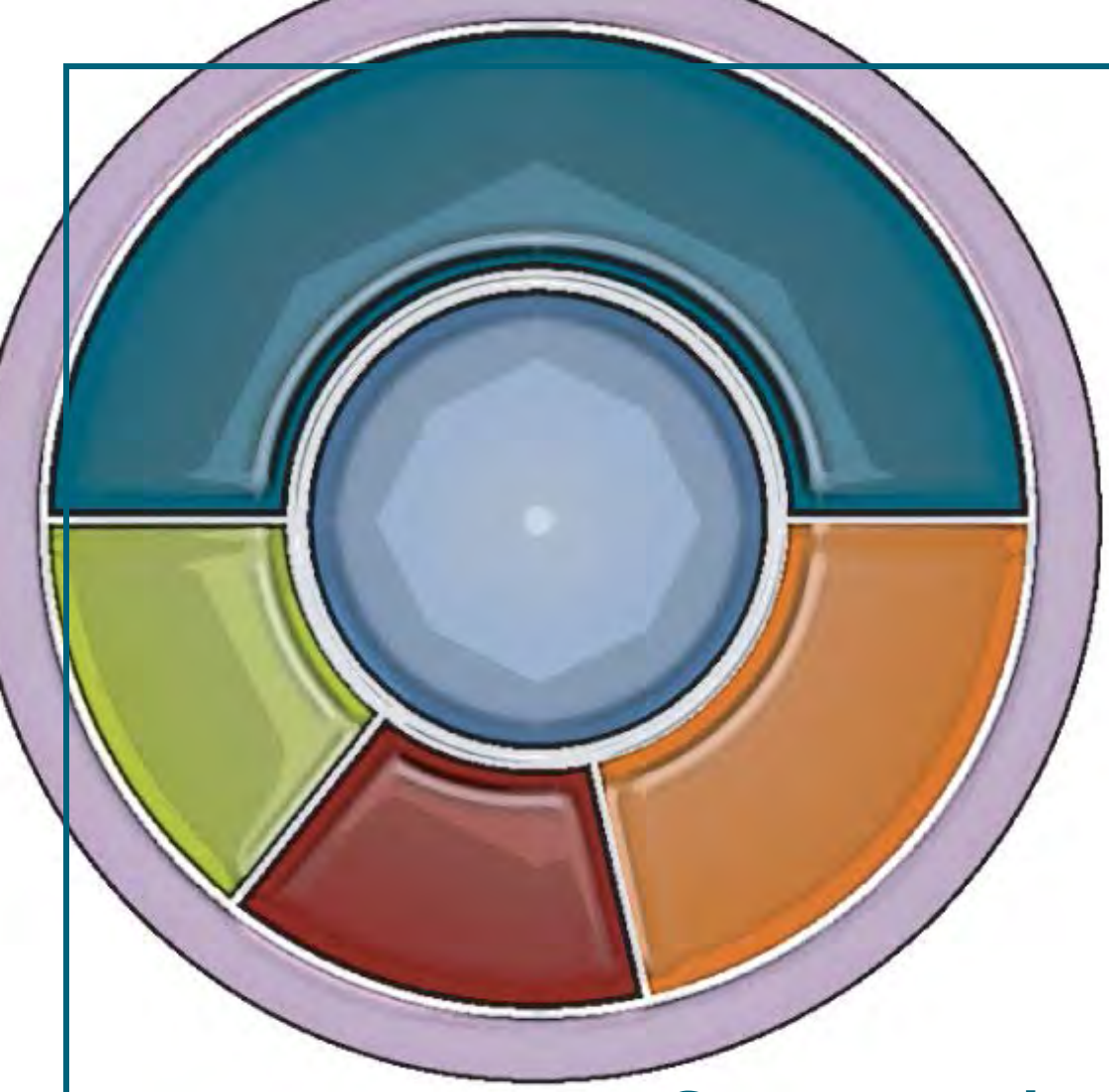

Compensation Strategies:
A Study of CPC Practice Approaches

August 2014

CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation

Compensation Strategies:
A Study of CPC Practice Approaches

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TMF Health Quality Institute

This material is presented by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

Purpose of This Guide

This Guide reflects on how CPC practices across the country have approached using compensation strategies to incentivize the non-visit-related work and population management activities. These practice strategies represent samples of the work and are not representative of every strategy for implementing enhanced payment methodology in a practice or system.

CPC practices are heterogeneous in size, geography, ownership and organization; they are encouraged to innovate and test strategies derived from evidence-based and/or best practices and customize the work according to their particular needs, local dynamics and other practice aspects that may shape how they deliver care. This Guide captures the energy, innovative ideas and rigorous and determined execution of the CPC practices as they test compensation strategies.

We hope that you find in your colleagues' work support for continuing to explore and refine your approach to this key component of Comprehensive Primary Care.

August 1, 2014

Overview of Compensation Strategies

Medicare fee-for-service payment rewards the volume of visits and of diagnostic tests provided. With a few exceptions, there is no compensation for services that improve health outcomes and reduce total cost of care, if these services are not provided through a visit. Provider or care team productivity in a fee-for-services payment environment is generally based on the volume of care provided.

Practices participating in the Comprehensive Primary Care initiative receive CMS payments in the form of a per-member, per-month payment to support comprehensive primary care functions that are not visit-based and not reimbursed under fee-for-service payment. They also have the opportunity to share in savings accrued to the Medicare Trust Fund that result from a decrease in the total cost of care. The other CPC payers have each committed to an aligned strategy, with population-based payment to support the Comprehensive Primary Care functions, and an opportunity for practices to participate in savings from reducing the cost of care.

If, however, physician or care team productivity is still based on volume, there may be limited incentive for those doing the work of patient care to do so differently. Payment aligned with comprehensive primary care at the practice level also needs to be aligned at the level of the provider or care team.

CPC practices have begun to explore strategies for aligning productivity metrics and compensation strategies with the CPC model of comprehensive primary care they are building. This will be an active and ongoing area of learning. The case studies below illustrate some of the early work of the CPC practices.

Relationship of this topic to the CPC Driver Diagram

Two change concepts were introduced as a means for practices to affect the impact payment reform has on the overall aim of this initiative. The first is to use budgeting and accounting processes effectively to transform care processes. The second is to create value and support processes of care that align with better health, better care and lower costs through improvement.

The change tactics employed include the following:

1. Using accounting and budgeting tools and processes to allocate new revenue,
2. Investing that new revenue in priority areas for practice transformation, and
3. Developing benchmarks and analytic capacity for quality improvement work and to maximize the likelihood of shared savings.

The case studies that follow should be thought of as tests of change, exploring ways to allocate resources to better support patient and population health outcomes. The practices tell us that they continue to evaluate these strategies and will be modifying them further based on the data they gather. We expect to see many more tests emerging out of the CPC practices in the next several years.

Case Studies

In the following case studies, CPC practices explain how they are revising productivity metrics and testing new compensation strategies in their practices.

Partners in Health Family Care of Westminster, Colorado
Independent; three physicians, three PAs; 7,842 patients

Partners in Health Family Care has focused on providing quality care since its establishment in 2005. The practice's work on the CPC initiative made it apparent that a method to achieve the required CQMs was needed. Providers meet weekly to review the measures. They are salaried, and this time is blocked during their regular schedule so that they can attend. The main focus of the practice's incentive plan, however, is the staff. No other incentives have been developed for the providers.

The incentives are targeted at behaviors that directly enhance their performance as a practice. All non-provider staff is eligible for the financial incentives as a means to include the entire team to work toward the goal. Once a goal is set, the method of measurement is created, and all staff is educated on their role. They are then eligible to receive a designated dollar amount each time they get a "hit." A timeframe for offering the incentive is set, which is developed around the amount of time the team believes the goal can be met, or the time required for the behavior of the team to become "a habit" or part of routine care.

Partners in Health implemented two incentives last year. One incentive was related to care coordination. The initial goal was that every hospitalized patient would be contacted, either during their hospitalization or immediately after, and an appointment for post-discharge follow-up arranged. Information on all patients admitted to the hospital is available through the practice's EHR messaging system or through CORHIO (Colorado Regional Health Information Organization), and patients are assigned to the appropriate care team. A transitional care code has been built in the EHR that signals the need for follow-up activity. Anyone on the team can contact the patient and schedule the appointment. A referral to the care coordinator also may be made if deemed appropriate by the team member speaking with the patient. Physicians will visit patients in their homes if they cannot come into the office – Partners in Health physicians made close to 100 home visits last year. If a patient has a reason (such as living in another state with family) that they cannot be scheduled for a follow-up appointment, this must be documented in the EHR. Team members were paid $2 for each "hit" (follow-up scheduled and completed, or valid reason visit not scheduled) and have $1 taken away for a "miss." A "miss" means the patient was not contacted or an appointment was set and the patient did not show up, and this did not receive follow-through by staff. This incentive lasted 90 days. Payment was made once at the end of the timeframe to the staff members as a team, with each member receiving the amount calculated using the formula [(Hits X $2) minus (Misses X $1)]. The goal was to promote team work and ingrain a routine of care that will continue. Management found that the discharge follow-up has continued at the same or even improved level as it was during the incentive. Outcome metrics are being obtained, and initial data shows that readmissions are down significantly due to this follow-up action. The practice is now working on follow-up with patients who use an emergency department. This task mimics the process already in place with hospitalization follow-ups, and they have simply transferred that skill set successfully without adding an incentive payment.

The second incentive addressed patient use of the portal. Patient electronic access to their health information for at least 50 percent of active patients is one of the Meaningful Use measures. To address this, an initiative to increase patient portal enrollment began for 120 days. During visits, a staff member asks the patient about enrollment in the portal and explains the process. IPads are available to use in each exam room so patients can enroll while in the office. Other team members have this same opportunity as they speak with patients on the phone or in person. Team members earn 50 cents for each enrollment, with an unlimited pot of money applied to this initiative. At the end of the incentive period, the payment was calculated using the formula (New enrollments X $.50) and given to all team members. The total number of enrollments during the designated timeframe was 366, which was a 32% increase. The practice admits that this was a difficult project with their patient population, comprised of many low-income and elderly patients who do not have email. Yet they recognize it is everyone's job to enroll as many patients as possible so that the access to the office is improved for their patients. They have noted not only increased enrollment but increased access by the patients via the portal. Although not available at this time, the practice is tracking both usage and response times for CPC and will have that data in the future. As with the previous incentive, staff continues this process, and enrollments continue to increase.

Incentives were also used to encourage staff to learn more about quality improvement. Each of the practice's 17 medical assistants (MAs) picked an area of quality, researched it and gave a presentation to all staff. They received a significant monetary bonus to compensate for their work and the time it took. This research had to be done on their own time or during down times at work. No time from regular duties was granted. They are then held responsible to continue educating teammates on that measure and stay current on information about their selected measure. The measures chosen are typical quality measures such as several diabetes measures, hypertension and preventive measures for screening for breast cancer, colon cancer and cervical cancer. Data is posted in the conference room and at the employee entrance as well as reviewed at team meetings. This led to greater accountability and teamwork and improved performance on the measures. That MA is then the "go to" person for ideas on improving that measure in the practice.

Partners in Health Family Medicine find that the teams are competitive and accountable for their success in achieving high quality care for their patients. The staff has taken ownership of quality; they now ask how they can improve their numbers and work as a team to be successful.

Other incentives the practice is considering are focusing on behavioral health follow-through, specific quality measures requiring improvement and shared decision making. They have found this incentive program a great motivator to link the CPC Milestones for the staff and enhance performance on the measures.

Family Physicians of Greeley, Colorado
Independent; 23 physicians, two PAs; 30,000 patients

Family Physicians of Greeley developed an incentive program for physicians that is doctor-driven, has an emphasis on fairness, is focused on practice-wide success and is aligned with the practice's payers' Pay for Performance (P4P) programs. Prior to the beginning of CPC, the practice developed a scorecard of 10 quality measures that were clinically important for its office. The criteria for selection of the measures included the following:

- Evidence-based with national standards
- Payers had money attached to the measure
- Room for improvement exists
- Large denominator in the practice
- Ability to get the data from the EHR

The **scorecard** was shared monthly; initially no incentive monies were attached. With the launch of CPC, the measures shifted to be more closely aligned with those of the CPC initiative with monetary rewards attached to individual performance. They developed achievable benchmarks for each measure using established benchmarks from national sources such as payers and CPC.

FP Greeley Benchmarks

Measure	Benchmark
BP < 140/90 18+ hypertension or diabetes	75%
Tobacco Cessation Intervention 18+ current users	80%
HgbA1C in past year and ≤ 9.0 18-75 diabetics	80%
LDL-C in past year and <100mg/dL 18-75 diabetes or ischemic vascular dz	53%
Attention for Nephropathy in past year 18-75 diabetics	82%
DEXA scan 65+ women	70%
PFT 12+ COPD/emphysema/ chronic bronchitis/asthma	60%
Mammogram in past 30 months 42-74 women	74%
Colonoscopy in past 10 yrs or FOBT in past year 50-75	58%
Pneumovax 65+	75%

The practice looked at two models they believed might work to calculate the incentive payment. The "carrot" model rewards good performance. This model has only upside risk and distributes outside money based upon achievement of quality benchmarks. The "stick" model does not require outside money. Instead, income redistribution is based on achieving quality benchmarks. This carries both an upside and downside risk but is a zero-sum game in terms of dollars. Both models were adopted in their final product.

The advantages of the stick feature are that no outside money is required, intense competition to reap a reward exists and fear of losing is a stronger motivator than hope of gaining. On the other hand, some disadvantages are the damage to the collegial environment, a strong disincentive for cooperation and extra work without extra money.

The balancing feature of the adopted incentive model is the "carrot." With this incentive, everyone is happy, and it provides money to do the extra work. The disadvantages are that some people are happy to simply receive the base payment they receive in addition to any additional monies offered by payers.

There are, therefore, two sides to the calculation, with approximately the same amount at stake (see appendix). With both the "carrot" and the "stick" in place, only about 15 percent of the physicians lose money each month. The "carrot" is referred to as the "pool." CPC and other P4P money fund the pool, which is used to reward positive performance only – these funds are not used to support the salaries of the physicians. The "stick" is called the "withhold" or "tax." Each physician has money withheld from his or her base pay, and that money is then redistributed based upon an established calculation. As the calculation

was developed, a need to address valid concerns about fairness was raised. In response, they sacrificed simplicity in the calculation to create fairness in the product.

One objection was that putting a flat amount at risk would be too much for some doctors and not enough for others. In response, they withhold a percentage of income (currently 3 percent) from each doctor (on the "stick" side of the equation). The withheld money is redistributed based on both the number of benchmarks met and their income level.

The second objection was that doctors with a higher number of patients in the denominators on the scorecard (such as the chronically ill and elderly) would do more work, so they should be rewarded for this work. In response, the pool money is distributed based on both the number of benchmarks met and the number of patients in the provider's denominator.

As the program rolled out, physicians were given a six-month window of opportunity to improve their quality measures before the incentive calculations began. One element needing attention was developing physician confidence in the quality reports. Physicians were given access to all data and could drill down to the patient level. This allowed them the opportunity to identify the deficiency and then remedy it. One finding was in the physicians' documentation – at times they met the measure but their input into the EHR did not allow the data to be mined. With access to all data in the numerator, physicians learned to improve their documentation in the EHR using discrete fields.

This incentive plan resulted in improvement on the percent of benchmarks met. In September 2012, 30 percent of the benchmarks were hit. By December 2013, the number topped 70 percent. This success is attributed to the physicians' financial responsibility for their MAs. They control how their staff "work the report" to improve population management and may have them work on the physician's day off to do follow-up on patients. In addition, physicians improved their documentation, including obtaining test results from outside sources and abstracting the test results instead of just scanning them into the EHR. They began giving a stronger sales pitch to patients in the exam room and improved their follow-up to document improvement.

This has been stressful for the physicians as they had some catch-up work to improve their scores, yet they also find it rewarding because they feel like they are being better physicians for their patients. One example provided is care of hypertensive patients. In the past, patients may have been given medication then not seen again until the next visit months down the road. Today, the MA will do a follow-up call, ask their blood pressure levels at home and set up an appointment as needed based upon the information received. The team has the opportunity to positively affect patients' health with this system, thus improving the quality measure.

The staff is now much more involved in population health. This helps them do the next right thing for every patient, motivating them to provide the care necessary to improve the outcomes. At times patients may be referred to the care manager if they need more intense attention.

The scorecard is adjusted every six months. Measures that are consistently met may be removed after a period of time and replaced with a stretch goal. New guidelines may change a measure. In the future they would like to add utilization measures and patient satisfaction. Inclusion of measures that may be used in shared savings calculations is under consideration.

Springfield Center for Family Medicine, Inc., Springfield, Ohio

Independent; six physicians, one PA; 7,128 patients

Springfield Center for Family Medicine, Inc. developed an incentive method to reward employees who worked outside of their regular roles to meet patient needs. These additional activities were done during the course of the regular work day, with consideration to employees' engagement in the additional activities and willingness to participate. Codes were set up in their time clock system similar to the Milestones in CPC. They include the following:

- CPC Risk Care Management
- CPC Self-Management
- CPC PFAC/Surveys
- CPC Learning Activities/Meetings

The employees' CPC hours for each pay period are entered on a spreadsheet. A performance rating of 1 through 4 is given if their hours were a portion of their normal job duties, or they were performing activities above and beyond their normal job in the course of their workday. This is an example using patient surveys:

- **1 = Poor.** Employee was asked to help tally patient surveys. Complained a lot and didn't bother coming to ask for more to do when they were finished with their initial assignment.
- **2 = Average.** Employee was asked to help tally patient surveys. Completed their initial assignment. No complaints, but did not make an effort to get more.
- **3 = Above Average.** Employee was asked to help tally patient surveys. Completed initial assignment. No complaints, and came back asking for more surveys.
- **4 = Exceptional.** Employee was asked to help tally patient surveys. Completed initial assignment. No complaints, and came back asking for additional surveys. Was excited and motivated co-workers to tally additional surveys.

Twice last year the practice distributed a small incentive payment to all employees based on their performance rating. Employee payments were paid in confidence, with their amount based upon their score. Management found this program increased the staff motivation to do the extra activities needed to improve performance in each Milestone. Initially staff voiced concern about competing with one another, but over time the program has positively affected staff performance. No direct impact on outcome metrics by the incentive plan has been noted, although certainly the efforts made by the staff have been one of the key reasons their metrics are improving.

As an independent practice, the physicians find that to prepare for a shared savings model it is best to invest their additional revenue into infrastructure instead of physician incentives. They have invested in CQM 2014 components, EHR upgrades, Meaningful Use Stage 2 development and care management staffing. This investment is explained to all physicians, and they are continually evaluating quality metrics to guide their team toward improvement. The outcome of this investment should be shared savings monies as those models roll out.

Grants Pass Clinic, LLC, Grants Pass, Oregon

Independent multi-specialty; 19 physicians, 2 PAs, 2 ANPs; 17,200 patients

Grants Pass Clinic, a for-profit, multi-specialty clinic, initiated their incentive compensation program on January 1st of 2014. Prior to this new program, partner compensation was 95 percent Relative Value Units

(RVU) based, with the remaining 5 percent based on managed health plan panel size. RVUs are a measure of value used to calculate the reimbursement value of physician services.

Their new incentive pay program was developed by the management team in conjunction with the physician partners. The practice has always had a culture of high quality, cost effective care, yet each provider had their own processes for the delivery of care with varying outcomes. To make a positive change in both the processes and the outcomes, management recognized the new payment model must drive behavior in that direction.

In 2014, all partners are paid using this new system. Compensation to the partners is 90 percent on a production basis, 5 percent on managed care panel size and 5 percent for meeting the metric score of various programs such as PQRS, CPC and State of Oregon PCMH, among others.

Partners are paid monthly draws that are based on a budget that considers historical production and managed care panel size. Ten percent of estimated income is withheld and partners are allowed to select a draw of up to 90 percent of the remaining estimate.

The incentive portion of physician pay is based on measures that are selected to drive performance in the practice and are clinically relevant. One criterion for selection is that the measure is one requiring reporting by one of the above programs. Another is that the outcome of the measure is under the direct control of the provider and his or her team. Benchmarks are set for each metric using the program benchmarks, if available, as a guide. The practice uses the most difficult level of each metric if the program presents more than one. Their goal is to drive the highest quality of care.

Calculating performance on the metrics is done using the reports from their EHR, Allscripts and the analytics engine from Allscripts. A spreadsheet is kept and updated regularly. Admittedly, this takes a lot of time and attention on the part of both dedicated staff and management, yet accurate and predictable reporting is the main driver of success for the program.

Providers must meet the metric benchmark to be paid. The system is built on points. If providers do not meet the benchmark on a measure, they get zero points. If they meet the minimum benchmark percentage, they earn one point. If they exceed the minimum benchmark by an established percentage, they score two points. Points for all measures are then tallied.

The dollar amount of the 5 percent available for incentive compensation is divided by the number of physicians qualified for incentive compensation to obtain the maximum incentive compensation per physician. Fifty percent of this is held until year end. The remaining 50 percent is distributed based on points earned. Unearned points are not distributed. If points remain unearned at year-end, the dollar amount of the unearned points will be distributed amongst all incentive qualified partners.

The physician and administrative clinic management are surprised at the attention this system is getting in their practice. Although this model is in its early stages, there has been clear progress in achieving benchmarks and establishing standardized clinic processes. Prior to this payment method, the number of physicians meeting program measures was low. Now they are at 100 percent. In addition, provider teams now follow very similar processes throughout the practice, increasing efficiency and group cohesiveness. The nursing staff were educated and encouraged about the new physician program at its start. When

physicians shared their metrics with their staff, the staff was eager to help their provider do well and sought help to improve performance as needed. They are definitely working as a patient care team toward the goal.

An impressive outcome has been staff retention. The staff turnover rate is less than 2 percent for staff leaving for another position. Physician retention is similar. This is attributed to the culture in the practice, not necessarily the pay.

The management team attributes the overall success of the program to three things:

- Accurate and predictable data reported monthly
- Total transparency in showing the data to all providers and staff
- Money is at risk

Future improvements will be made as the payment system for health care changes. According to the leaders, "We have no other reason for being here other than improving provider and patient interaction." They would like to pay their providers the best they can as they operate under that motto.

Conclusions

This Guide demonstrates how CPC practices are using their creativity and current resources to enhance the incentives to provide the necessary non-visit related care and strengthen their performance in providing care that improves the quality of their population health. These tests of change are moving the needle toward care that provides better health at lower cost, with movement toward a value-based payment system.

References

Payment Reform to Support High-Performing Practice: Report of the PCPCC Payment Reform Task Force
This 26-page report gives an overview, with pros and cons, of some of the common models piloted to support primary care and payment reform.

Colorado Multi-Payer, Multi-State PCMH Pilot: Partnering to Transform Health & Health Care
The information on this site provides an overview of this pilot, including a description of the payment model used.

Massachusetts Payment Reform Model: Results and Lessons
This PDF is an overview of the Massachusetts Alternative Quality Contract model from Blue Cross Blue Shield of Massachusetts.

Compensation Strategy Webinars and Resources

Please note: *These resources are posted to the CMS Partner Collaboration Site: https://collaboration.cms.gov/. To access the Collaboration Website, you must be a registered user and logged in to view those pages.*

Shared Savings Methodology, National webinar, Nov. 12, 2013 (40-page PDF)
An overview of the CMS shared savings methodology

Payment Reform and Shared Savings, Colorado Learning Session, March 7, 2014 (37-page PDF)
A discussion on payment reform and shared savings in CPC

Effectively Using a Budget to Meet PY2014 Milestones, New Jersey Regional Webinar, March 26, 2014 (29-page PDF)
New Jersey presentation on budgeting for the 2014 Milestones

Budget as a Planning Tool, Oklahoma webinar, January 10, 2014 (34-page PDF)
Oklahoma learning session on budgeting and its impact on financial outcomes

2014 Implementation and Reporting Guide, updated version, June 10, 2014 (84-page PDF)
This updated guide contains all updated guidelines for budgeting, and assists with planning your compensation strategy for your practice.

Appendix

Family Physicians of Greeley Scorecard

Physician Quality Scorecard

Year ending 5/31/14

Measure ->	BP < 140/90 18+ hypertension or diabetes			Tobacco Cessation Intervention 18+ current users			HgbA1C in past year and ≤ 9.0 18-75 diabetics			LDL-C in past year and <100mg/dL 18-75 diabetes or ischemic vascular dz			Attention for Nephropathy in past year 18-75 diabetics		
	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%
Doctor A	234	307	76%	108	128	84%	69	80	86%	47	97	48%	70	80	88%
Doctor B	155	207	75%	158	190	83%	31	42	74%	29	48	60%	37	42	88%
Doctor C	148	225	66%	157	195	81%	39	57	68%	38	68	56%	50	57	88%
Doctor D	102	126	81%	145	172	84%	24	39	62%	14	42	33%	35	39	90%
Doctor E	243	302	80%	146	173	84%	58	72	81%	60	86	70%	68	72	94%
Doctor F	203	268	76%	163	163	100%	74	91	81%	60	103	58%	81	91	89%
Doctor G	223	262	85%	180	191	94%	58	70	83%	53	80	66%	59	70	84%
Doctor H	287	340	84%	123	148	83%	82	96	85%	75	115	65%	90	96	94%
Doctor I	254	335	76%	133	160	83%	71	100	71%	62	131	47%	89	100	89%
Doctor J	256	331	77%	188	193	97%	77	87	89%	81	98	83%	86	87	99%
Doctor K	197	227	87%	135	167	81%	74	89	83%	50	102	49%	70	89	79%
Doctor L	122	175	70%	48	58	83%	34	41	83%	20	45	44%	35	41	85%
Doctor M	237	308	77%	95	116	82%	75	97	77%	70	108	65%	86	97	89%
Doctor N	232	322	72%	213	247	86%	76	99	77%	55	110	50%	92	99	93%
Doctor O	139	181	77%	64	76	84%	37	45	82%	27	50	54%	37	45	82%
Doctor P	176	201	88%	94	105	90%	47	56	84%	37	63	59%	45	56	80%
Doctor R	194	274	71%	203	212	96%	81	113	72%	47	119	39%	98	113	87%
Doctor S	144	167	86%	180	194	93%	44	58	76%	37	68	54%	53	58	91%
Doctor T	290	425	68%	139	168	83%	78	97	80%	69	133	52%	80	97	82%
Doctor U	134	169	79%	73	85	86%	41	48	85%	34	54	63%	41	48	85%
Doctor W	156	210	74%	205	232	88%	47	73	64%	45	87	52%	65	73	89%
TOTAL	**4,126**	**5,362**	**77%**	**2,950**	**3,373**	**87%**	**1,217**	**1,550**	**79%**	**1,010**	**1,807**	**56%**	**1,367**	**1,550**	**88%**
Benchmark			**75%**			**80%**			**80%**			**53%**			**82%**
St Dev			**6%**			**6%**			**7%**			**11%**			**5%**

= Meets Benchmark

DEXA scan 65+ women			PFT 12+ COPD/emphesema/ chronic bronchitis/asthma			Mammogram in past 30 months 42-74 women			Colonoscopy in past 10 yrs or FOBT in past year 50-75			Pneumovax 65+			Total Denominator	Total Measures Met
Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%		
109	194	56%	33	54	61%	94	152	62%	238	341	70%	296	359	82%	1,792	**7**
60	66	91%	14	25	56%	372	502	74%	285	399	71%	73	77	95%	1,598	**7**
79	94	84%	19	40	48%	238	317	75%	327	469	70%	169	196	86%	1,718	**7**
33	61	54%	20	44	45%	174	238	73%	125	215	58%	65	85	76%	1,061	**5**
92	103	89%	34	57	60%	196	252	78%	317	419	76%	178	204	87%	1,740	**9**
56	70	80%	29	44	66%	93	116	80%	267	320	83%	174	195	89%	1,461	**10**
95	117	81%	34	60	57%	112	165	68%	192	328	59%	192	231	83%	1,574	**8**
64	72	89%	93	126	74%	249	302	82%	367	484	76%	167	175	95%	1,954	**10**
94	119	79%	64	117	55%	299	413	72%	392	697	56%	178	228	78%	2,400	**5**
67	76	88%	51	81	63%	155	208	75%	280	408	69%	171	186	92%	1,755	**10**
97	126	77%	25	41	61%	255	377	68%	244	365	67%	114	155	74%	1,738	**6**
81	112	72%	17	40	43%	220	287	77%	183	290	63%	115	139	83%	1,228	**7**
47	53	89%	50	76	66%	158	188	84%	243	316	77%	129	131	98%	1,490	**9**
109	143	76%	26	57	46%	162	246	66%	335	519	65%	254	317	80%	2,159	**5**
128	138	93%	20	41	49%	191	257	74%	161	248	65%	137	163	84%	1,244	**9**
92	102	90%	47	53	89%	219	282	78%	185	269	69%	111	125	89%	1,312	**9**
83	117	71%	38	60	63%	382	502	76%	292	404	72%	126	142	89%	2,056	**7**
45	60	75%	33	48	69%	114	155	74%	156	252	62%	119	139	86%	1,199	**8**
141	186	76%	23	96	24%	339	452	75%	572	706	81%	289	352	82%	2,712	**7**
97	120	81%	31	44	70%	167	208	80%	165	207	80%	138	158	87%	1,141	**10**
46	62	74%	23	40	58%	120	152	79%	166	276	60%	115	145	79%	1,350	**6**
1,715	**2,191**	**78%**	**724**	**1,244**	**58%**	**4,309**	**5,771**	**75%**	**5,492**	**7,932**	**69%**	**3,310**	**3,902**	**85%**	**34,682**	
		70%			**60%**			**74%**			**58%**			**75%**		
		10%			**13%**			**5%**			**8%**			**6%**		

Family Physicians of Greeley Reimbursement Calculations

Internal Quality Reimbursement

Fill in the highlighted fields only

	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L
	QUALITY	WITHHOLD						POOL				TOTAL
	Scorecard measures met	Receipts	3% withheld from doctor (B x 3%)	Weighted value (A x B)	Weighted value % (D ÷ Total D)	Returned to doctor (E x Total C)	Net to doctor (F - C)	Score-card patients	Weighted value (A x H)	Weighted value % (I ÷ Total I)	Net to doctor (J x Total K)	Net to doctor (G + K)
Doctor A	5	$37,000	$1,110	185,000	6.97%	$740	-$370	1,700	8,500	8.63%	$863	$493
Doctor B	10	$68,000	$2,040	680,000	25.60%	$2,719	$679	1,400	14,000	14.21%	$1,421	$2,100
Doctor C	8	$35,000	$1,050	280,000	10.54%	$1,120	$70	2,000	16,000	16.24%	$1,624	$1,694
Doctor D	7	$17,000	$510	119,000	4.48%	$476	-$34	1,200	8,400	8.53%	$853	$819
Doctor E	3	$33,000	$990	99,000	3.73%	$396	-$594	1,000	3,000	3.05%	$305	-$290
Doctor F	9	$29,000	$870	261,000	9.83%	$1,044	$174	1,300	11,700	11.88%	$1,188	$1,361
Doctor G	10	$53,000	$1,590	530,000	19.95%	$2,119	$529	1,900	19,000	19.29%	$1,929	$2,458
Doctor H	7	$46,000	$1,380	322,000	12.12%	$1,288	-$92	1,700	11,900	12.08%	$1,208	$1,116
Doctor I	5	$36,000	$1,080	180,000	6.78%	$720	-$360	1,200	6,000	6.09%	$609	$249
TOTAL	**64**	**$354,000**	**$10,620**	**2,656,000**	**100%**	**$10,620**	**$0**	**13,400**	**98,500**	**100.00%**	**$10,000**	**$10,000**

This is the 3% withheld from monthly receipts.

It is distributed based on the number of Scorecard measures you met weighted by your receipts.

This is the physicians' monthly portion of the revenue from CPCi, etc.

It is distributed based on the number of Scorecard measures you met weighted by the number of patients included in your Scorecard measures (denominators).

This is the amount of the incentive for each provider