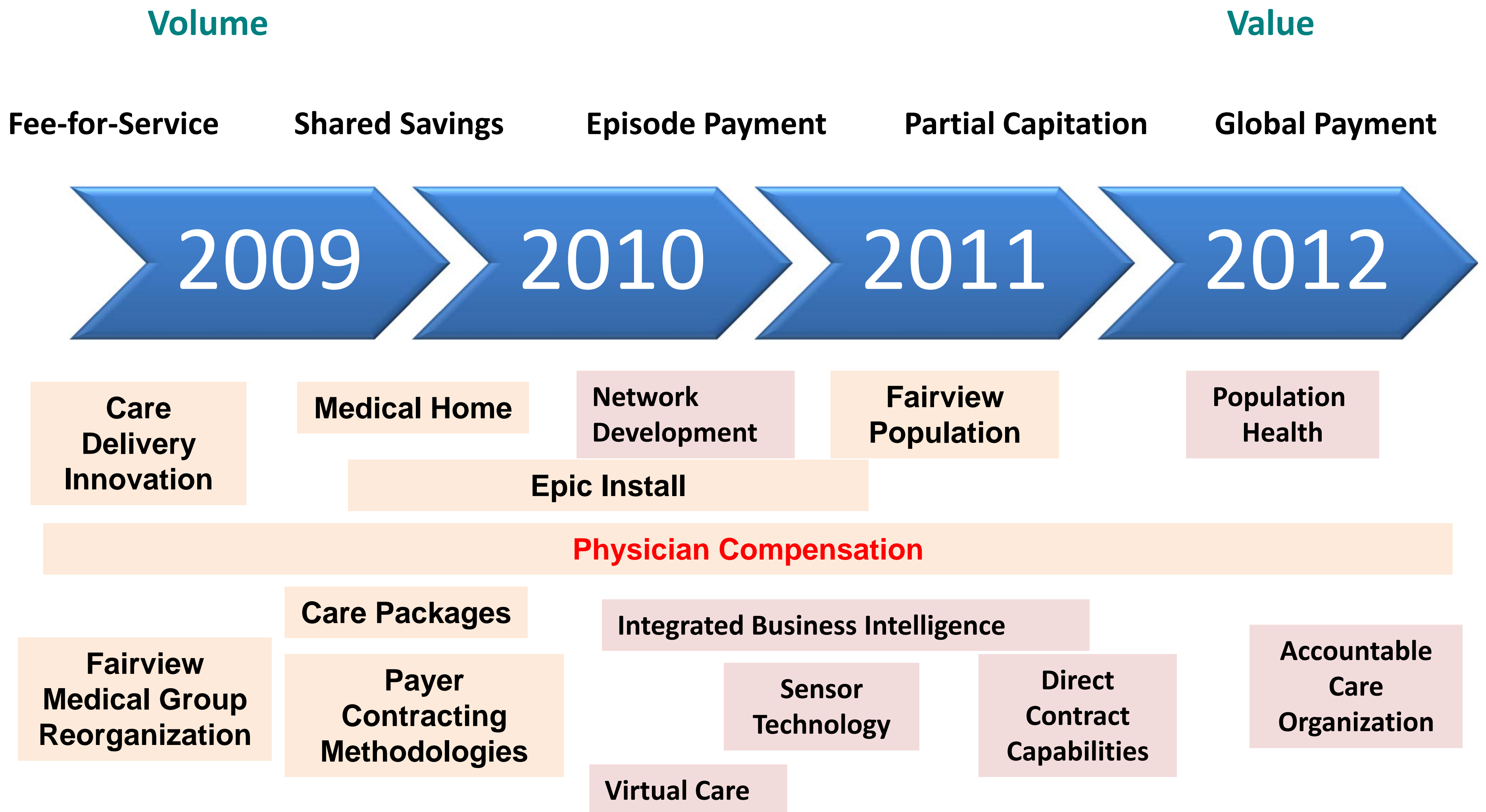
Fairview Medical Group

Minneapolis, Minnesota

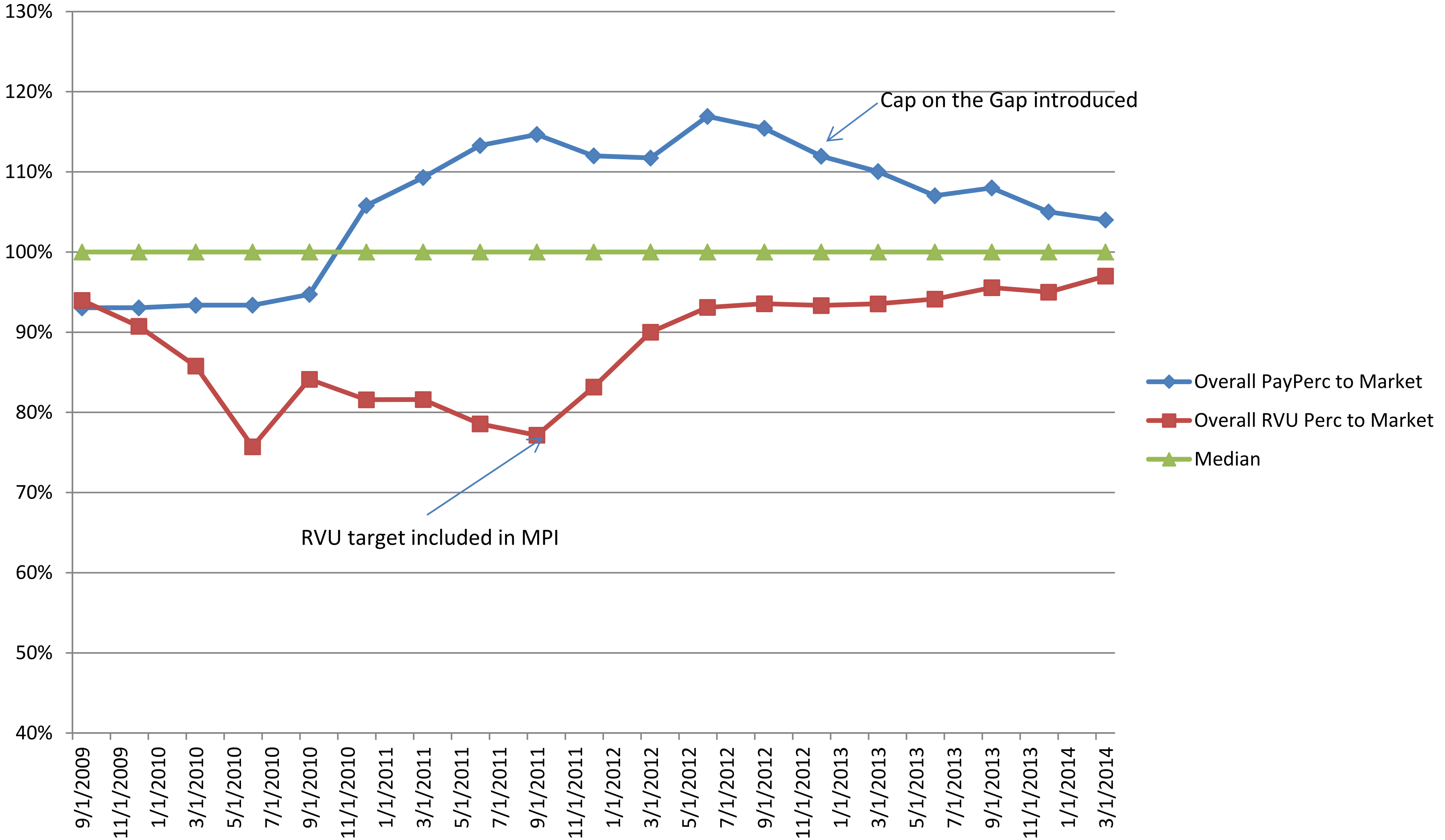
Timeline –Building Capabilities and Capacity



Rewarding for Outcomes: Elements of CMI Compensation 2010-14

Performance Measures	Payout Percent	Outcomes based on	Measures based on	Payout Range
Quality	40%	Team	External benchmarks	0% to 150%
Patient Experience	10%	Team	External benchmark	0% to 150%
Citizenship	5%	Individual		0% to 200%
Productivity •AAPS •Clinical Activities	45%	Team – 10% Individual - 35%	Internal benchmarks	50% to 150%

Pay to Market vs.
RVU Production to Market
September 2009 through March 2014
(includes only providers not on guarantee)



Evaluation Highlights

- Quality metrics improved in the first two years of the compensation model, and narrowed the variation in performance across PCPs
  - The magnitude of improvement was not related to the size of the financial incentives, which differed by metric

- The largest predictor of which PCPs improved on quality metrics was low baseline quality metrics
  - Since PCPs with low baseline performance disproportionately treated lower income patients, their quality increases resulted in a narrowing of gap in quality between those treating highest and lowest income patients

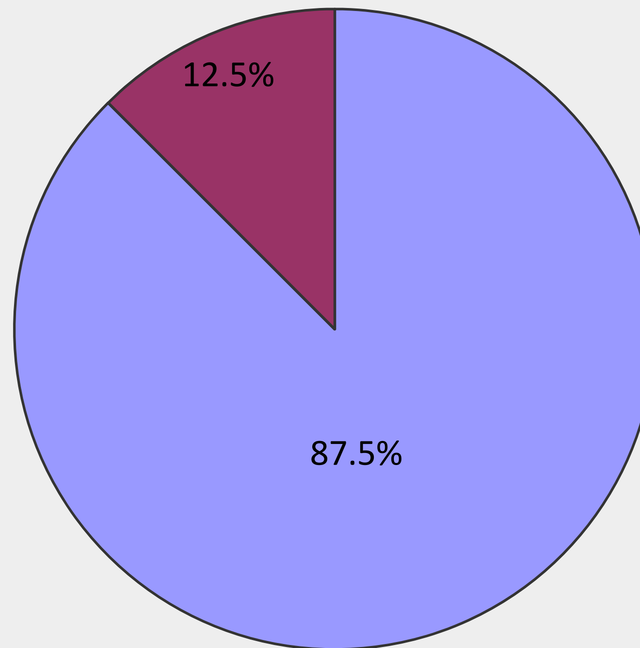
The evaluation was led by Jessica Greene and Judy Hibbard, and funded by The Commonwealth Fund

Evaluation Highlights

- Most PCPs reported using a number of approaches to improve quality of care, including ensuring patients were up to date on metrics when unrelated to the visit
  - Few viewed supporting patients self management and activation as a productive way to improve quality
- PCPs reported pros and cons of incentivizing performance at the clinic-level
  - Their overwhelming preference was a mix of individual and clinic-level incentives to maintain collaboration but to recognize individual performance
- Productivity dropped as quality improved
  - PCPs reported that quality takes more time and without an incentive they were less inclined to squeeze in extra patients
- PCP satisfaction also dropped

Should the current compensation plan be fundamentally changed?

Responses from Primary Care Compensation Committee and Dyad Leads (total n = 30)



Yes No

The following metrics are being considered as part of the compensation plan. Rate their importance as part of the compensation plan.

Answer Options	Do not include	Low importance	Medium importance	High importance
RVUs	0%	4%	16%	**80%**
Individual quality	0%	13%	**54%**	33%
Team quality	4%	16%	**52%**	28%
Individual patient satisfaction	4%	32%	**36%**	28%
Team patient satisfaction	16%	36%	**40%**	8%
Individual panel size	8%	28%	24%	**40%**
Team panel size	20%	32%	**36%**	12%
Total Cost of Care	28%	**36%**	32%	4%
FMG EBIDA	**57%**	22%	17%	4%
Citizenship	17%	**42%**	**42%**	0%

Survey of all FMG primary Care providers summer 2013

Did we change?

- Yes, beginning this month---
- Primary care comp is based 90% on individual productivity and 10% acuity adjusted panel
- Everyone pays in a ‘7.5%’ contribution portion for overhead (which is fully refunded + for people at median productivity and beyond)
- Ability to earn up to 15% above base comp for quality (individual> team), patient experience (individual) and citizenship

A few policy ideas:

- Tax primary care providers like we do hedge fund owners (~15%)—why am I as a private employer trying to correct an societal issue?

- Consider expanding value based payments from Medicare/Medicaid to using a Value Factor (which could run .9 to 1.15 based on quality/experience and TCOC calculations) to reward those generating high value and discourage those who don’t—then I can reward higher value providers beyond what can be currently generated in FFS payments