Chapter 14: Evolving compensation methodologies for employed physicians in an era of changing clinical practice, reimbursement and health reform

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I. Introduction

In an attempt to achieve the triple aim of lower costs, higher quality and better health, payers, especially the Centers for Medicare and Medicaid Services (CMS), have been introducing additional financial incentives, quality reporting and care coordination approaches into their reimbursement models. While physician employers, whether physicians practices, hospitals or health systems, are still mostly paid based on fee-for-service and capitated risk payer methodologies, increasingly hospital, health system and physician group reimbursement has elements which include:

- financial incentives that tie to achievement of specific quality or performance measures;\(^\text{53}\)
- incentives for managing total cost of care or increased use of generics;
- bundled payments to achieve more cooperation between stakeholders to achieve outcomes;
- global capitation for professional services, institutional services and/or pharmaceuticals;
- a global reimbursement for episodes of care;
- penalties or lower reimbursement for preventable hospitalizations; and
- additional payments to patient-centered medical homes.

This article explores new individual physician compensation models that will enable integrated delivery systems, accountable care organizations (ACOs), and physician practice organizations to better align compensation with these payer incentives. These incentives typically address management of costs associated with a patient or episode of care or provide disincentives for events which result from poor quality. We will discuss changing reimbursement methodologies and care delivery models and suggest ways to modify the prevailing compensation models for employed physicians to create meaningful incentives and alignment suggested by these trends.

The first mover opportunity for physicians is to increase their income from earning financial incentives for their demonstrable quality, outcomes and population and patient health and disease management. All these are attempts to pay for outcomes rather than activity. Each will have levels of risk for physicians depending on whether the parent organization is capable of managing risk, if the risk resides within the confines of the physician practice, or if some or all of the risk is borne by the physician as a withhold.

\(^\text{53}\) An overview of international reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviors and patient outcomes found little conclusive evidence that introducing quality incentives change healthcare professionals' practice.\(^\text{53}\) An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviors outcomes.\(^\text{53}\) Cochrane Database of Systematic Reviews 7. 2011: Web of Knowledge. Web. 31 June 2012.
II. How are most employed physicians currently compensated?

A. Fee-for-service. The physician compensation methodologies adopted by various health systems and group practices in markets dominated by fee-for-service have heretofore prioritized different incentives both as to the nature of the incentive and the specific measurement. These physician compensation systems generally measure physician productivity on an individual or departmental basis and from a fee-for-service standpoint. Payments based on satisfaction of quality measures typically are in addition to the usual fee-for-service payments and do not necessarily focus on cost reduction, and quality-based incentives typically focus on patient encounters and surveys, process measures, not outcomes or population health management. Accordingly, generally 80% to 100% of a physician's compensation, if not a straight fixed salary, is tied to individual "productivity" and the non-financial incentives typically address citizenship, quality, achieving system goals, or program compliance, with little incentive for care co-ordination. See *Appendix one*.

In the rash of physician integration transactions over the past four years, compensation methods have been less about alignment and more about how to get the deal done and to provide security to the physicians in an environment where fee-for-service payment amounts are either flat or declining. In order to make these transactions commercially reasonable, the compensation incentives have been designed to assure a stream of revenue from physician's fee-for-service productivity. This has often been supported by achieving higher reimbursement from transferring group practice ancillaries to outpatient departments of hospitals to support that compensation. Worse yet, the incentives have been structured as a withhold, and physician receipt of 100% of scheduled compensation has been conditioned upon achieving all the redirects or quality measures.

1. **Historic methods for measuring physician productivity.** Most physicians employment agreements measure productivity either from a "top line" perspective by tying physician compensation to that physician's measured fee-for-service production (in capitated environments it might also be expressed as panel size based upon lines of business, quality measures, and coding accuracy) or from a "bottom line" or net margin approach by matching physician allocated revenue to attributed expenses in producing that revenue. Under the top line approach, expense and resource utilization are employer-controlled. In contrast, the "bottom line" approach often allows the physician (or in the context of a physician services agreement the physician group) greater latitude and corresponding accountability for managing operating expenses, revenue cycles, and patient intake practices.

Health systems generally have paid individual physician salaries, many with little incentive for production or outcomes. When productivity incentives or accountability are measured, typically the measurement is top line via work relative value units (wRVUs). These wRVU-based payment systems use personally performed physician services, but may include incident to ancillary or physician extender services (subject to Stark limitations). The objective of this approach is to remove payer mix from the equation and to produce productivity data that hospitals and not-for-profit payers can use for required fair market value appraisals. More enlightened contracts extracted a higher fee-for-service multiple if contracted providers controlled the overall cost of care more efficiently.

Health system compensation often supplements productivity measures with bonuses/witholds for meeting quality metrics, patient satisfaction scores, participation in administrative duties, and chart completion. Generally "citizenship" is expected, but not separately compensated. Finally, there is little uniformity among health systems as to the role of productivity in determining physician compensation as many prefer straight salary arrangements rather than tying physician compensation to unit of service productivity.

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Certain specialties such as hospitalists and pediatrics often use departmental productivity metrics to assure coverage and avoid payer mix anomalies. These can be applied to the group, but many times not to the individual. Incentives can be structured as "bonuses," "floor productivity requirements," or "withholds.” At present, there is little uniformity among health systems as to the role of productivity in determining physician compensation, as many prefer straight salary arrangements rather than tying physician compensation to unit of service productivity.

In contrast, physician groups often look to bottom line methods by crediting physicians with revenues and allocating expenses. Depending on the specific payment methodology, these can be allocated at the physician, office site, or department level. There are three general approaches to measuring productivity: (1) production-only calculated as attributed revenue minus allocated expense; (2) production with sharing of overhead evenly or by an equal percentage; and finally, (3) a portion of reimbursement based upon the physician group's (or a department within the physician group) achieving pre-determined non-financial goals of the health system (implementation of protocols, use of electronic medical records [EMR], patient satisfaction, patient outreach/education, etc). Group practices often carry the "net profit" concepts to ancillary services within the group practice (subject to Stark limitations) by allocating a portion of all of such ancillary margins to offset (or, if negative, to increase) individual physician allocated expenses.

2. Practical challenges of the current fee-for-service model. Compensation based on individual physician services almost inevitably results in a creation of silos and makes it very difficult to implement team-based care initiatives. RVU models do not take into account payer mix, group objectives and outcomes and uneven distribution of payer mix by individual physicians. These approaches also do not hold physicians accountable either for practice expenses or for revenue cycle management through improved realization via timely and complete intake and billing and fewer claim denials and expensive resubmission for missing data. These models also present legal issues in assuring a Stark "group practice" exception with respect to division of ancillary revenue profits or in compensating physicians for "incident to" services based on the employer of the clinician. This is because absent a specific exception under Stark, physicians are prohibited for having a financial interest in entities to which they make referrals of designated health services.

These productivity measures also do not incent behaviors which might produce performance bonuses from governmental or private payers. Now that health systems are facing lower margins, penalties for certain never events, and payers and employers are insisting on accountability for rising per capita expenditures, there are compelling reasons to change. For most practices, the change will be evolutionary and driven by new payer incentives, cost of care by individual physician decisions, and group mandates for quality or meaningful use of electronic health records (EHR).

B. The current state of capitation. Mature groups with capabilities to manage cost, quality, and networks have capitivated with the payer. This allows them more control of their destiny. Capitation at the group level means they are receiving a monthly check based upon number of assigned or attributable lives, age-sex mix and in some cases the illness burden. This is defined as a risk-adjusted factor. This payment is in the form of per member per month (PMPM).

The types of capabilities an organization may need to manage capitation are found in the following departments: legal, contracting, network management, finance, analytic, actuary, claims, and medical management. The above can be complicated, but usually when a group takes risk it is delegated many functions a health plan would otherwise perform. The above departments will allow the organization to carry out the delegated functions and manage quality and cost. Medical management would include discharge planning from the hospitals, complex case management, disease management, concurrent

55 A study conducted in the United States on improvement incentives in relation to measures of high-quality ambulatory care concluded that an inconsistent relationship exists between the two factors. Bishop, Tara F., Federman, Alex D., Ross, Joseph S. "Association between physician quality improvement incentives and ambulatory quality measures." The American Journal of Managed Care 18.4 01 April 2012: 126-34. Web of Knowledge. Web. 31 May 2012.
review in the hospital, managing hospitalists and more. For more information on capitation, see chapter four, Capitation.

Once a contract with the health plan is capitated, the organization has many options to align incentives with its physicians and other health care providers. Assuming the contract capitates services for primary care provider (PCP) and high-volume specialists, the PCP may be paid for the assigned panel of patients on a PMPM basis just like the organization, although individual capitation is very challenging due to the potential lack of adequate panel size and the limitations of current risk-adjustment systems, and should not be undertaken without significant thought and provision for risk mitigation, such as stop-loss insurance with a relatively low attachment point. Again, see chapter four, Capitation, for further information. Other payment types are made using fee-for-service with a bonus, case rates for time periods, a certain payment amount per patient seen for a period of time no matter the services, contact capitation, or case rate based upon an episode of care (certain payment per patient referred through the entire episode of care). For PCPs and specialists, this requires knowledge of the cost of care both by the practitioner and for all referred or prescribed treatments, tests, consults, pharmaceuticals, therapies, and rehabilitation services, as well as patient self-referred health services. Entering into these types of agreements has a great deal of positives, but unless there is good and complete data, knowledge of how to analyze the data, scale, and adequate protection from adverse selection including appropriate risk adjustment and cost effective re-insurance, the financial consequences can be dire. Again, see chapter four, Capitation, for a more detailed discussion.

C. Bonuses. Regardless of the type of base payment, many times there is a bonus based on financial cost projections, but paid based upon quality, service and administrative measures. This assures that there are funds there to pay, while limiting any incentive to shrink, reduce or delay necessary care or necessary but expensive treatment.

III. The current transformation in payment and health care service delivery

A. New payer incentives/expectations generally. To address the challenges of the fee-for-service model and to direct resources towards population health, increased patient access to primary care services, and team-based medicine, a number of new payer incentives/expectations have been introduced and focused on demonstrable improvement in or achievement of:

- programs and methods for patient engagement to improve their health and comply with necessary monitoring and regimens;
- improved care coordination, especially in transitions of care, which reduces cost or prevents readmissions and manage post-discharge medications;
- use of evidence-based medicine;
- cost containment, both as to assigned populations and specific episodes of care;
- population health and disease management programs which reduce hospital admissions and demand for acute interventions;
- improved quality of patient encounters and demonstrable outcomes; and
- avoidance of preventable readmission, in-hospital medication errors, hospital acquired conditions, never events and disease management, National Committee for Quality Assurance (NCQA) recognition and “meaningful use” of electronic health records (EHR).


57 Criteria and standards for each level of NCQA's PCMH recognition are available at: http://www.NCQA.org/tabid/631/default.aspx
These, and other, new payer expectations, and their roles in much-discussed emerging payment and delivery models such as ACOs, bundled payment arrangements, and patient centered medical homes (PCMHs) are extensively discussed in “ACOs, CO-OPs, and other options: A ‘how to’ manual for physicians navigating a post-health reform world 2nd edition.” For ease of comparison a brief comparison of these models is attached as Appendix two.

B. CMS’ development of the Medicare Shared Savings Program and the impact of Medicare Advantage programs

In many respects, Medicare Advantage under a full risk provider agreement through an Independent Practice Association (IPA) or staff model and Medicare Shared Savings Program (MSSP) ACOs share a similar set of incentives—the principal difference being Medicare Advantage's (MA) prospective patient assignment and greater in-network control, versus the ACO’s retrospective patient assignment coupled with unrestricted patient choice in the selection and geographic location of the Medicare provider. The financial risks are greater in MA programs since there is no fee-for-service component equivalent to that paid to ACO participants. Both programs, however, incent improved and increased access to primary care services and care coordination in the transitions of care as core clinical attributes to enable the cost savings and quality benchmarks to be achieved.

Physician groups and health care delivery systems alike will need significant capabilities in order to manage the risk. In addition, each individual physician participating in the arrangement must also realize the utilization patterns, his or her own cost of care and how illness burden can affect the overall cost of care. By understanding these patterns, contracts can be set up that will control cost, improve quality, lower utilization and advantage the practicing physician monetarily.58

C. Private payer and employer-based strategies. Increasingly, private insurers are experimenting with incentives for team-based care, quality or cost containment. In Colorado, for example, a consortium of insurers, self-insured employers, and primary care providers entered into a three-year pilot project in which PCPs were paid both fee-for-service and paid a PMPM fee based upon a commitment to progress to level 3 NCQA Patient-Centered Medical Home (PCMH) recognition. Numerous managed care agreements provide incentives for increased use of generics, quality reporting, reductions in certain costs or treatments, bundled payments for physician and hospital services or even tied to reductions in the projected total cost of care for assigned populations. In addition, insurers have been willing to pay facility fees for certain invasive procedures in physician offices whose surgical suites have been accredited in an attempt to lower costs of care.

We are starting to see payers implementing many initiatives using CMS demos, such as the Physician Group Practice Demonstration as the justification. In many ways, the private sector is trying creative experiments much faster than CMS, by, for example:

- Paying higher fee-for-service payments for practices that have PCMH certification;
- Paying physician practices a care management fee for being a certified PCMH;
- Paying gain sharing opportunities for lowering costs in PCMHs on PPO products;
- Payers buying physician groups—it is not just a hospital game anymore; and
- Payers starting physician group practices, and even independent physician associations.

No matter the strategy, the key elements for physician success are legal knowledge, contracting knowledge, care coordinated work flows in physician offices, and EHR use, preferably in conjunction

with participation in a health insurance exchange (HIE). Physicians should also know their outcomes so that information can be used for financial negotiations with the payers.

**D. Fractionated payment methodologies often create the same challenges as fractionate delivery.** The above-referenced payer initiatives are generally payer and program specific. Accordingly, absent pilots or programs where multiple payers adopt the same payer metrics or markets where a single payer dominates the private insurance market, it may become more difficult to tie physician bonuses and incentives to a particular payer’s incentive. Accordingly, any payer-driven model designed to reduce hospitalizations through better care coordination, use of PCMHs, or by assuring patients greater access to primary care services and specialty consultations will need to represent a significant portion of the physician employer’s revenue or would need to drive market share to that hospital or health system employer to compensate for the reduced admissions and other health care service utilization that these payment methodologies often produce.

**E. New clinical delivery models are driving change**

1. **Team-based care and care management.** Tremendous pressure is being exerted in both public and private sectors to create a health care delivery system that is founded on a team-based approach. Physicians and health care providers that gear their work-flows and personnel to maximize care coordination for their patients will be rewarded. Prioritizing care coordination will require physicians to accept new responsibilities within the care coordination process and many physician practices to: retain care coordinators; create new job descriptions for office staff; and develop the ability to track multiple types of care transitions from various locations and all care ordered for, and specialists used by, the practice’s patient population.

   In addition, connections to your organization’s care coordination team (if viable), or the payer’s care coordination team, is vital in this team-based health care delivery transformation. (For further information regarding care coordination, please see section II.D.2 of chapter nine “Retaining independence while embracing accountability: Care coordination and integration strategies for small physician practices,” which is part of the AMA publication entitled “ACOs, CO-OPs, and other options: A ‘how-to’ manual for physicians navigating a post-health reform world 2nd edition.” This ‘how-to’ manual may be accessed at www.ama-assn.org/go/aco). Such connection would include disease management coordinators, social workers, complex case managers, discharge planners at the hospitals, hospitalists, and care coordinators who can track the universe of transitions that may affect your patients, e.g., not simply transitions from hospital to home, but transitions to and from the hospital emergency department, skilled nursing facility, and long-term care facility, as well as inter-hospital transfers, changes with respect to insurance, changes in residence (e.g., relocation to another state), etc. Connecting the key clinical data sets with the appropriate, coordinated interventions is the key to improving quality and lowering cost. This is why a functioning health information exchange is important. An EHR will help coordinate care in your own office, but the HIE will coordinate care externally. As different reimbursement models emerge that reward administrative function as well as financial and clinical outcomes, this transition will become easier to perform.

2. **Service line co-management and professional service agreements.** An increasing number of hospitals are entering into departmental or service line co-management agreements or using professional service agreements with their physicians. The objective of these agreements is to create significant efficiencies and physician engagement in achieving per unit cost savings through equipment and supplies standardization, and to innovate care delivery to improve patient care quality and efficiency. These agreements typically provide incentives for quality improvements through the development and implementation of clinical care guidelines. Another cost containment objective is achieved through efficiency improvements both as to staff, utilization and coordinated and timely discharge assessments, instructions and post-discharge monitoring, and care coordination. Patient and staff satisfaction are typically measured. Finally, these service line agreements attempt to improve disease management, population health programs, and coordination at the transitions of care. While typically these service line agreements focus on specialists and inpatient quality measures, they can and should be structured to involve primary care physicians in the transition of care and to assure timely access to specialist care both
clinically and as part of patient education and engagement. An example of service line quality metrics for orthopedics is attached as Appendix three.

III. How changes in healthcare delivery and payment will alter the way in which employed physicians are paid, and how you can adapt to those changes

A. Your payment will be based on measurable performance

1. Performance metrics as a foundational element in payment methodology. In this new health care delivery and payment environment, employed physicians’ payment will increasingly depend on physicians’ performance, as measured by a broad spectrum of metrics. Health systems and large physician groups have identified a number of metrics more closely aligned with health reform’s triple aim that are not directly production based in terms of unit of service. These metrics include:

- Patient access via extended hours and appointment availability (effective only if tied to demonstrable reduction in ED use and admits which exceed the higher costs of primary care);
- Panel size generally deployed for providers receiving integrated or fully capitated reimbursement (typically contemplates a commercial/senior mix of 2,000 patients where seniors are weighted 3:1);
- Effective mid-level provider management and supervision since the pressure to coordinate care and have PCPs manage is high, but the numbers of PCPs is low; and
- Disease management (this is best if combined with a case management/care coordination program).

2. Metrics to consider for primary care. With respect to PCPs, payers are experimenting with supplements to fee-for-service compensation by incenting improved patient access to primary care services via supplemental payments. These supplemental payments physician employer to provide PCPs with shift differentials for evening and weekend office hours and help offset the cost of establishing and managing secure email communications with patients as to scheduling, assessment, medical records, reports, follow-through, and monitoring and the lost revenue from such uncompensated patient management services. Others compensate PCPs for the extent of their mid-level provider supervision and panel size, or pass through to the physician some meaningful use and e-prescribe benefits, or reward PCPs for NCQA achievement levels. Finally, other incentives are targeted around the establishment and improvement of disease management programs. Health systems also have tied incentives to participation in and development of community outreach and education programs intended to serve their core missions and expand their market reach for tertiary services while providing needed access to primary care. A number of payers publically offer either incentive-based or value-based programs for physicians or physician groups to adopt and use care guidelines, driving the quality of treatment their patients' receive. Typical quality metrics would include the following pay-for-performance measures: Healthcare Effectiveness Data and Information Set (HEDIS) criteria, coding accuracy, ED rates as an indication of access, readmits rate to acute care facilities, meeting attendance, cost of care, generic usage, EHR adoption, etc.

59 Many health insurers have announced primary care quality incentives, patient healthy lifestyle incentives or ACO incentives. For example, Anthem Blue Cross and Blue Shield has a primary care quality incentive program for primary care providers that includes a combination of chronic disease and preventive measures, both process and outcome based, as well as measures focused on technology and pharmacy utilization. The more detailed description of the program is at: http://www.anthem.com/provider/noapplication/f5/s2/t0/pw_b155821.pdf?refer=ahpprovider&state=me Aetna’s incentive program also consists of incentives that impact its beneficiaries or its user’s health care spending such as premium reductions through participating in programs such as Aetna Healthy Actions Program, See Guidelines. http://www.aetna.com/employer/commMaterials/Roadmap_to_Wellness/incentiveprograms.html United Healthcare is introducing a variety of value-based contracting approaches with greater emphasis on shared risk and accountability for improved outcomes. See also, http://www.uhc.com/live/uhc_com/Assets/Documents/ViewpointACO.pdf. Other care programs can be found at: http://www.uhc.com/physicians/care_programs.htm.
3. Metrics for specialists. For specialists, payers seek to improve care coordination, and may do so by improving timely consults as measured by surveys or specific time frames, or by requiring a minimum number of unallocated scheduling slots. Other initiatives focus on transitions of care, creating expectations and rewards for specialist involvement and communication with respect to timely discharge assessments, approval and communication to PCPs of discharge plans and post-discharge medical reconciliation. To support these initiatives, some physician employers are compensating specialists for improving their timely consults and/or for open scheduling. Through the use of service line co-management services or properly structured gain sharing arrangements, specialists are being rewarded for on-time surgical starts, management of implant and other supply costs, and oversight of pre-admission and post-admission care coordination. Finally, specialists might be provided incentives for participating in improved patient access through medical neighborhoods. Some other metrics include: compliance of preferred drugs, readmits, cost of episode, availability in hospital, meeting attendance, surveys by PCP, and HEDIS-specific scores.

4. Measuring quality. For PCPs, quality metrics generally focus on preventive measures, patient satisfaction, citizen metrics, and system alignment. Examples are summarized in Appendix four. Specialists are increasingly being asked to proactively improve and participate in care coordination. Similarly, metrics are being developed to address post-acute care, medication reconciliation, and discharge planning with the goal of reducing readmissions and of assuring that both PCPs and specialists have real time information regarding discharge, discharge notes and patient medications and post-acute therapies. An example of a payer medical home benchmarking chart is attached as Appendix five and a quality report against NCQA standards is attached as Appendix six.

B. Payment may in large part also depend on the physician employer’s ability to successfully manage financial risk

Many of the organizations that will be employing physicians will receive a substantial amount of their revenue within the context of risk arrangements. For example, more and more such organizations will want to acquire the ability to successfully engage in partial or global capitation arrangements, and a number of private and public initiatives are incentivizing organizations to move in this direction. See, e.g., the CMS Pioneer ACO Program. In those organizations receiving a substantial portion of their fees on a capitated basis, physician compensation will generally include a base salary coupled with bonuses based upon both individual and group achievement via sharing of payer withholds or bonuses. Productivity is generally determined based upon size of panel, office visits or patient encounters. Quality incentives focus on patient satisfaction, waiting times, and specific measures in the capitation agreements, as well as performance as determined by the types of metrics discussed in III.A. above. See, for example, the Blue Cross and Blue Shield of Massachusetts Alternative Quality Contract.

It is very important to remember that in a capitated payment model, physicians are not rewarded for activity per se. Longer visits and administrative focus may actually prove more effective at reducing total healthcare costs, and thus reward the physician more than the traditional 10-15 minute visits. If reimbursement is tied to lowering cost and improving quality, then paying attention to these factors makes fiscal sense.

C. Adapting to changes in employed physician compensation

1. Commonality of all the care models and payment methodologies. Although this chapter has discussed a number changes that will take place with respect to payer-driven care models and payer reimbursement methodologies that will alter the way in which employed physicians are paid, all of these care models and reimbursement methodologies will require the following common capacities and characteristics:

- Contracting;
- Analytics;
- Outcome tracking and reconciliation;
- Physician and/or group accountability; and
Some basis for quality and utilization review.

Where they differ is as to the risk assumed, the openness of the provider network, the degree of patient choice, and the specific financial and quality metrics being employed.

As the future becomes the present, each practice should consider changing to a care coordination model. In so doing, the practice’s physicians can position themselves to anticipate, and take advantage of, changes in employment compensation. The care coordination model has been described previously, but more information can be attained at the NCQA website and further resources concerning care coordination can be accessed on the AMA website. As this transition happens, the practice should institute a disease registry (DR) to track all patients and whether the practice is complying with nationally recognized guidelines for preventive care and treatment of common diseases. All these can be embedded in the practice. The DR and associated review processes will ensure better results and improve compliance. Analytics need to be implemented which will track this and any other metrics that are embedded in the payment system to be sure the practice is properly rewarded for this activity.

2. **Positioning your practice and simplifying complex decisions.** We have found that physicians tend to do better when there are a series of small decisions rather than a large one. A large decision is whether to sell the practice to the local hospital, how to do it, for how much, and what should the employment agreement look like. If you look at what CMS is doing through payments or demonstration projects, several conclusions can be made. CMS is pushing for:

- EHR adoption;
- HIE connection so clinical information is available at the point of service;
- Care coordination;
- Tracking of outcomes and adherence to evidence-based guidelines; and
- Team approach so care is improved through the whole continuum.

This, in turn, will require that a physician be prepared to do all of the following:

- Purchase and implement an EHR, or EHR capability, e.g., cloud computing, after obtaining the appropriate assistance in making the choice and performing the implementation;
- Implement a disease registry and track your outcomes;
- Change the office workflows to maximize care coordination – acquiring a PCMH certification is at least 100 hours of work and $1,000 in fees; and
- Obtain expertise from medical associations, hospitals, and larger physician groups. This would include contracting knowledge so as to leverage your outcomes for more reimbursement.

When the time comes for a big decision, then all the little ones will be done so the practice is prepared and of more value.

D. **Anticipate and prepare for evolving salary agreements**

Changes in existing compensation formulas generally will be driven by the needs of the physician’s employer. Those health systems that currently use fixed-salary models may shift towards productivity models while maintaining quality standards. In contrast, those physician employers with pure productivity models may shift emphasis from productivity towards more team-based care and quality incentives. Still others will blend approaches.

Productivity, however measured (panel size, patient encounters, wRVUs, revenue minus expenses, call availability, office hours etc.), will likely continue to comprise between 85% to 95% of a physician's base compensation. Given the adage that "you are what you measure," physicians should be wary of compensation incentives that are triggered by new metrics which have not historically been tracked and addressed. Best alignment occurs when the process for developing the quality initiatives is led by physicians and the financial implications are introduced after a minimum of a year's operation in which
the measures are tracked. With the introduction of pay-for-performance at the hospital level, it is reasonable to assume that hospitals and health systems will seek to create incentives for the care coordination necessary to reduce readmissions within 30 days of discharge and physician efforts to help prevent "never events" and help achieve nationally recognized quality benchmarks.

The challenge in the pure physician employment context is that physicians lack the clinical control over many of the clinical and other services being performed at the various practice settings outside their offices or other site of their personally performed services. Accordingly, physicians should continue to advocate for professional services agreements and service line co-management agreements where they can more effectively impact the algorithms, care coordination, vendor selection, practice setting, and staff coordination necessary to meaningfully improve patient satisfaction, cost effectiveness and outcomes.

In addition to the above, more evolutionary changes, in those markets where major payers are shifting towards lower fee-for-service in exchange for group performance bonuses under a variety of care coordination, quality or cost effectiveness incentives, physicians can maximize both alignment and compensation by understanding the revenue drivers and identifying those components which they should manage and then share in the value produced.

E. The transparency imperative: what types of compensation information will the individual physician need, both prior, and often subsequent, to entering into an employment relationship?

As already discussed, just as practice revenue will increasingly be based on the practice’s meeting applicable quality measures and successfully managing risk, so to will the employed physician’s compensation depends on the employer’s evaluation of the physician’s quality performance and health care resource utilization. Accordingly, a physician offered an employment opportunity will be incapable of evaluating properly the appropriateness of the applicable compensation formulae or predicting actual payment amounts unless the physician receives accurate and complete information concerning:

- the specific quality and resource utilization metrics or standards that will be used to evaluate the physician’s performance (or better yet, is able to help define those metrics);
- the employer’s overall compensation methodology;
- the data that that methodology will use to determine both ultimate performance results and actual payment amounts; and
- the appraisal methodology being used to set (and perhaps cap) physician income.

Transparency with respect to compensation should also be present over the entire course of employment. In other words, agreements should be structured such that the employer, on an ongoing basis, provides the physician with accurate and complete performance and other financial and quality data to enable the physician to contemporaneously predict payment amounts and make practice adjustments, where necessary, to achieve reasonably expected compensation. Transparency with respect to those listed above will also enable the employed physician on the back end to evaluate the extent to which actual payments received adhere to the compensation formulae specified in the employment agreement. For further information on tracking quality and utilization, see chapter three, Pay-for-performance programs.

Transparency with respect to those listed above is unlikely by itself to produce a complete picture of all the factors that may affect compensation, and that the employed physician will therefore want to know. For example, it will not only be important for the physician to know what metrics the employer will be using to evaluate quality performance, but the physician will also need to know the extent to which those metrics are clinically appropriate for the physician’s specialty and patient population. Again, see chapter three, Pay-for-performance programs for further information. Also, if the employer is involved in a risk arrangement, and if individual physician compensation will be based in part on the physician’s meeting or beating a utilization budgets, then it is imperative that the physician understand whether the employer will adequately risk-adjust the physician’s performance with respect to those budgets. See chapter eight, Risk adjustment, for additional information.
The physician also needs to understand up-front the extent to which the employer will support the physician’s practice via health information technology and other infrastructure essential to: coordinate care internally and externally; manage patients (particularly those with chronic conditions); monitor patient compliance; and educate and otherwise remediate cases of patient noncompliance. In the most successful programs, physicians receive "coaches" who help them transform their practices to enable them to achieve the quality metrics being measured and to obtain the patient engagement and to utilize physician extender resources to maximum advantage.

As previously discussed, compensation can depend significantly on hours worked or wRVU production. In such cases, it may be crucial that the potential employer provide the physician with a reliable estimate concerning the amount of income the physician can expect to receive, given factors such as the employer’s current patient population and patient demand.

For additional information concerning key physician employment issues where transparency is essential, e.g., appeal rights, covenants-not-to-compete, etc., please see the Annotated Model Physician-Group Practice Employment Agreement. For additional information concerning the key issues that must be made transparent for physicians in the hospital employment context, see chapter eight, Hospital physician employment agreements, which is part of the AMA publication entitled “ACOs, CO-OPs, and other options: A ‘how to’ manual for physicians navigating a post-health reform world 2nd edition.”

Although it may appear from this discussion that employer transparency obligations primarily benefit the employed or prospectively employed physician, as opposed to the employer, this is not the case. For many physician practice employers, particularly the small or solo practices in which most of the physicians in the United States still practice, entering into an employment relationship with a physician is a very serious matter that involves a significant commitment of resources and is not without significant risk. Accordingly, once such a practice enters into an employment arrangement, the practice will be heavily invested in the arrangement’s long-term success. Full transparency is key to maximizing the communication, alignment and trust which are essential to both ongoing physician satisfaction and practice transformation.

IV. Final tips

For the most part, healthcare markets are local or regional so there will not be a one-size-fits-all solution to your next agreement.

- Employed physicians and their hospital or health system employers may do better with dedicated administrators and areas of additional clinical responsibility including incident to services and management of ancillary services that enable values physicians the control necessary to be accountable for productivity, quality, patient outcomes and satisfaction.
- Quality incentives and other changing benchmarks or incentives should be developed under a process which is patient-centered and clinically sound, by also physician-led and physician-driven.
- Compensation plans vary significantly as to whether the value of excess wRVUs are recognized at a higher dollar per wRVU level (since fixed overhead is absorbed, as in tiered compensation plans) or at a lower dollar per wRVU (based upon appraiser data suggesting that the higher compensated physicians in the aggregate earn less per wRVU than their lower performing counterparts).
- As physician extenders become the norm, physicians should propose ways to be recognized for the clinical production of those clinicians. Thus, many agreements provide for “mid level provider” eligible wRVUs of nurse practitioners and physician assistants to be included in measuring the productivity of their supervising physician.
- Physicians should be prepared to discuss all compensation elements from quality incentives (Are they aspirational, tiered or reasonably achievable?), stipends/other compensation for selected administrative activities, call coverage and approved non-wRVU generating services (such as independent medical exams and other medical-legal, non-expert witness assessments).
For most hospital and health system employers, even where productivity incentives are in place, most agreements will place aggregate compensation limits on maximum physician compensation. Physicians should understand the basis for these limits, and to the extent they are intended to reflect reasonable market-value, ensure that the current specialty-specific data is accurately reflected.

For a physician who is entering the job market for the first time, or who is not bringing an existing patient base, it will be essential to understand the extent to which the employer will offer an income guarantee while the physician builds his or her practice, and the specific amount and duration of such a guarantee. Such physicians will also need to know what, if any, efforts the employer will take to help the physician develop a patient base, e.g., by advertising.

Many factors will define physician compensation after the initial term and physicians should request:

i. protection against non-market rate renewal offers;

ii. exclusions from an non-compete clause which would force relocation outside of the area;

iii. adequate time from the renewal offer to assess options or address challenges;

iv. governance rights that ensure the employer’s decision making has appropriate physician input;

v. transparency in future appraisals and ability to provide independent data or use of an agreed data set;

vi. adequate capital and administrative resources to support the practice; and

vii. a significant role in recruitment of new physicians to assure a culture that would be patient-centered, collaborative, accountable and clinically effective.

V. Conclusion

As payers move from fee-for-service payment methodologies to methodologies focused on population health, outcomes measures and efficient health care delivery, so should employed physicians expect that the compensation systems used by employers to pay those physicians will also change. While the data are less than clear as to what specific incentives and other changes in physician compensation will produce measurable differences in the achieved quality, patient engagement and cost effectiveness that payers seek, experimentation in physician compensation models and incentives will continue until a general consensus is reached concerning the successful alternatives to, or variations of, the models that were utilized in the traditional fee-for-service payment environment. Increasingly, larger physician organizations and health systems are making their case by publically reporting the "value" they create via nationally recognized benchmarks and internally developed initiatives.60 This presents an opportunity for physicians to gain control over the health care dollars spent in their communities, and to obtain transparency over insurers’ current costs, so that wellness and savings can be achieved other than through continued discounting of physician services and other caps on reimbursement. Hopefully, this chapter will help individual physicians understand the key issues at play as they evaluate, and then attempt to succeed under, employment arrangements utilizing new and evolving compensation methodologies.

60 An example of published quality metrics used for market share development and for payer incentives, covering the entire range of quality, care coordination, inpatient, preventative health, disease management, wellness, and efficiency metrics, see Advocate Physician Partners Value Report: http://www.advocatehealth.com/2012valuereport
Chapter 14 Appendix 1: Incentives embedded in prevailing fee-for-service physician reimbursement models

Until recently, the predominant physician reimbursement models were either fee-for-service or total or partial risk sharing via full or partial capitation or withholds.

**Fee-for-service/DRG reimbursement incentives in the group practice setting**

The traditional fee-for-service model reimbursed physician and outpatient services based upon specific services associated with patient encounters with reimbursement levels set by governmental payers or negotiated with third party payers. For a significant number of physicians, the fee-for-service payment is a percentage of Medicare Reimbursement for the same service. Historically a physician group's profitability was dependent principally upon the volume and reimbursement levels for services performed, the gross margin and utilization rates for ancillaries and diagnostics captured in the group practice setting, and the efficiency of operations from a staffing and facility utilization standpoint. Physician compensation in the group practice setting rewarded "productivity" either based on collections or where payer mix was disregarded, on an RVU basis. Physician efficiency was addressed via specific overhead allocations or credits based upon ancillary margins. While the formulas differed greatly from highly specific cost and revenue allocations to percentage-based formulas, most formulas and methods distributed 100% of profits via an allocation of revenue and expense. Quality was managed via normal payer QA/UR reviews. Thus, the physician compensation generally increased with greater numbers of procedures, office visits and reimbursable activities and increased use of compensable ancillaries. Uncompensated patient directed activities were generally ignored and there was little accountability for utilization or efficiency with respect to inpatient care, third party referrals or pharmaceuticals.

**Fee-for-service reimbursement incentives in the hospital employed or professional service agreement practice settings**

Typically, physician compensation plans sponsored by health systems, whether direct employment or through foundations or professional services agreements, either compensate physicians on a salary plus bonus (often tied to minimum vRVUs) or on a wRVU basis. These agreements may also compensate physicians for documented administrative time and contain other bonuses tied to achieving certain quality or efficiency metrics (either established in advance or mutually developed post integration). Again the incentives are focused on compensable activities of physicians and quality metrics often tie to inpatient initiatives of the health system.
### Chapter 14 Appendix 2: Comparison of payment reform model

<table>
<thead>
<tr>
<th></th>
<th>MSSP Accountable Care Organization</th>
<th>Patient Centered Medical Homes</th>
<th>Bundled Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Triple Aim Strengths</strong></td>
<td>Makes providers accountable for total patient costs and preserves patient choice. Requires transparency and quality reporting.</td>
<td>Supports PCP effort to better manage population health and provide greater resources for patient engagement. Extended hours and management of chronic conditions can avoid expensive ED visits and hospitalizations.</td>
<td>Promotes efficiency and care coordination as to specific episodes. Limits unnecessary re-admits. Requires quality reporting and transparency.</td>
</tr>
<tr>
<td><strong>Triple Aim Weaknesses</strong></td>
<td>Retrospective allocation undermines accountability/requires substantial infrastructure investment, which may have large health systems or insurers driving the organization versus physicians.</td>
<td>Requires significant training and multiple payer buy-in to be meaningful to PCPs and specialists.</td>
<td>Does not address chronic conditions or total cost of care.</td>
</tr>
<tr>
<td><strong>Affect on Primary Care</strong></td>
<td>Provides flexibility and potential source to drive primary care participants to medical home model. No clear source of funding for required infrastructure investment.</td>
<td>Redefines office visits and drives PCPs to team-based care model. Requires use of allied professionals. To be successful must complement fee-for-service with PMPM payments to provide proactive support and expanded access.</td>
<td>Can be structured to compensate PCPs for management of post-discharge medications throughout all transitions of care. Requires a culture of coordination of care and trust to meaningfully affect primary care.</td>
</tr>
<tr>
<td><strong>Rewarding Improved Care Coordination Among Providers</strong></td>
<td>Significant incentive on both quality and cost side for care coordination. May provide safe harbor funding for same. Includes as quality measures EHR infrastructure to facilitate coordination of care.</td>
<td>Yes if combined with medical neighborhood in which patients have more immediate access to specialty consults. Yes if PMPM payments are available to support communication and coordination.</td>
<td>Will drive care coordination for bundled payment programs which cover substantial periods post-discharge. Limited effect as to inpatient-only bundles. Generally will address only a portion of all admitting diagnoses. No incentive to coordinate to avoid inpatient admissions.</td>
</tr>
<tr>
<td><strong>Financial Impact on Volume and More Expensive Interventions</strong></td>
<td><strong>MSSP Accountable Care Organization</strong></td>
<td><strong>Patient Centered Medical Homes</strong></td>
<td><strong>Bundled Payments</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Rewards greater primary care services. Continues fee-for-service to individual providers. Outside providers have no accountability for costs.</td>
<td>Objective is to expand primary care offerings beyond services that are currently reimbursable. In combination with open access scheduling, longer office hours, and patient monitoring and coaching should reduce ED visits and some acute episodes in fragile populations.</td>
<td>Might reduce certain inpatient services and shift volume to lower cost providers or settings post-discharge. No incentive to avoid hospitalization as commences with inpatient admission based on DRG.</td>
<td></td>
</tr>
</tbody>
</table>

| **Quality Incentives** | Requirement for significant quality reporting and financial payments conditioned on exceeding minimum benchmarks. | Absent payer collaboration, difficult to coordinate among payers. No financial accountability but possible material impact on managing total patient cost. | Isolated to the episode with no population health component. Should minimize inpatient infection rates and medication errors and post discharge adverse events. |

| **Required Infrastructure** | Significant for ACOs, especially in EHR, patient engagement processes in quality reporting, and other compliance aspects. | Yes as to EHR, expanded human resources, and physician training and quality reporting. | Common or interoperable EHR would help. Development of care coordination and discharge protocols among providers. |

| **Patient Choice/Ability to Steer** | Unrestricted patient choice/ACOs must demonstrate value of in-network providers. Risk that due to site of injury, location of adult children, or marketing by centers of excellence that higher cost procedures will be performed outside the ACO. | Generally patients will remain with PCMH based on the proactive monitoring and engagement. Use of PMPM should offer greater sense of connection to PCMH and need not be contractually steered. When successful employers may reinforce. | Generally physicians and hospitals can steer patients through the transitions of care—more likely if participants are in a normal referral pattern. |
Chapter 14 Appendix 3: Sample orthopedic service line co-management measures quality

Improvement and reporting on applicable Physician Quality Reporting Initiative Measures

- Venous Thrombosis Complication Rate
- Post operative wound infection rates
- Surgical Care Improvement Project Measures
- Order Entry, Medication Reconciliation, PCP notification
- Patient Satisfaction

CMS Core Measures/Infection Prevention

- Pre-Surgical Antibiotic Administration
- Post-Surgical Discontinuance of Antibiotic

Operational Improvement

- On Time First Case
- Reduced Operating Room Turnover Times
- Inpatient and Outpatient Cost Per Case
- Achieving Operational Budget
- Unallocated Scheduling Slots
Chapter 14 Appendix 4: Prevention management, outcomes and other quality measures

Preventative measures

- Well Child Visits, Adolescents Well Care Visits
- Age, gender and patient appropriate cancer screenings and tests
- Vaccinations
- Cholesterol, blood pressure screenings, LDL-C test, osteoporosis
- Eye (glaucoma) and foot exams
- Completed Health Risk Assessments, Depression Screening

Patient and Population Health Management Measures

- Timely follow-up and recordation of blood pressures, blood sugar, or cholesterol
- Active monitoring of certain drugs for potential side effects
- Coaching and information regarding lifestyle changes
- Conduct of individual or a group coaching
- Medication reconciliations

Objective Outcome/Process/Infrastructure Measures - Improvement on Inpatient Surgical Care Improvement Project (SCIP) and Core Measures

- Eligibility of Patient Quality Reporting System (PQRS) and e-prescribe payments, Electronic Prescription (e-Rx), Electronic Disease/Patient-Registry, use of Anthem Quality Insights Web Portal
- Level of Achievement with respect to NCQA Certifications (for example, with respect to diabetes, a one control and cholesterol control or blood pressure control).
- Attainment of Meaningful Use of EHR

Qualitative Measures - Improvement or minimum levels on

- Patient satisfaction
- Peer reviews
- Staff reviews
- Phone surveys
**Good Citizenship Measures** - Often mandated and only occasionally compensated

- Meeting Attendance
- Risk Management Education
- Community Outreach
- Seniority
- Protocol Development
- Research
- Administrative/Leadership
- Teaching
### Chapter 14 Appendix 5: Clinical measure benchmarking example

<table>
<thead>
<tr>
<th>Clinical Measures</th>
<th>Base Threshold for P4P (80% Target)</th>
<th>Target for P4P</th>
<th>Baseline Denominator Practice</th>
<th>Baseline Numerator Practice</th>
<th>Baseline Rate for Practice</th>
<th>Post Denominator Practice</th>
<th>Post Numerator Practice</th>
<th>Post Rate for Practice</th>
<th>Attainment Score</th>
<th>Improvement Score</th>
<th>Best Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HgA1c &gt; 9 (DM)</td>
<td>18%</td>
<td>15%</td>
<td>294</td>
<td>126</td>
<td>42.9%</td>
<td>347</td>
<td>65</td>
<td>18.7%</td>
<td>0.0</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>2. BP &lt; 130/80 (DM)</td>
<td>20%</td>
<td>25%</td>
<td>294</td>
<td>42</td>
<td>14.3%</td>
<td>347</td>
<td>139</td>
<td>40.1%</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>3. LDL &lt; 100 (DM)</td>
<td>29%</td>
<td>36%</td>
<td>294</td>
<td>101</td>
<td>34.4%</td>
<td>347</td>
<td>172</td>
<td>49.6%</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>4. Tobacco Counseling (DM)</td>
<td>64%</td>
<td>80%</td>
<td>45</td>
<td>23</td>
<td>51.1%</td>
<td>60</td>
<td>58</td>
<td>96.7%</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>5. Depression Screening (DM)</td>
<td>32%</td>
<td>40%</td>
<td>276</td>
<td>162</td>
<td>58.7%</td>
<td>347</td>
<td>285</td>
<td>82.1%</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>6. LDL &lt; 100 (CV) (1/2010)</td>
<td>40%</td>
<td>50%</td>
<td>116</td>
<td>64</td>
<td>55.2%</td>
<td>252</td>
<td>116</td>
<td>46.0%</td>
<td>0.6</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>7. BP &lt; 149/90 (CV) (1/2010)</td>
<td>60%</td>
<td>75%</td>
<td>116</td>
<td>73</td>
<td>62.9%</td>
<td>252</td>
<td>196</td>
<td>77.8%</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>8. Tobacco Counseling (CV)</td>
<td>64%</td>
<td>80%</td>
<td>9</td>
<td>7</td>
<td>77.8%</td>
<td>29</td>
<td>28</td>
<td>96.6%</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>9. Depression Screening (CV)</td>
<td>32%</td>
<td>40%</td>
<td>255</td>
<td>162</td>
<td>63.5%</td>
<td>252</td>
<td>174</td>
<td>69.0%</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total - Actual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total - Possible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Final Bonus Rate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>94%</td>
</tr>
</tbody>
</table>

Cost Measures

Inpatient*

ER Visits*

*Health Plans
Chapter 14 Appendix 6: Sample medical home performance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Feb-12</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count of DM patients greater or equal to age 18</td>
<td>388</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with &gt;=1 A1Cs</td>
<td>56</td>
<td>91</td>
</tr>
<tr>
<td>Pct of DM patients with &gt;=1 LDLs</td>
<td>50</td>
<td>77</td>
</tr>
<tr>
<td>Pct DM pts w/ medical attention for nephropathy</td>
<td>56</td>
<td>81</td>
</tr>
<tr>
<td>Pct of DM patients queried about tobacco use</td>
<td>90</td>
<td>99</td>
</tr>
<tr>
<td>Pct of DM patients aged 40-75 on aspirin</td>
<td>65</td>
<td>56</td>
</tr>
<tr>
<td>Pct of DM patients with latest BP &lt; 130/80</td>
<td>70</td>
<td>36</td>
</tr>
<tr>
<td>Pct DM pts screened for depression</td>
<td>40</td>
<td>55</td>
</tr>
<tr>
<td>Count of DM patients 55-75</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>Count of DM patients with latest LDL &lt;130</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Count of DM patients with SM Goal</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td>Count of DM pts with pneumonia vac.</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Count of DM patients 40+ y/o</td>
<td>384</td>
<td></td>
</tr>
<tr>
<td>Pct of DM patients with latest A1C &gt;9</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Pct of DM patients with latest LDL &lt;100</td>
<td>90</td>
<td>50</td>
</tr>
<tr>
<td>Pct of DM patients with eye exam</td>
<td>80</td>
<td>19</td>
</tr>
<tr>
<td>Pct DM pts w/ smoking cessation counseling</td>
<td>95</td>
<td>99</td>
</tr>
<tr>
<td>Pct of DM pts prescribed a statin</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td>Pct of DM patients with current flu vaccination</td>
<td>75</td>
<td>59</td>
</tr>
<tr>
<td>Pct of DM pts reassessed w/severity scale in 3 mos</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Pct of DM pts w/ABP measurement decreased 50%</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Pct DM patients with latest BP &lt;140/90</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>Pct DM patients with foot exam</td>
<td>52</td>
<td>0</td>
</tr>
<tr>
<td>Pct DM pts 55-75 taking ACE/ARB</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Pct DM patients referred for eye exam</td>
<td>62</td>
<td>0</td>
</tr>
</tbody>
</table>