How Otolaryngologists Are Adjusting to Value-Based Compensation Amid Mixed Success in Primary Care Settings

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The nationwide shift in medicine from productivity-based to value-based compensation (VBC), a payment model becoming more prevalent in otolaryngology, is centered on the quality and outcomes of care rather than the quantity of services.

In 2016, *ENTtoday* covered the initial adjustment to VBC, which aims to improve patient outcomes by incentivizing physicians to deliver high-quality, cost-effective care (2016;12:1). More recently, data from the Centers for Medicare and Medicaid Services (CMS) showed that otolaryngologists receive less compensation for the most common procedures (2023;18:1). In this latest installment, we provide otolaryngologists' insights on the transition to VBC, including the ongoing need for organizational support to address VBC implementation challenges.

Productivity-Based versus Value-based Models

In the traditional productivity-based compensation model, the "production," or work output, is directly linked to compensation. The fee-for-service model is the classic model, and, over

time, many funds flow structures have evolved to a relative value unit (RVU) instead of a pure cash collection method, “but the tight alignment with work effort and compensation has remained,” explained Gregory Farwell, MD, Gabriel Tucker professor and chair of the department of otorhinolaryngology–head and neck surgery at the University of Pennsylvania in Philadelphia.

Meanwhile, “value-based models insert some risk to compensation based on performance against value-inspired metrics,” Dr. Farwell said. “Many of these are quality-based, where compensation would depend in part on how a group or health system performed against a quality metric such as the length of stay or a surgical site infection metric.” He added that other VBC models base compensation on performance against financial benchmarks to reign in healthcare costs.

The productivity-based care model acknowledges that “there are no funds for compensation without the associated work. It incentivizes productivity, which is critical in an era of tightening economic realities. The risk to productivity-based models is the incentive to bill and produce over and above evidence-based standards and to not be able to influence the cost curve in a positive direction,” said Dr. Farwell. The risk to VBC models “is an overall decrease in compensation for the amount of work being done if predetermined metrics are not met. Additionally, there is a theoretical risk to value-based compensation that the priority is on cost containment, which may override the patient’s best interest and the need to continue to innovate and advance care.”

According to Matthew Naunheim, MD, MBA, an assistant professor of otolaryngology–head and neck surgery at Harvard Medical School in Boston, “value-based care has become a fashionable buzzword but remains an elusive goal.” The holistic approach “rewards less easily measurable outcomes such as patient satisfaction, long-term outcomes, and population health.”

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“From a provider perspective, a productivity model is easy to administer and quantify,” Dr. Naunheim said. “The more codes you bill for, the greater the revenue. The metrics to analyze ‘success’ are baked into the existing financial infrastructure. It may also ease access issues, as providers are incentivized to take on more patients. However, a drive for productivity may lead some physicians to provide too much care, avoid certain types of high-risk cases, and lead to less focus on teaching and research.” For hospitals, more productivity means “higher surgical

volume and revenue. Because most otolaryngology practices still function this way, it requires minimal changes to infrastructure and administration."

Dr. Naunheim added that a VBC model can be considered "advantageous because it evens the playing field between proceduralists and non-proceduralists." Non-proceduralists have long bemoaned the fee-for-service model that compensates surgeons at higher rates. A VBC model "may lead to better outcomes and patient satisfaction, although evidence on this in otolaryngology is far from robust. However, this almost certainly will reduce remuneration for otolaryngologists (and perhaps broadly across medicine)." From a hospital perspective, a VBC model signals that the healthcare system cares deeply about quality of care. "There is some potential financial benefit to systems that do this well, but the risk to volume and revenue is significant," he added.

Challenges in Defining and Measuring Value

Performance metrics in VBC models typically include patient outcomes such as readmission rates, mortality rates, and patient satisfaction; cost of care, such as total cost per patient and resource utilization; and adherence to clinical guidelines and best practices, according to AnnMarie Merta, MBA. She serves as the chief executive officer of BridgepointMD, a value-based enabler company in St. Charles, Mo. "Consensus on what constitutes 'value' and how to measure it varies across different healthcare organizations and specialties," Merta explained. "While there are widely accepted metrics, there is no one-size-fits-all approach." She suggested finding a partner with experience in defining, measuring, and executing episodic models.

Many databases, including the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) registry, attempt to measure quality, but the "metrics across specialties have been spotty, hard to measure, and are often less clinically meaningful than would be desired," Dr. Naunheim explained. Some systems rely on patient-reported outcome measures for performance assessment, "but these do not always correlate with objective clinical outcomes."

According to Dr. Farwell, value-based metrics vary and include quality metrics, such as preventive care use and a reduction in surgical site infections, and fiscal metrics, such as keeping inflation at a certain level and using specific tests against evidence-based or payer-based guidelines. "In the ideal world, the health providers and payers agree to evidence-based metrics that can be appropriately risk-adjusted for the patient mix and specific care environment. In reality, that is a very complex process, and the agreement on the evidence (especially when not high level) is a challenge," he said.

Practical Success

Merta noted that healthcare organizations like Kaiser Permanente and Mayo Clinic have adopted VBC models with positive results, including improved patient outcomes and reduced costs.

“Performance review and ongoing monitoring of metrics are essential to evaluate the efficacy of value-based compensation models. This may involve regular data analysis, quality assessments, and feedback mechanisms,” Merta continued. Primary care has had support in this area through Accountable Care Organizations (ACOs) or aggregators. “The ability to obtain and analyze performance, quality, and cost data is what leads to the success of these organizations. It is important [that] specialists find a partner who can obtain, process, analyze, and provide recommendations and solutions for operations, care pathways, and contracting,” she added.

Dr. Naunheim explained that the Medicare Comprehensive Care for Joint Replacement (CJR) Model successfully cut costs while maintaining quality but did so by decreasing postoperative rehabilitation, a move that comes at the patient’s expense. “Most value-based compensation models have not been truly successful,” he said. The Medicare Hospital Readmissions Reduction Program (HRRP) did decrease readmission rates but yielded increased morbidity and mortality for certain patient subsets. The value-based program of the Merit-Based Incentive Payment System (MIPS) has been unsuccessful from a cost and quality standpoint, he added.

According to Dr. Farwell, many managed care organizations have employed physicians, and tight governance has successfully controlled costs and standardized care through these efforts. Increasingly, insurers are inserting these metrics into payments.

However, “this is not as common in otolaryngology as it is in orthopedics and other specialties where payment bundles have been implemented for standardized procedures such as joint replacement. Quality metrics around infections are commonly placed, and, because of bundled payments, value decisions around the type of implant and the location of services are directly or indirectly incentivized,” Dr. Farwell said.

Payers look at this data and use it to influence rates. “At a system level, Vizient and other standardized quality data are increasingly used in negotiating payments with health systems. At a provider level, I don’t think it is quite as common. The location of practice may influence whether otolaryngologists will be exposed to these metrics and to what level,” Dr. Farwell said. “For better or worse, our specialty is so diverse that the absolute number of cases and the ability to standardize them in a bundle is more daunting for payers. As such, specific otolaryngology impact may be delayed compared to other fields. However, as more and more otolaryngologists are employed, they will at least indirectly be exposed to these with health system negotiated rates, which will increasingly be affected by these.”

Implementation Challenges

“It is extremely difficult to create a system nuanced enough to look at all of the factors that go into outcomes,” Dr. Farwell said. Patient and disease factors create variability that is difficult to accurately account for in these models. “As such, systems are often left trying to implement more global quality or purely fiscal models. For larger groups/systems, there will be increasing scrutiny on ‘cost/case.’” Many electronic health records can provide a surgical receipt for each procedure, and “more health systems are socializing these to surgeons in an effort to influence case expenses. I am sure there will be increasing efforts to use those data to influence decisions around disposables, implants, and other high-cost components of a surgical case,” Dr. Farwell said.

Health systems have contract experts who can help explain the current state of their value-based at-risk dollars and “should work closely with you to optimize your work. However, as a relatively small player in most health system dollars, otolaryngologists may have to work a little harder to get that data and be aware of how it influences their reimbursements,” Dr. Farwell said.

Primary care has years of a head start and multiple resources to aid them in the process of switching to a VBC model, said Merta. “Specialists have been on the outside looking in,” she said, except for CMS programs like Bundled Payments for Care Improvement Advanced (BPCI-A), which has been extended. Often, the controlling entities are health systems or ACOs comprising primary care physicians (PCPs), and specialists are participants without the resources, data analytics, or support. “Spending

on specialty care remains high despite the efforts of PCP-focused models,” Merta added.

According to Dr. Naunheim, inertia is a “huge problem” when implementing VBC models. “Fee-for-service is the status quo, and it will be hard to change,” he said, due to the risk of financial disadvantage associated with a value-based model. “Additionally, there will be a new administrative burden—an outcome that many physicians, already burdened by the burgeoning cost and oversight of hospital administrators, fear immensely. The cost of this administrative burden is likely to be high,” Dr. Naunheim added.

“We need resources from our specialty groups, created by physicians,” said Dr. Naunheim, adding that the CMS recommendations are unlikely to help most otolaryngologists. “There has already arisen a cottage industry of third-party consultant ‘experts’ who will be happy to take your money in exchange for a slick PowerPoint presentation and then sail off into the sunset. Caveat emptor,” he said.

Future Support

Merta, who is actively engaging those involved with otolaryngology, orthopedics, cardiology, ophthalmology, and other specialties, noted that the challenges associated with implementing VBC models for physicians include resisting change from traditional fee-for-service models; handling data collection and analytics requirements; ensuring fairness and transparency to compensation; and balancing quality of care with financial incentives.

"Overall, transitioning to VBC models requires careful planning, stakeholder engagement, and ongoing evaluations to ensure alignment with the goals of improving patient care while controlling costs," Merta said. "A great deal of resources and expertise has been directed at PCPs. While effective in some scenarios, the cost of specialty care remains a challenge, which explains the focus of CMS and other payers."

To support physicians in navigating VBC models, Merta suggested that healthcare organizations provide:

• Training on quality improvement and value-based care principles;

• Access to data analytics and performance-tracking tools;

• Assurance that a practice is optimized for efficiency and patient engagement;

• Understanding of the contract structures with payers or the at-risk entity;

• Collaborative approaches involving physicians in decision-making processes; and

• Financial incentives tied to achieving quality and outcome targets.

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ENTtoday - https://www.enttoday.org/article/how-otolaryngologists-are-adjusting-to-value-based-compensation-amid-mixed-success-in-primary-care-settings/

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