MIPS, APMs, ACOs and the Like: A Translation to Compensation Plan Objectives

03/23/2017
Presentation Roadmap

• MACRA Overview
  – MACRA Overview
  – MACRA Scenario

• Aligning Compensation to Desired Outcomes
  – The Changing Reimbursement Model
  – Perspectives on wRVU Production

• Approaches to New Compensation Models
  – Early Incremental Model
  – Intermediate Model
  – Advanced Model
AMGA Consulting Biographies

Tom Dobosenski is President of AMGA Consulting, LLC, and serves as a member of the Strategic Planning Team. Prior to joining AMGA Consulting Services Tom was employed for half years as a Managing Principal and co-leader of the physician compensation consulting at Sullivan, Cotter and Associates, Inc. Previous to working at Sullivan Cotter Tom was Partner/Managing Director for RSM McGladrey (5th Largest International Accounting, Tax and Consulting Firm). In his 25 years with RSM McGladrey, Tom served in several leadership positions including Executive Vice President of Consulting where he lead the consulting line of business which included more than 700 consultants and over $250 million in revenue. Tom was also the Executive Managing Director of the Human Capital Services and the Executive Partner for the National Healthcare Consulting service line.

With more than thirty years of accounting, business management and consulting experience in both health care and private industry, Tom has significant experience in providing strategic and financial consulting services, involving organizational development, compensation systems design and implementation and corporate finance. A sampling of his extensive variety of projects includes:

Tom is a member of the American Institute of Certified Public Accountants and the Minnesota Society of Certified Public Accountants. He graduated with high honors from the University of Minnesota-Duluth where he earned a Bachelor of Science degree in accounting. He also completed an extensive executive education program at the University of Chicago’s Graduate School of Business. He is a frequent author and speaker on the topics of physician compensation, benchmarking and recruitment.
Will Holets is a Consultant with AMGA Consulting. His areas of expertise include strategic planning, operational excellence, process improvement, and data analytics. Prior to joining AMGA’s consulting group, Mr. Holets held various management and leadership positions across the healthcare field in settings ranging from academic medical centers to for-profit integrated delivery systems. He has over 5+ years of experience in healthcare operations, planning and analytics.

Will received his MBA from the University of Iowa’s Tippie College of Business and his MHA from The College of Public Health at the University of Iowa. He holds a Bachelor’s of Science in management from the University of Denver.
MACRA: The Language

- **MACRA** - Medicare Access and CHIP Reauthorization Act
- **MIPS** - Merit Based Incentive Payment Systems
- **APMs** - Alternative Payment Model
- **ACI** - Advanced Care Information
- **CPI** - Clinical Practice Improvement
- **PQRS** - Patient Quality Reporting System
- **MU** - Meaningful Use
MACRA: Transition to Value

Current Fee for Service
Starting in 2019, based on 2017 metrics, physician groups will transition to one of two value-based reimbursement systems.

Merit Based Incentive Payment Systems (MIPS): A combination of PQRS, MU and other value based metrics established to adjust Medicare Part B reimbursement based on performance.

Alternative Payment Model (APM) System: Advanced systems that have the potential for lump sum bonuses above the MIPS reimbursement adjustments.

MIPS Timeline

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Adjustment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2019</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
</tr>
<tr>
<td>2019</td>
<td>2021</td>
</tr>
</tbody>
</table>

- **Quality Performance**: 15%
- **Advancing Care Improvement**: 25%
- **Clinical Practice Improvement**: 30%
- **Cost Performance**: 50%
- **10%**
MACRA Timeline

**Fee Schedule Updates**
- 2015 and earlier: 0.5
- 2016: 0.5
- 2017: 0.5
- 2018: 0.5
- 2019: 0
- 2020: 0
- 2021: 0
- 2022: 0
- 2023: 0
- 2024: 0
- 2025: 0
- 2026 and later: 0.75

Source: Centers for Medicare and Medicaid services

**MIPS**
- 2015 and earlier: 4%
- 2016: 5%
- 2017: 7%
- 2018: 9%

MIPS Payment Adjustment (+/-)

**Certain APMs**
- Qualifying APM Participant
  - Medicare Payment Threshold
  - Excluded from MIPS

5% Incentive Payment

Excluded from MIPS

Source: Centers for Medicare and Medicaid services
ABCMG is a 100-provider physician-led medical group with total revenue of $100 million in 2016, 30% of which are Medicare-based claims.

- Scenario 1 (Red): No participation in MIPS, penalty of 4% in 2019.
- Scenario 3 (Green): Full participation in MIPS with exemplary performance, 4% bonus in 2019.
Provider Compensation: Aligning Pay with Desired Outcomes
Changing of the Revenue Stream

**Current State**
- **wRVUs**
- **Quality**
- **Access**

**Intermediate Models: Paying for Value**
- **wRVUs**
- **Quality**
- **ACI / CPI**

**Advanced Models: Paying for Value**
- **wRVUs**
- **Quality / Resource Use**
- **ACI / CPI**

**Physician Compensation Models**
Aligning Compensation with Reimbursement

Medicare Part B Reimbursement Formula

Fee Schedule

Volume

MIPS Adjustment (+/- 4%)

Volume

MIPS Adjustment (+/- 7%)

Volume

Today 2019 2021

Quality Pt. Access Volume

ACI CPI Quality Volume

ACI CPI Cost Quality Volume

Physician Compensation Model

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Approaches to New Compensation Models

**Production Models**
- Provider has influence/control over production
- Easy to administer
- Easily quantifiable
- Non-value-based

**Early Incremental Models**
- Shift to value
- WRVUs matter
- Require physician engagement and education
- Transitional by design

**Intermediate Models**
- More salary-like
- Still link to wRVU
- Require more data for metrics
- Not yet proven in some cases

**Advanced Models**
- Meet conceptual objectives
- High discretion
- Elicit concerns about production
- Can raise questions on regulatory side
Approaches to New Compensation Models

• Models that move away from wRVU, as the primary driver of compensation, are slowly emerging.

• Organizations with less pressure to move to risk- or value-based models are responding cautiously.

• Organizations with more at risk today need to balance physician acceptance of a model change with business risk.

• Whenever possible, we suggest an incremental approach to compensation model changes.

• As MACRA adjustments materialize in 2019, the rate of change in the market appears to be accelerating.

• If you start earlier, you will have more time for a smooth transition.
Keys to New Compensation Models

- Data Expertise
- Robust IT/EHR Reporting
- Information Transparency
- Aligned Incentive
- Shared Vision
- Physician Engagement
Perspectives on Work RVU Production
### Production Based Plan Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>2016</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVUs</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>Net Collections</td>
<td>26%</td>
<td>34%</td>
</tr>
<tr>
<td>Gross Productivity</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Cost Accounting</td>
<td>8%</td>
<td>15%</td>
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Early Incremental Models
Early Incremental Models

- Intentionally simple/transitional by design.

- May work best for organizations resistant to big changes and/or early in the process of changing to value-based models.

- Should be considered incremental/intermediate model – beginning a path for change.

- NOT the ultimate strategy, a stepping stone to the final strategy.

- If you want to make a compensation plan change now and **not** re-visit it in a few of years, consider an intermediate or advanced model.

- First step in transition from 100% wRVU-based model.
The weighting can be adjusted to align with your value-based performance targets.

- **Volume**: Tiered/banded wRVU or Panel Size approach
- **Quality**: MIPS aligned quality goals
- **Access**: CPI aligned Access goals
Intermediate Models
Intermediate Models

• These models are more complex; and are more value based in a substantial way.

• May work best for organizations that accept a mandate for change from production-based models.

• Intended to shift thinking away from *each and every wRVU*, towards providing a higher value of care.

• Assume production remains a factor in the future (even as a proxy for access).

• Organizations may integrate panel size into their compensation equation.

• Call for a shift in thinking regarding regulatory issues such as FMV.
Intermediate Models

Again, consider the compensation philosophy and drivers for change in the compensation approach:

• The market is changing, including risk-based arrangements with employers.

• Access is a key concern of employer groups and patients.

• Need to shift from fee-for-service to value-based care.

• New models significantly tie reimbursement to demonstrating high quality, while maintaining access and cost.
Intermediate Models: Refining Philosophy and Plan Design

Driving Forces

- Value-Based Care, with a meaningful impact on reimbursement
- Payors and large Employers are actively engaged in value-based contracting
- Current Compensation model features insignificant value-based metrics
- Current Compensation models are solely production based

Desired State

Value-Based Compensation Model(s)

Actions

- Develop compensation model(s) that focus on value-based metrics such as quality, and efficiency with less emphasis on wRVUs
- Align incentives to value-based reimbursement and value-based contracts
- Incentivize value-based activities that are not reflected in a wRVU-based model
Intermediate Models: Panel Size Considerations

- Panel size can also be a factor in the compensation plan (risk-adjusted).
- Given limited market data, internal benchmarks may be helpful.
- Few organizations base compensation solely on panel size.

Reference for risk adjustment: *Mark Murray, MD, MPA, Mike Davies, MD, Barbara Boushon, RN, Fam Pract Manag. 2007 Apr;14(4):44-51.*
Intermediate Model Example:

- Volume: Tiered or banded wRVU productivity approach
- Quality: MIPS aligned quality goals
- Access: Panel Based Access Goals
- Production Bonus: Bonus paid to high producing providers

The weighting can be adjusted to align with your value-based performance targets.
Intermediate Models: Transitional Approach to Incentive Compensation

Year 1
- Quality: 10%
- CPI: 5%
- ACI: 5%

Year 2
- Quality: 15%
- CPI: 10%
- ACI: 5%

Year 3
- CPI: 15%
- ACI: 5%
- Quality: 20%
Advanced Models
Advanced Models: Modified Salary-Based Approach

• More advanced in that such models truly move away from wRVU.

• Market reality = wRVU still factor into FMV.

• Require internal stability, to manage increases or decreases in compensation over time as productivity and performance fluctuate.

• Must be well socialized with physicians as non-production pay becomes more substantial.

• Can promote a team-based approach with shared goals and metrics.

Less “formulaic” which will require education of administrative leaders such as legal, compliance, and FMV consultants.
Advanced Models: Modified Salary-Based Approach

• Model may be 75% Base Salary and 25% Incentive Compensation.

• Set a Target Total Cash Compensation (total salary).

• Determine the approach to allocate Incentive Compensation.

• Align allocations/incentives to MACRA or value-based contracts.

• Develop the Plan Administration guidelines.
Advanced Models: Modified Salary-Based Approach

Setting the initial target cash compensation level can be a function of several factors:

- Market-based compensation at the individual level:
  - Productivity level (wRVU).
  - Compensation percentile rank (e.g., up to P75).
  - Compensation per wRVU percentile rank (e.g., ~ median up to P60 or P65).
  - Production to compensation ratio (e.g., P60 production : P65 compensation).
- Equity within the department and across the organization.
- Individual contributions in areas such as administration and research (FTEs).
- Individual quality and related performance.
- Recruitment and retention needs.
Advanced Model Example: Modified Salary-Based Approach

The weighting can be adjusted to align with your value-based performance targets.

- **Clinical Quality and Efficiency**: Clinical Quality and cost based portion of compensation
- **Patient Satisfaction**: Patient Satisfaction or Value-Based Goals
- **Access**: Panel Based Access Goals
- **Discretionary / Production Bonus**: Discretionary portion of compensation can be based on Production

60% - Clinical Quality and Efficiency
20% - Patient Satisfaction
15% - Access
5% - Discretionary / Production Goals
Advanced Models: A Salary-Based Approach

The Plan Administration Guidelines might include:

- Annual performance evaluations.
- Compensation and productivity will be reviewed periodically (minimally at mid-year.)
- Individuals projected to increase or decrease annualized work RVU production by 5%/10% or more will be subject to individual review.
- Individual review *may* result in adjustment to the compensation level at the mid-year review (a change is not mandatory if there is a documented, approved change in work expectations).
- Each year Medical Director/Chair/Specialty Leader will be allocated dollars for increases to base salaries, which are to be distributed based on individual merit consistent with the compensation philosophy.
- Total cash compensation cap (can be productivity adjusted).
- Adjustments for FTE status will occur based on service line/department policy.
Advanced Models

• Have any of the employers represented here today contracted directly with providers? With what specific goals?

• Are any employers working with payers on disease-specific or condition-specific improvement plans, such as diabetes?

• For large employers, do you have on-site wellness or urgent care clinics?

• How are these programs working for you?
Questions and Comments
"They always say time changes things, but you actually have to change them yourself."

-Andy Warhol