AMGA

Advancing High Performance Health

AMGA Consulting

Advanced Strategies in APM Qualification, Development and Operations

11/30/2016

Presentation

I. MACRA Overview
II. Merit-Based Incentive Payment System (MIPS)
III. Medical Group Risk Readiness (AMGA Survey)
IV. ACO Survey Overview
V. Advanced Alternative Payment Models (APMs)
VI. Transitioning from MIPS to APMs
VII. Journey to Population Health and Value Based Care
VIII. Provider Compensation: Aligning Pay with Desired Outcomes

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

AMGA Consulting Biographies

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.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Advanced Strategies in APM Qualification, Development and Operations

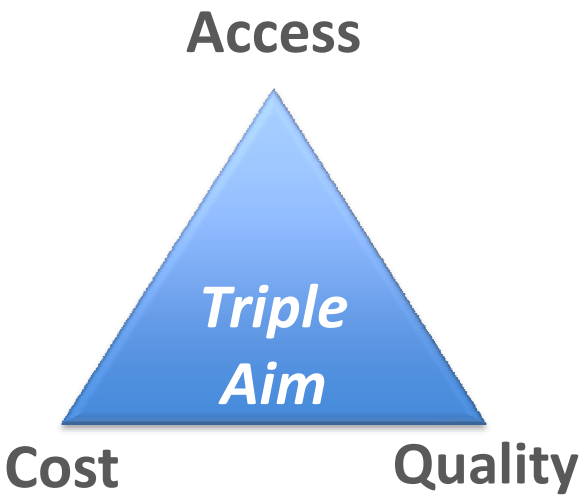
MACRA is here to stay

"Both sides of the aisle agree fee-for-service medicine has to change and coordinated care is better than uncoordinated care"

–Mike Leavitt, FMR. Utah Governor Founder Leavitt Partners,

Health Care Reform – *A Road to Value?*

- Innovative Delivery Models
- Population Health
- Bundled Payments
- Medicaid Expansion
- Health Exchanges
- Accountability and Shared Risk
- Market Consolidation
- Gainsharing
- MACRA, MIPS and APMs
- Provider-Sponsored Health Plans



Background: MACRA and the Final Rule

The Medicare Access and CHIP Reauthorization Act ("MACRA")

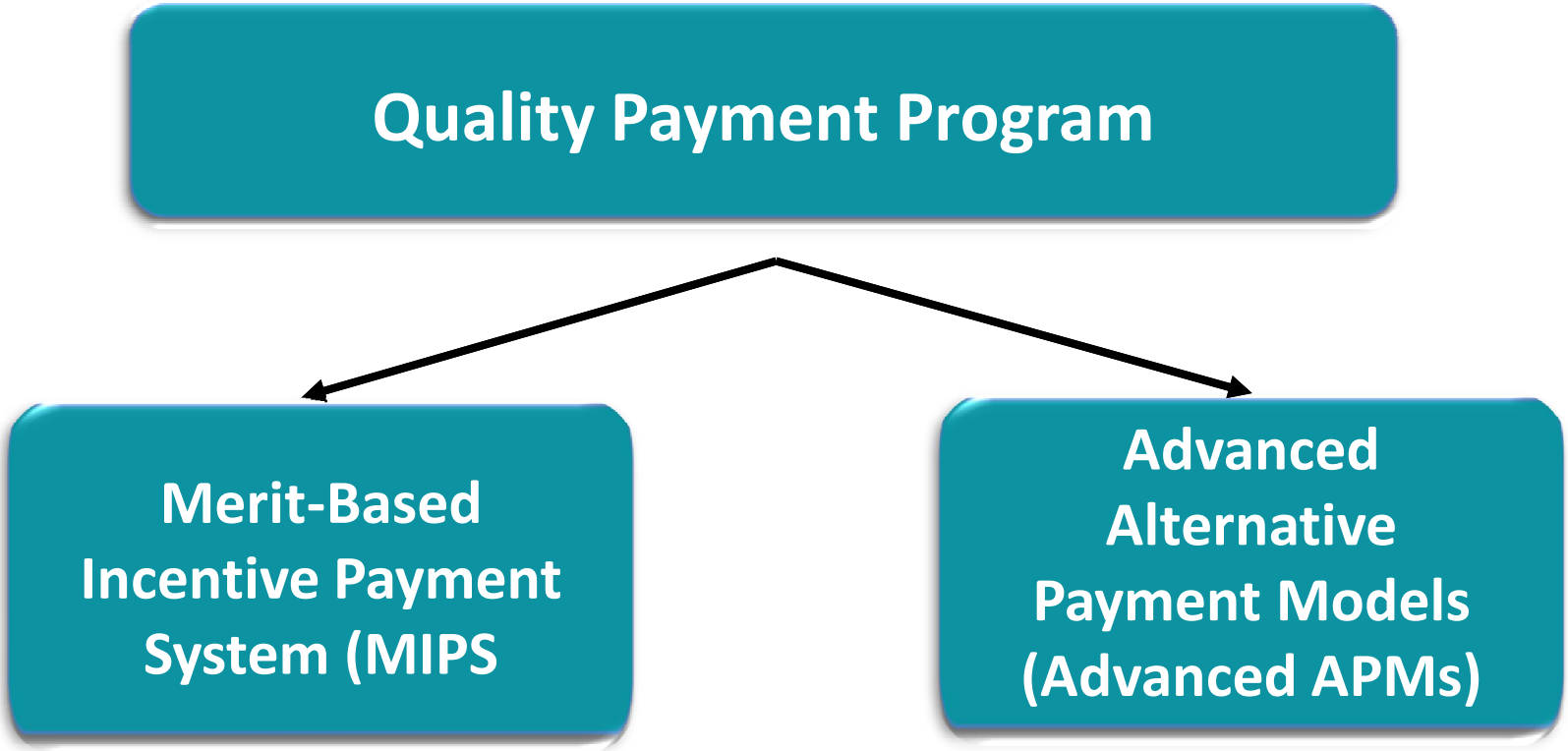
- Repealed the Sustainable Growth Rate ("SGR") Formula methodology
- Streamlined multiple quality reporting programs into the new Merit-based Incentive Payment System ("MIPS") for MIPS eligible clinicians or groups under the PFS.
- Established the Physician-Focused Payment Model Technical Advisory Committee.
- Proposed Rule was issued on April 27, 2016. Comment period ended on June 27, 2016.

The Final Rule

- Issued on October 14, 2016, with 60 day comment period.
- Over 2,400 pages.
- CMS received over 4,000 comments. Over 100,000 physicians and other stakeholders attended its outreach sessions.
- Frames the Quality Payment Program as a program that will evolve over multiple years.

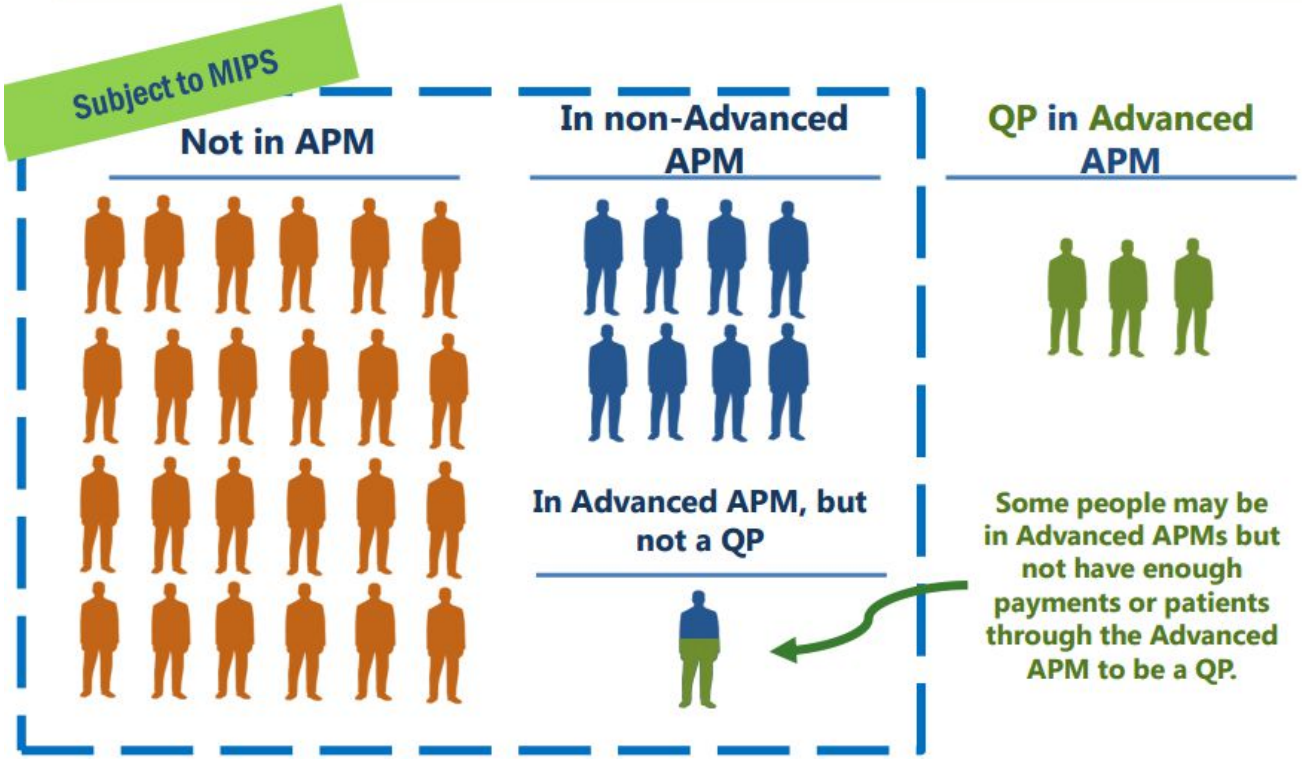
Introduction to the CMS Quality Payment Program

What is the Quality Payment Program (QPP)?



Which Program Will I choose?

Note: Most clinicians will be subject to MIPS.



CMS calculated that 92% of eligible clinicians will fall into the MIPS track while only approximately 8% of clinicians will fall into the APM track.

MIPS: Eligible Clinicians

Years 1 and 2

Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

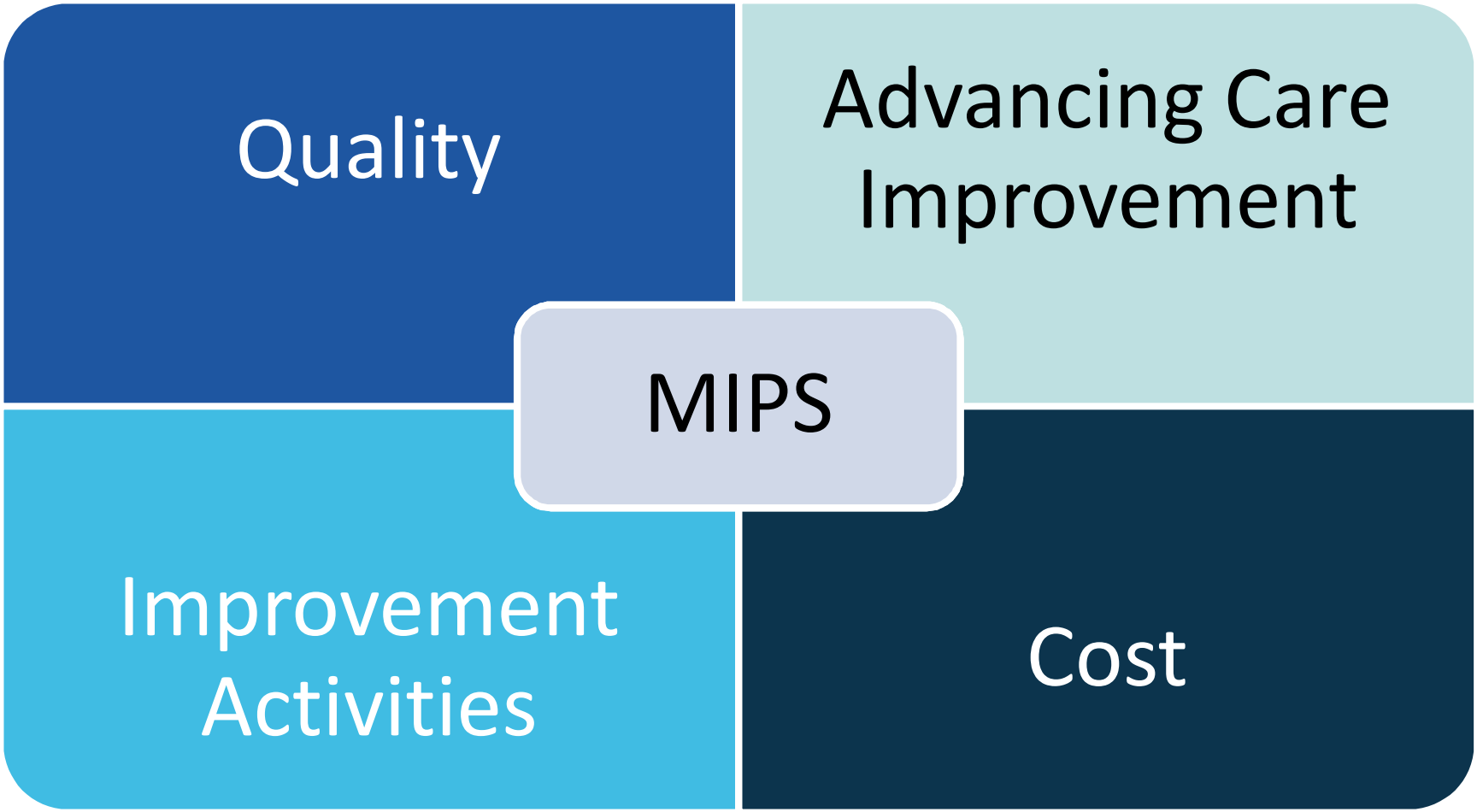
Secretary may broaden Eligible Clinicians group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

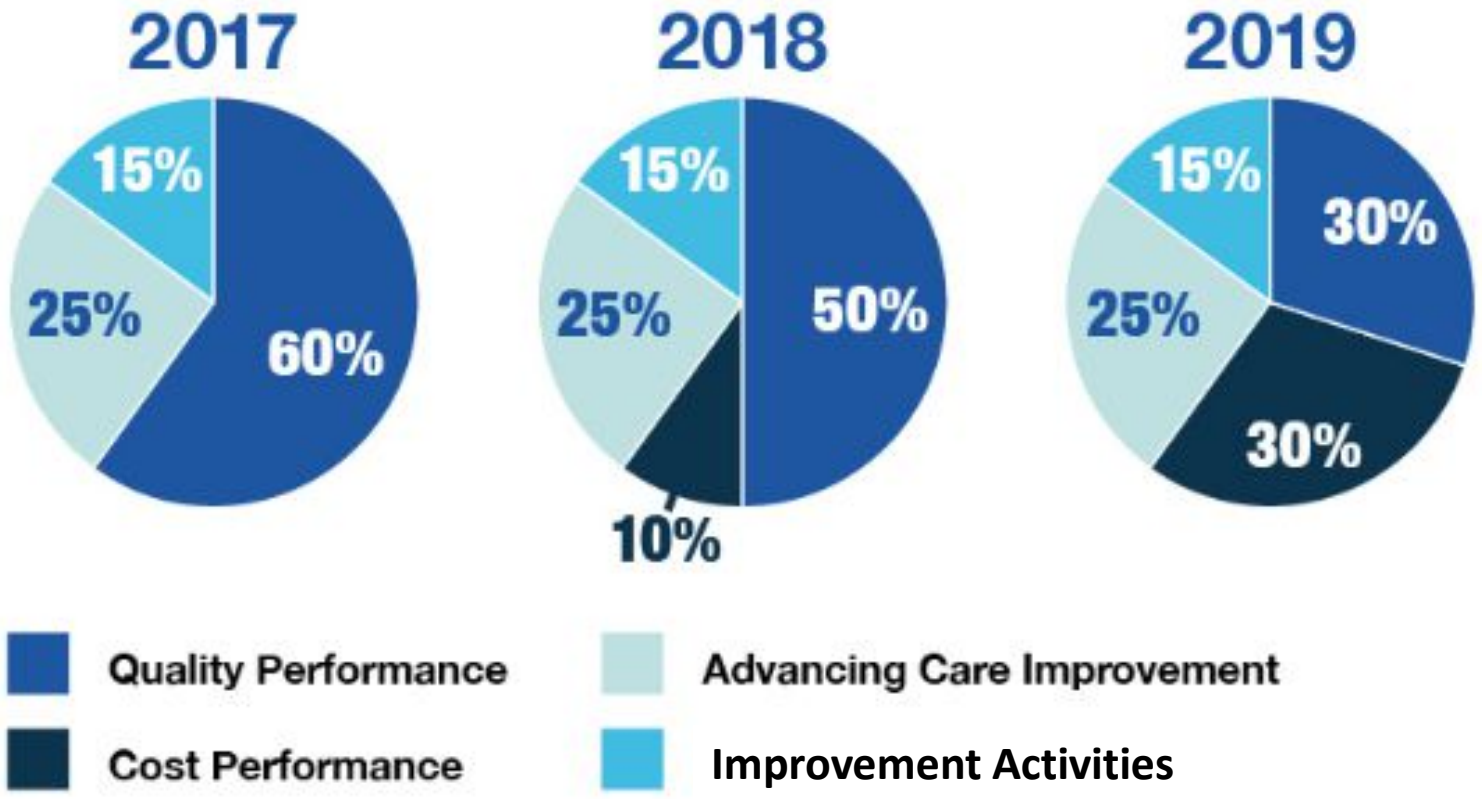
Minimum inclusion criteria:

Medicare Part B clinicians billing more than $30,000 a year **and** providing care to more than 100 Medicare beneficiaries, in each performance year.

MIPS: Four Components of MIPS Composite

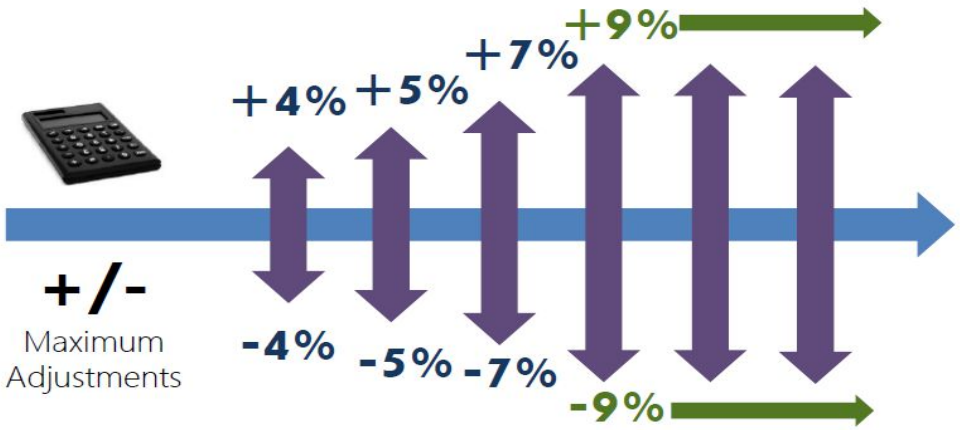


MIPS: 2017 – 2019 Composite Scoring



Upside/Downside Risk Under MIPS

Based on a MIPS Composite Performance Score , clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



2019 2020 2021 2022 onward

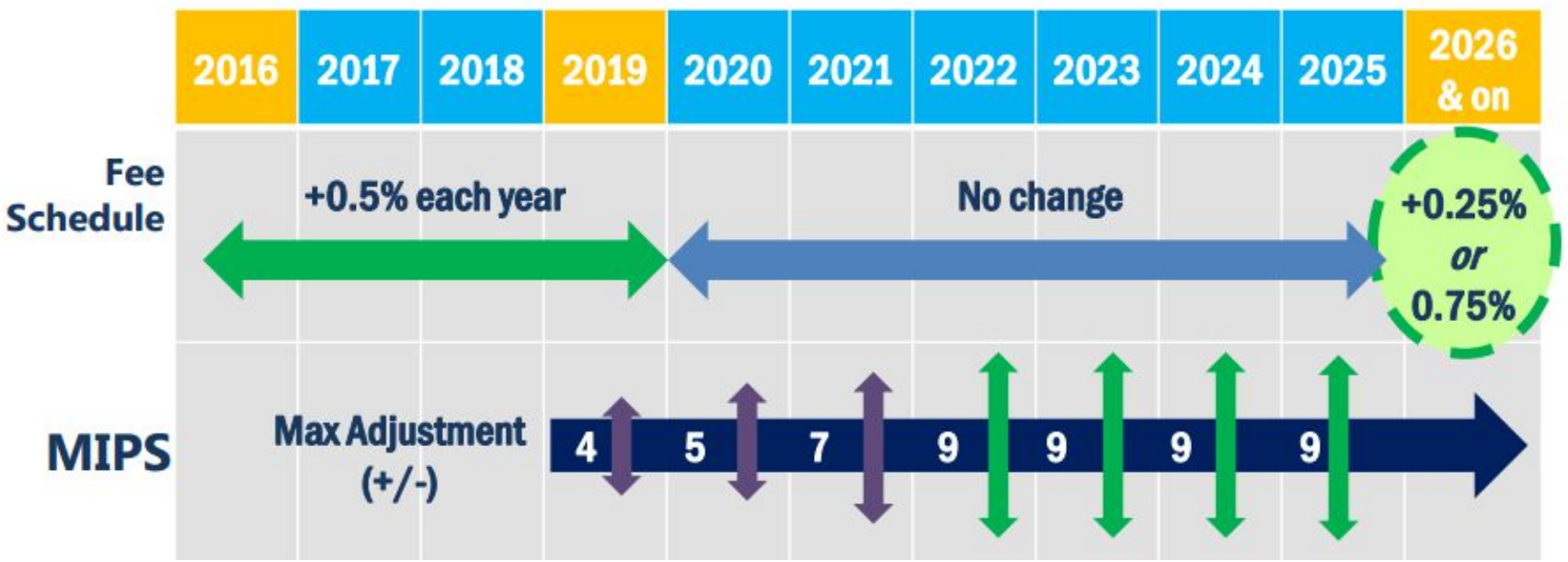
Merit-Based Incentive Payment System **(MIPS)**

Adjusted Medicare Part B **payment** to clinician

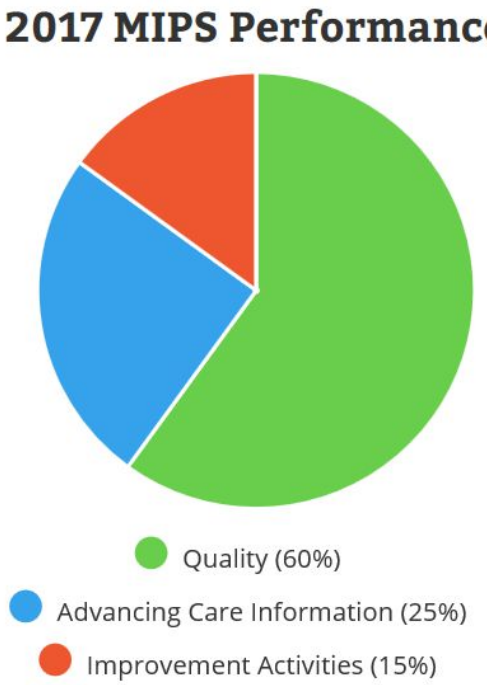
The potential maximum adjustment % will increase each year from 2019 to 2022

Source: CMS Website

MIPS Fee Schedule and Reimbursement Adjustments



The MIPS Performance Categories



Quality	Improvement Activities	Advancing Care Information	Cost
Replaces PQRS.	New category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

Quality	Improvement Activities	Advancing Care Information	Cost
2017	**2017**	**2017**	**2018**

MIPS: 2016 – 2024 Key Dates

Year	
2016	**QPP Proposed and Final Rule released.**
2017	Quality Payment Program first performance year begins.
2018	MU, PQRS and VBPM sunset for Medicare providers at the end of 2018.
2019	MIPS Payment Adjustment (+/-) 4% plus up to a 12% bonus for achieving 25th percentile or Qualifying Alternate Payment Models (APM) Participant 5% Incentive Payment.
2020	MIPS Payment Adjustment (+/-) 5% plus up to a 15% bonus for achieving 25th percentile or Qualifying APM Participant 5% Incentive Payment.
2021	MIPS Payment Adjustment (+/-) 7% plus up to a 21% bonus for achieving 25th percentile or Qualifying APM 5% Participant Incentive Payment.
2022	MIPS Payment Adjustment (+/-) 9% plus up to a 27% bonus for achieving 25th percentile or Qualifying APM Participant 5% Incentive Payment.
2023	MIPS Payment Adjustment (+/-) 9% plus up to a 27% bonus for achieving 25th percentile or Qualifying APM Participant 5% Incentive Payment.
2024	MIPS Payment Adjustment (+/-) 9% plus up to a 27% bonus for achieving 25th percentile or Qualifying APM Participant 5% Incentive Payment.

MIPS: 2017 Pick your Pace – Overview

- **No participation:** Organizations not exempt from MIPS that do not send in any 2017 data will receive a negative 4% payment adjustment.

- **Report one measure for a minimum 90-day period to avoid a penalty:** Reporting only one Quality, ACI, or CPIA measure will earn enough MIPS points to avoid a penalty and possibly earn a small incentive.

- **Report more than one measure for a minimum 90-day period:** Reporting more than one measure in any or all of the Quality, ACI, or CPIA categories avoids a penalty, maximizes the MIPS score, and potentially earns the highest possible incentive.

- **Report more than one measure for the entire year:** Reporting more than one measure in any or all of the Quality, ACI, or CPIA categories avoids a penalty, maximizes the MIPS score, and potentially earns the highest possible incentive.

- **Participate in an Advanced APM:** Organizations that Sufficiently participate through an Advanced APM earn a 5% Part B bonus and are exempt from MIPS.

MIPS: 2018 and Beyond

- For each performance year, CMS sets a performance threshold (PT) number of points at which providers earning PT points receive a 0% adjustment to their Medicare Part B payments.
- Starting in 2019, the performance threshold is determined annually as the mean or median of the MIPS scores for all eligible clinicians in a prior period selected by CMS.
- For 2017, CMS has set the performance threshold as 3 points and the exceptional performance threshold to 70 points in order to greatly reduce the chance of being penalized for low performance during the transition year
- Each incremental point that a provider earns above the PT results in progressively higher incentives, whereas for each point the final score is below the threshold, the clinician is assessed a proportional penalty until a floor is reached

MIPS: A New Level of Transparency

- Beginning in 2018, Medicare's Physician Compare website will publish each eligible clinician's annual final score and the scores for each MIPS performance category.
- Consumers will now be able to see their clinicians rated on a scale of 0 to 100 for Quality, and Advancing Care Information categories. This increased level of transparency will also allow patients to compare providers.
- In addition to a 0 to 100 score, all statistically significant measures will be reported in the Quality and Advancing Care Information categories, for every clinician.
- Clinical improvement activities reported for the Clinical Practice Improvement Activities (CPIA) category will be listed for every clinician.
- Following the 2018 performance year for the Resource Use, this data will also be published. Physician compare will continue to publish cost utilization data for all Medicare Part B clinicians.

MIPS: Exceptional Performance Bonus

- $500 million available each year from 2019 – 2024 for those with exceptional performance
- Exceptional performance threshold is 70 points for performance year 2017
- Limited to stop-gain restrictions

MIPS: Budget Neutrality

- 90% est. to receive positive or neutral MIPS payment adjustment
- 90% of practices w/ 1-9 clinicians est. to receive positive or neutral payment adjustment
- CMS "Flattening the Curve": score distribution will be more limited
- 3x scaling factor can increase or decrease composite scores to ensure budget neutrality

Size	% Positive/ Neutral	% Negative	Aggregate Positive/ Neutral	Aggregate Negative	Aggregate $500 M	Net
1-9	90%	10%	$72	-$99	$173	$145
10-24	90%	10%	$24	-$37	$55	$42
25-99	92.6%	7.4%	$31	-$47	$70	$54
100+	98.5%	1.5%	$72	-$16	$202	$258

Aggregate Positive/Neutral = $199 Aggregate Negative = -$199

Figures in Millions

MIPS : Take-Away Points

- MACRA and MIPs are here to stay
- Payment adjustments will begin in 2019, based on the 2017 reporting period
- Initial projections show >85% of providers will participate in MIPs
- MIPS Provides streamlined method for data collection and submission
- MIPS Replaces 3 complex Quality reporting systems with one program
- Providers/organizations are allowed to pick the pace of participation from 2017 - 2019

AMGA MIPS Learning Collaborative Begins March 2017

To learn more visit amga.org/mips

Learning Objectives

1. Develop strategies to achieve success in all four MIPS domains.
2. Implement MIPS educational and engagement programs for your organization.
3. Understand your organization's relative performance to benchmarks.
4. Understand your Quality Resource Use Reports (QRURs.)

Benefits

- Participate in 2017 to be potentially rewarded in 2019
- Choose efficient and cost-effective reporting option
- Measure organizational performance in quality and cost domains
- Learn best practices, optimize and standardize operational tips and tools, and utilize resources from other leading medical groups and health systems
- Develop a culture that enables your organization to achieve better quality and efficiency
- Cultivate a lifelong peer-learning network

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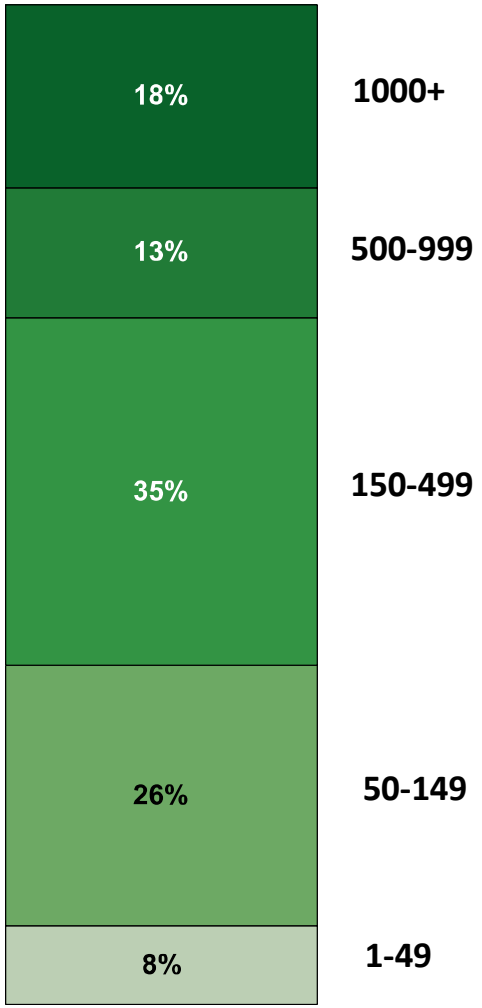
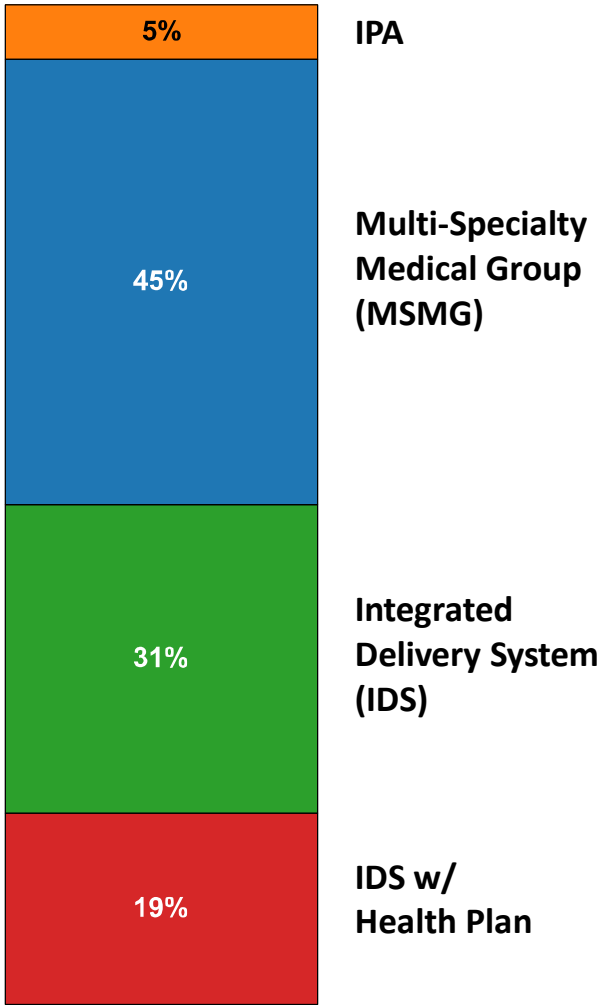
2016 AMGA Risk Readiness Survey Results

Demographics

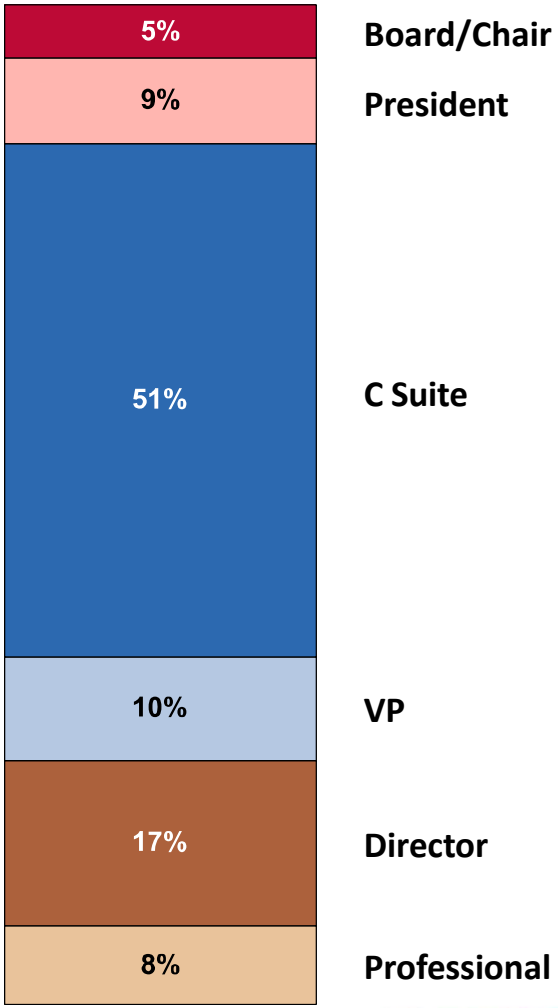
of Physician FTEs



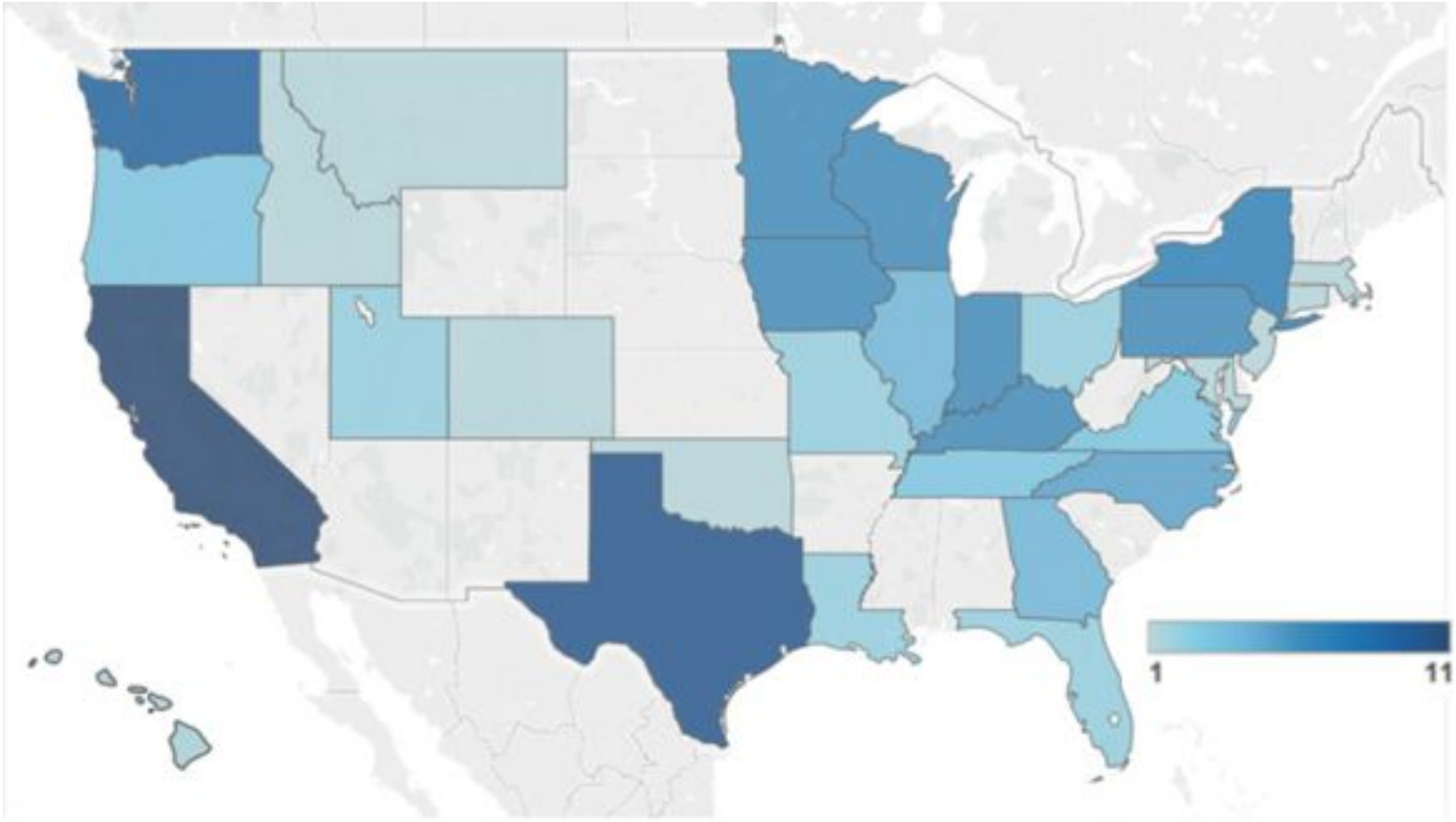
Organization Type



Role

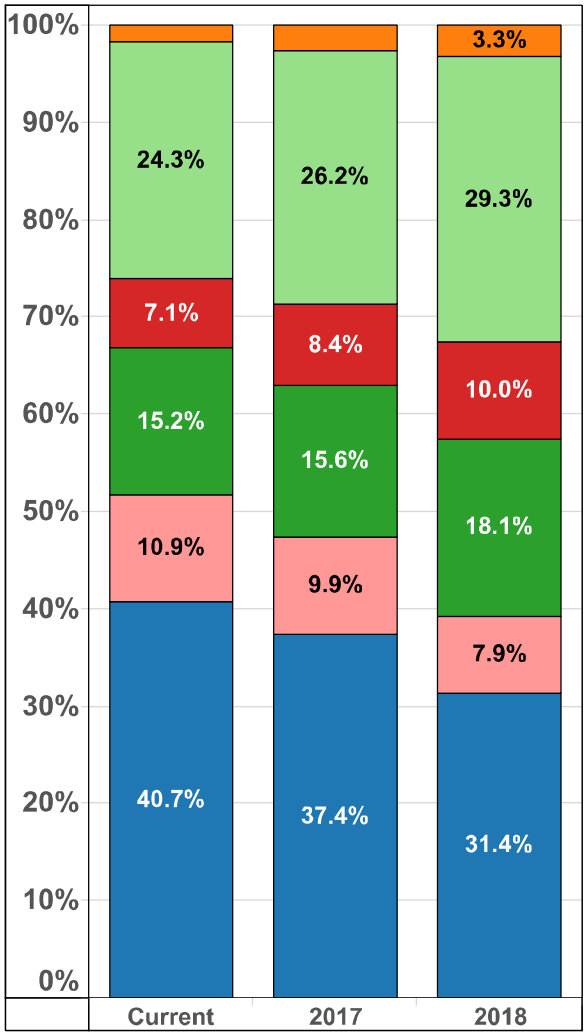


Map of number of complete responses

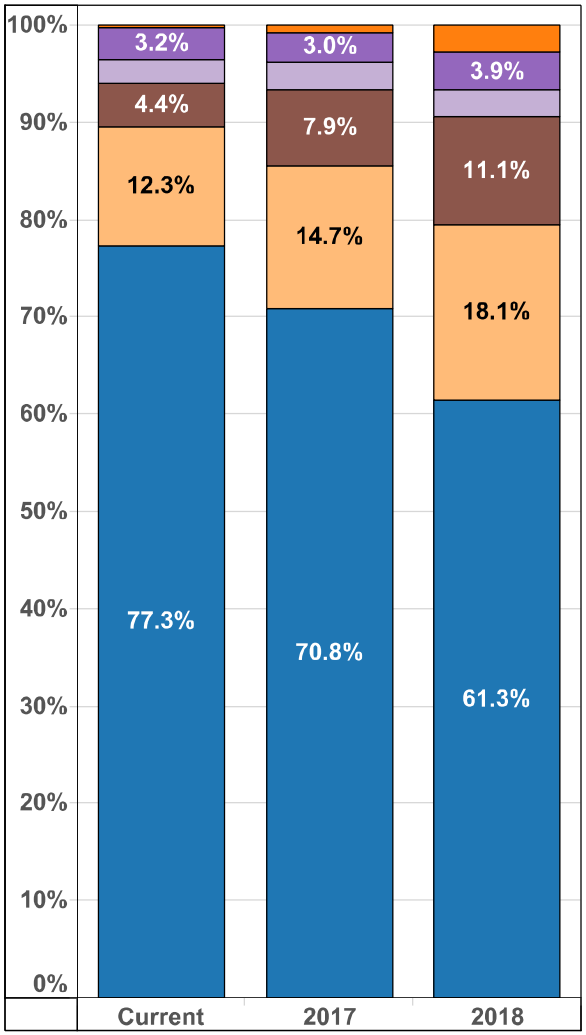


Revenue Sources: Overall

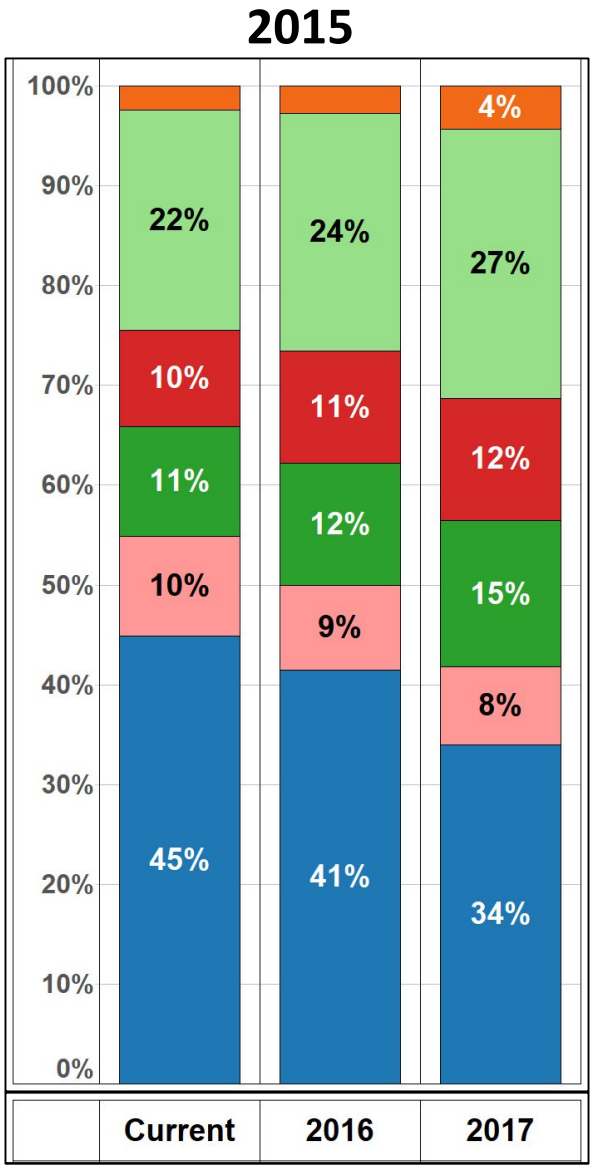
Federal

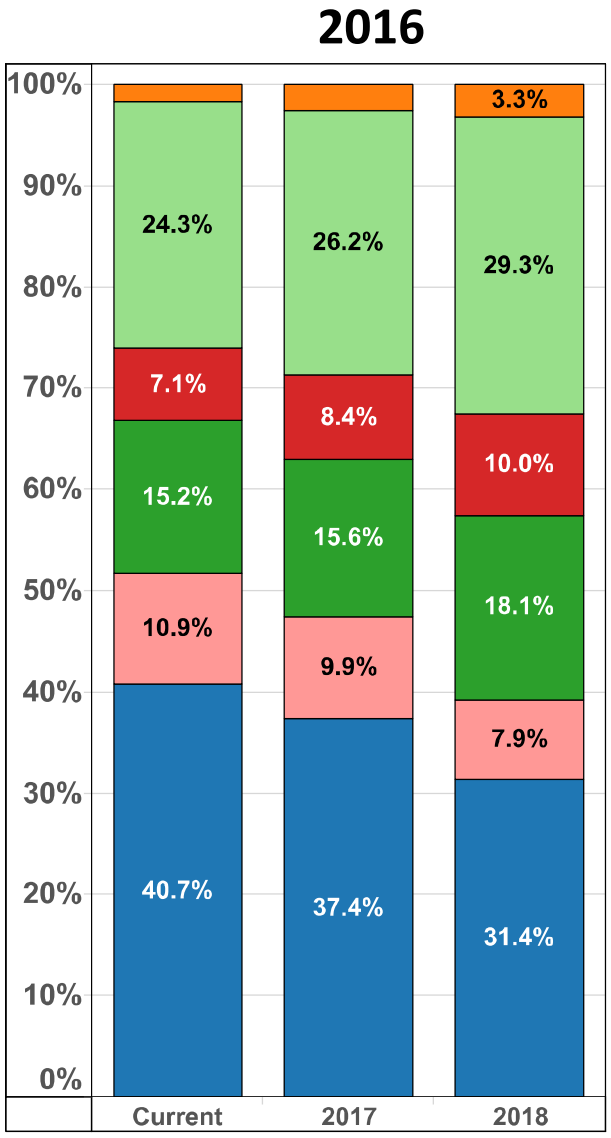


Commercial



Revenue Sources: Federal Overall





Bundled Payment

Medicare Advantage

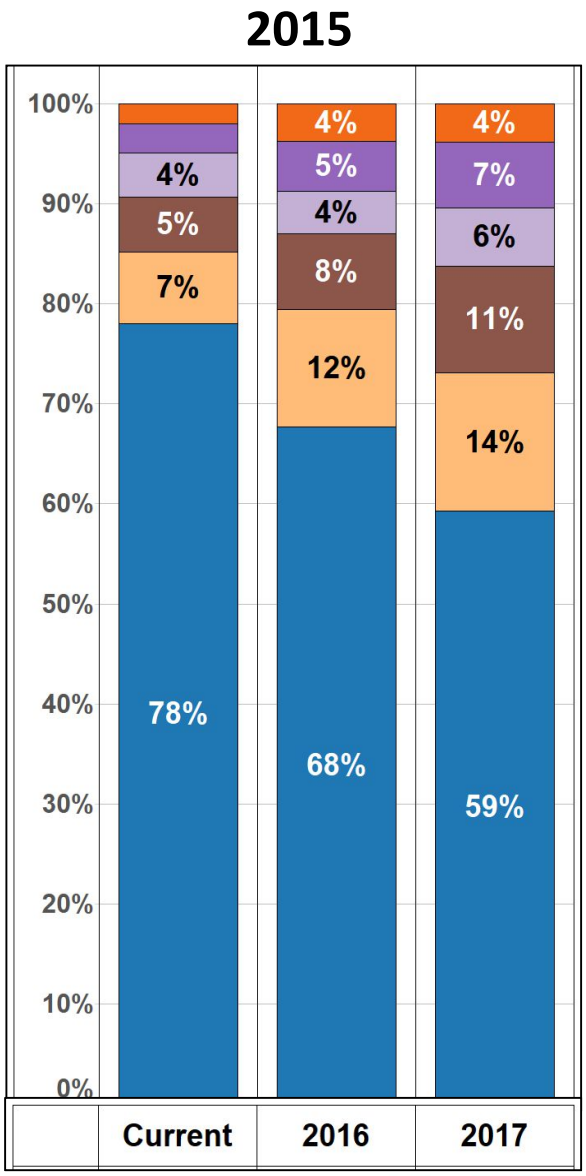
Medicaid Mgd. Care

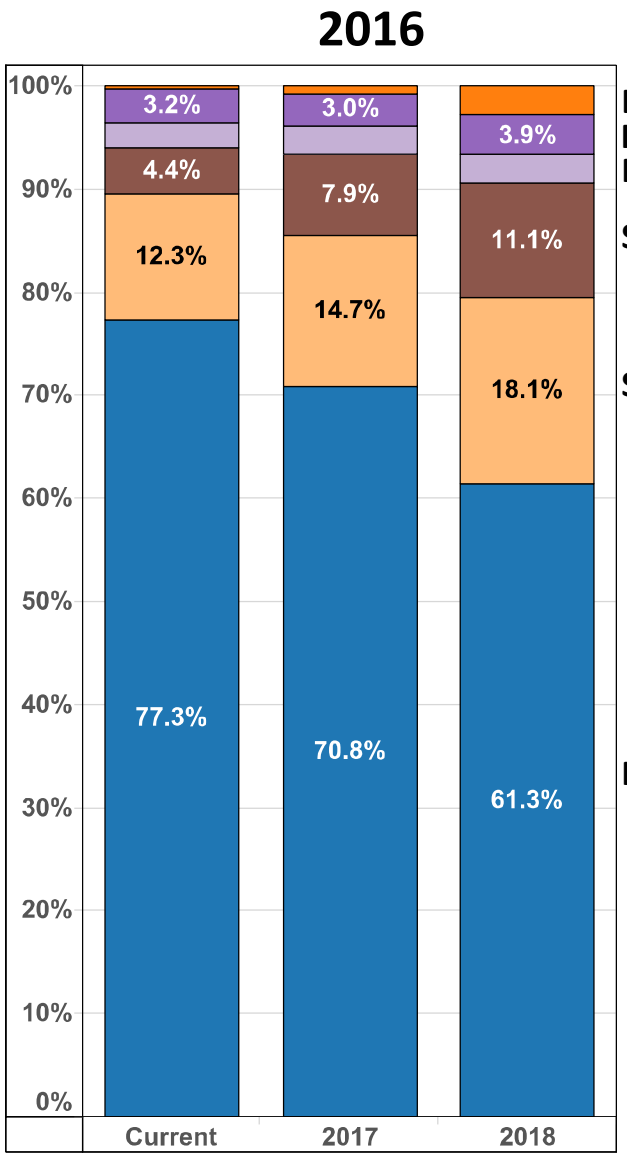
ACOs

Medicaid FFS

Fee for Service

Revenue Sources: Commercial Overall





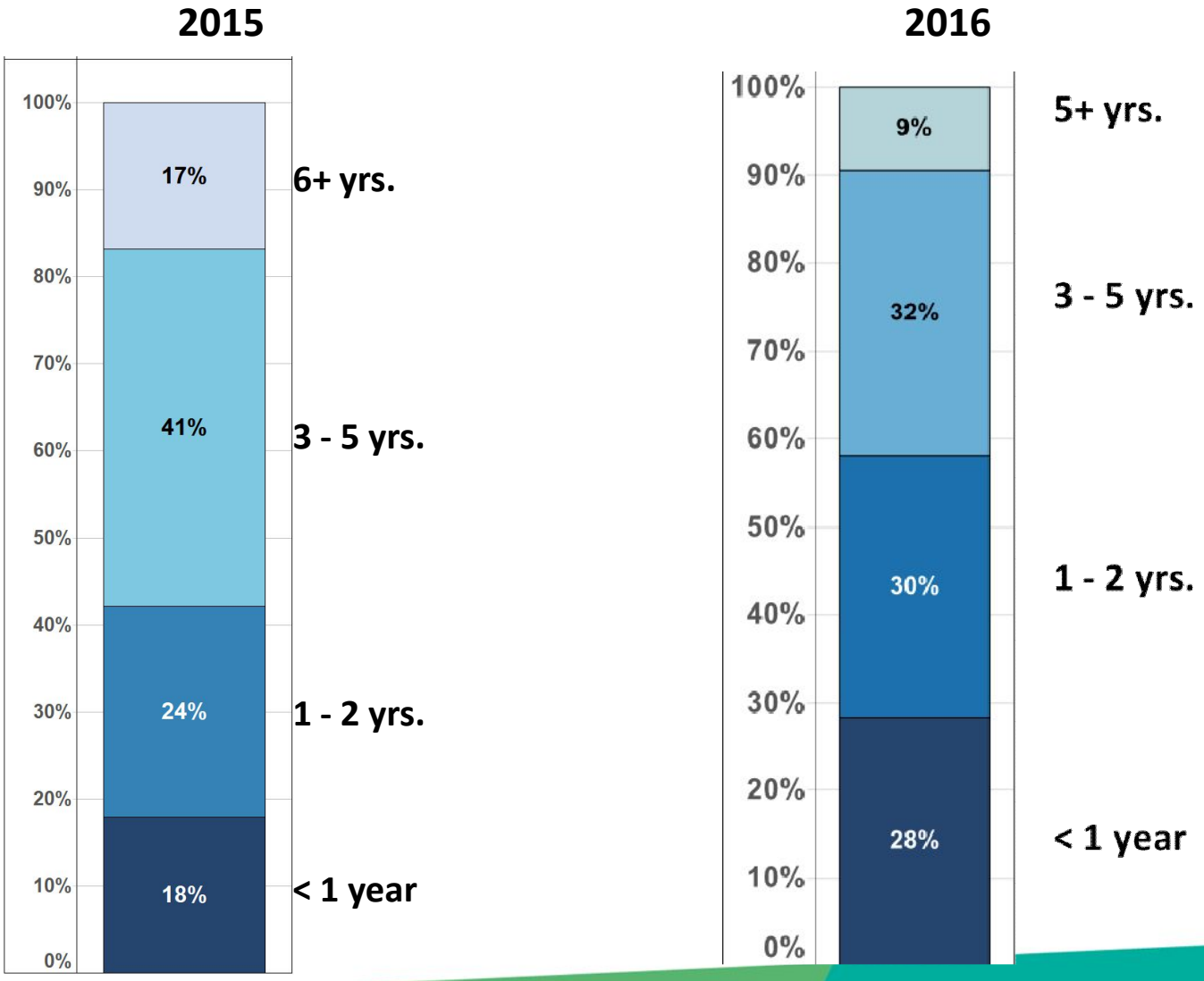
Bundled Payment
Full Capitation
Partial Capitation

Shared Risk

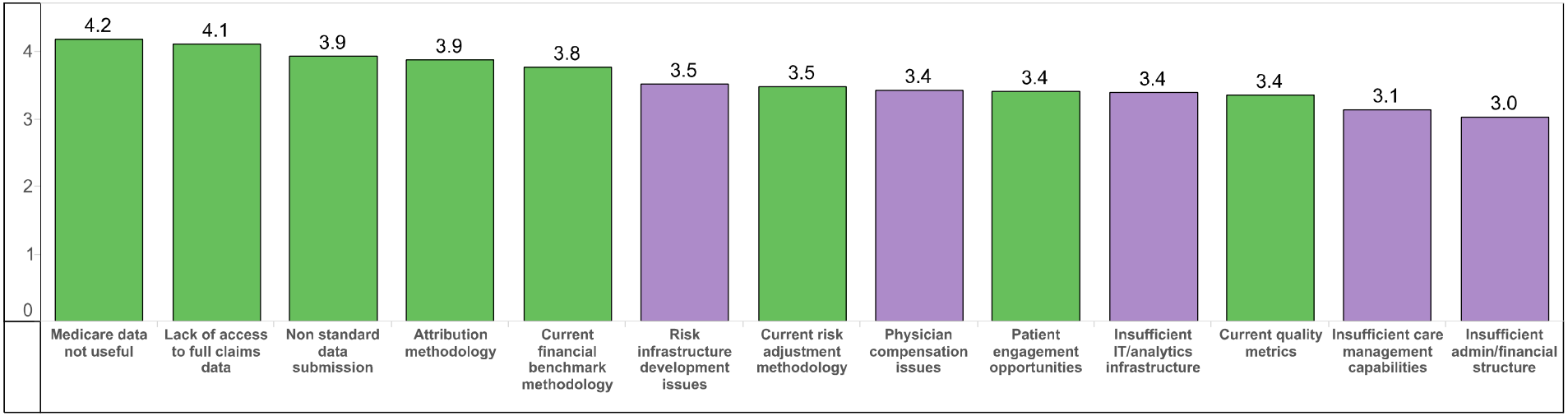
Shared Savings

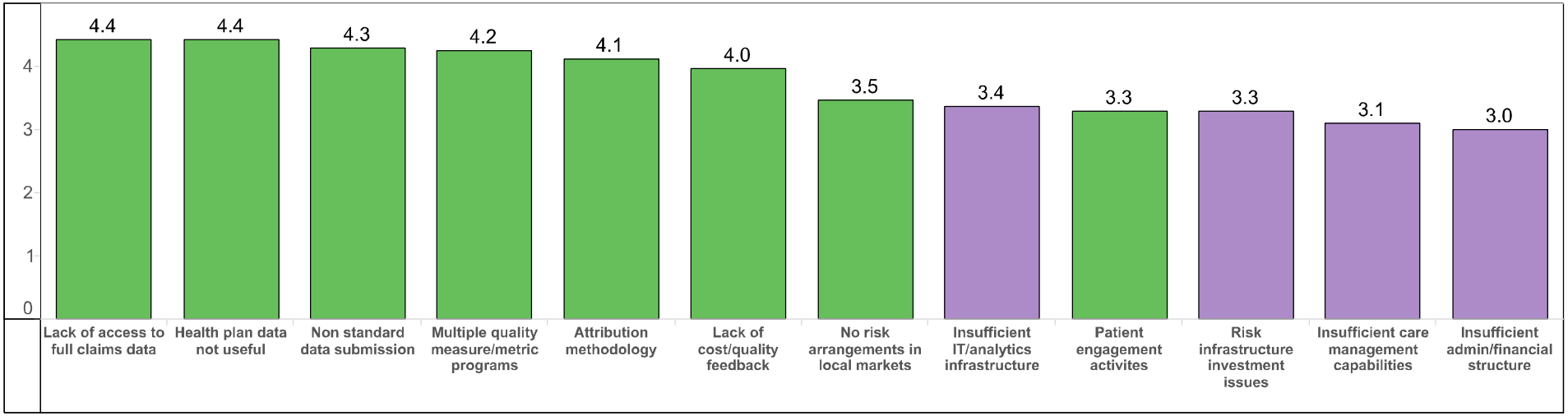
Fee for Service

Length of time before we can accept downside risk: 2015 - 2016

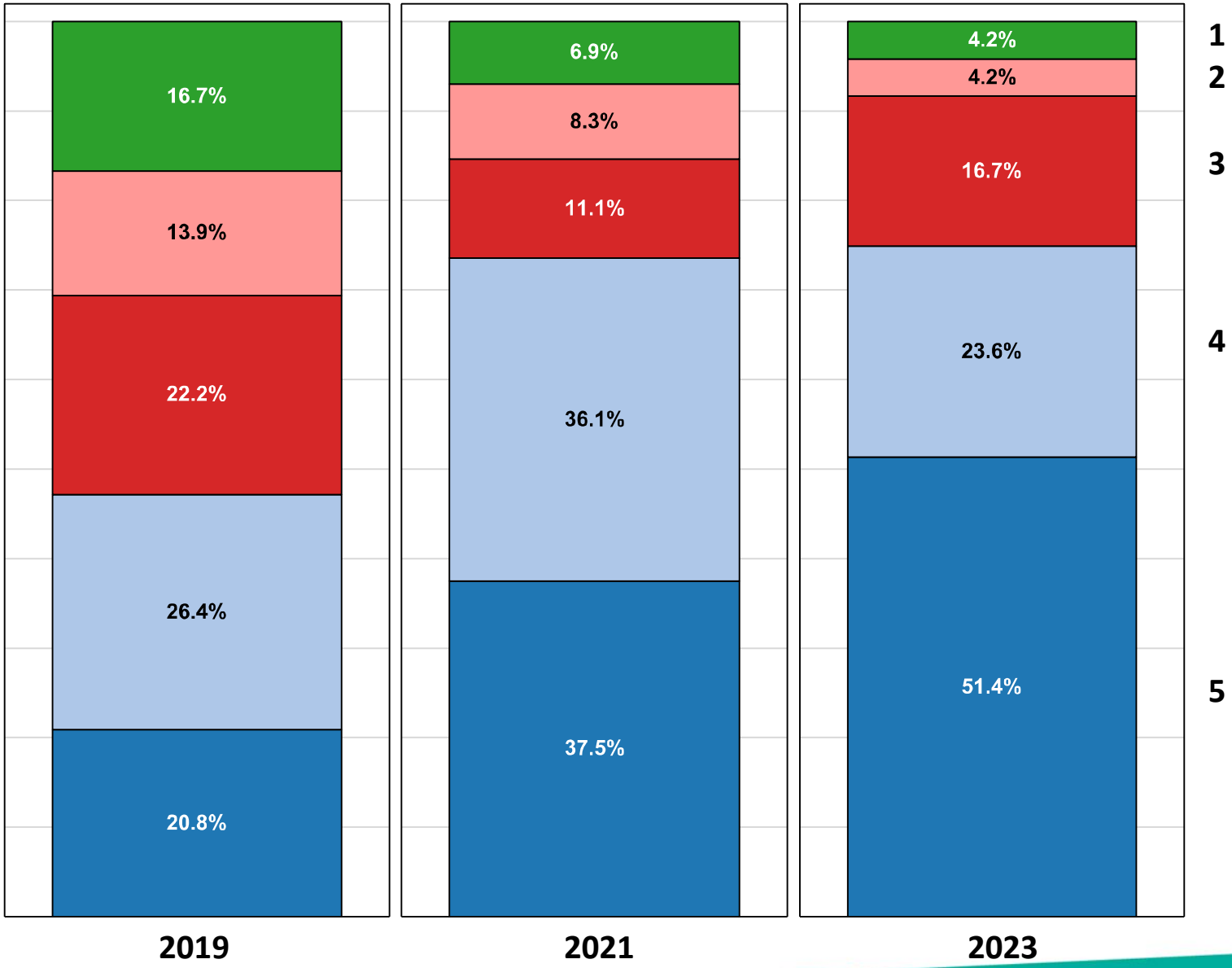


Impediments to taking on risk: Federal/Commercial

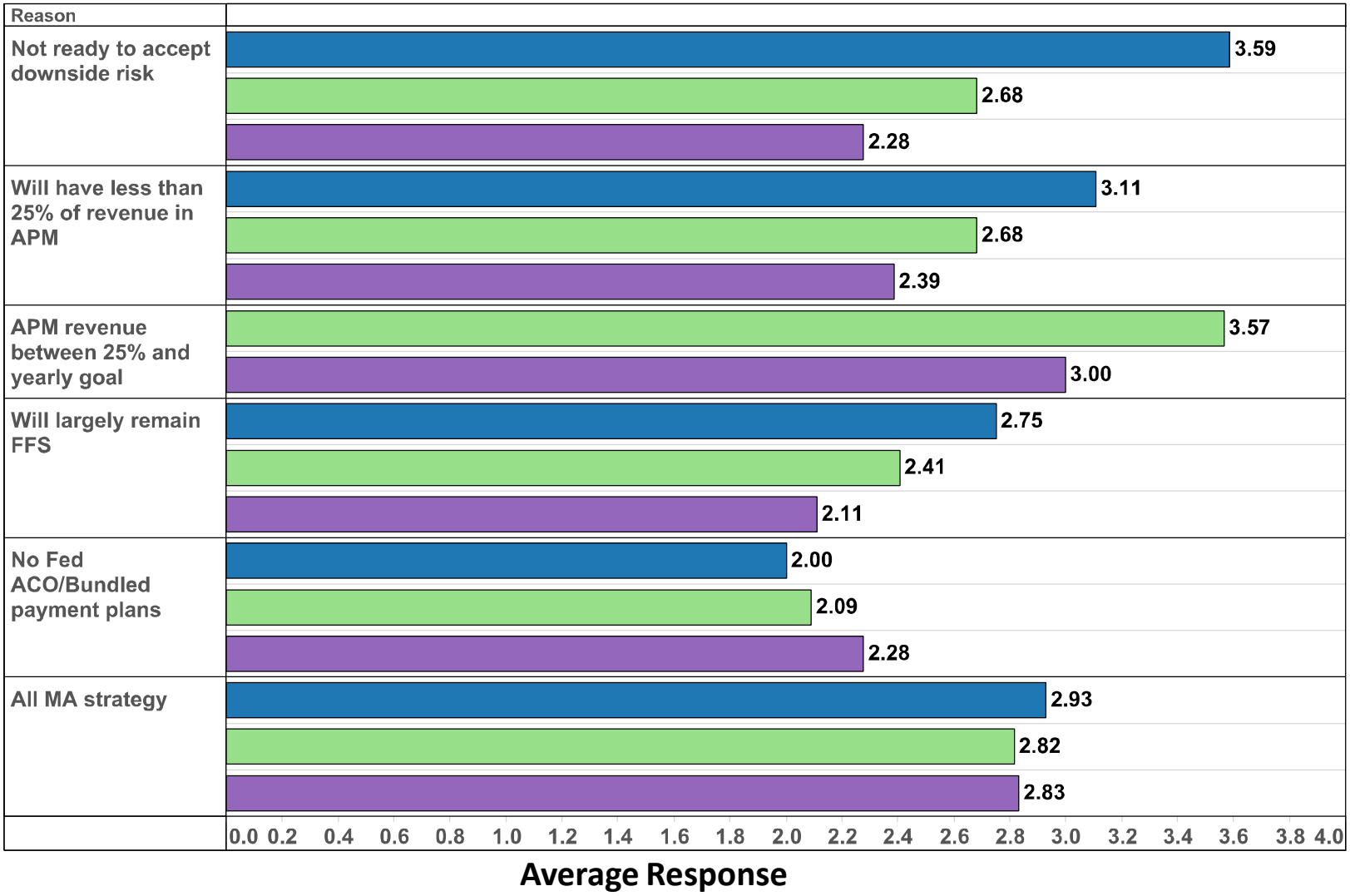




Scale of 1 – 5, APM readiness by year



Reasons why groups will not be APM ready



Conclusions

- Provider organizations are taking on more risk with their federally insured patients than with their commercial patients
  - Groups appear to be “testing the waters” of risk on their federally insured population
  - Retaining a high proportion of fee-for-service payment for commercial patients provides a hedge, since commercial FFS payment rates are generally higher than government fee schedules
- Most groups predict more risk/value payment models and less fee-for-service
  - Trends are consistent across all differences in structure, size, and geographical region
- Larger medical groups tend to have more commercial risk based arrangements
  - They also plan to take on more risk in the future
- More than half of respondents need at least 3 years until they will be ready to take on downside risk
  - Larger groups will be ready earlier
- 70% of respondents have < 20% of commercial insurers offering risk based arrangements

Conclusions continued

- There are several impediments to groups' taking risk—it's not just one thing
  - External factors are perceived as slightly more significant than internal factors
- Data issues are perceived as slightly more significant than financial issues
- < 50% of respondents agree or strongly agree that they will be well prepared for APMs by 2019

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Mechanisms Used By Accountable Care Organizations to Enhance Performance: Findings from the National Survey of ACOs

Original Presentation:
David Peiris
2015 - 2016 Australian Harkness Fellow
Harvard T.H. Chan School of Public Health

THE Dartmouth INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE

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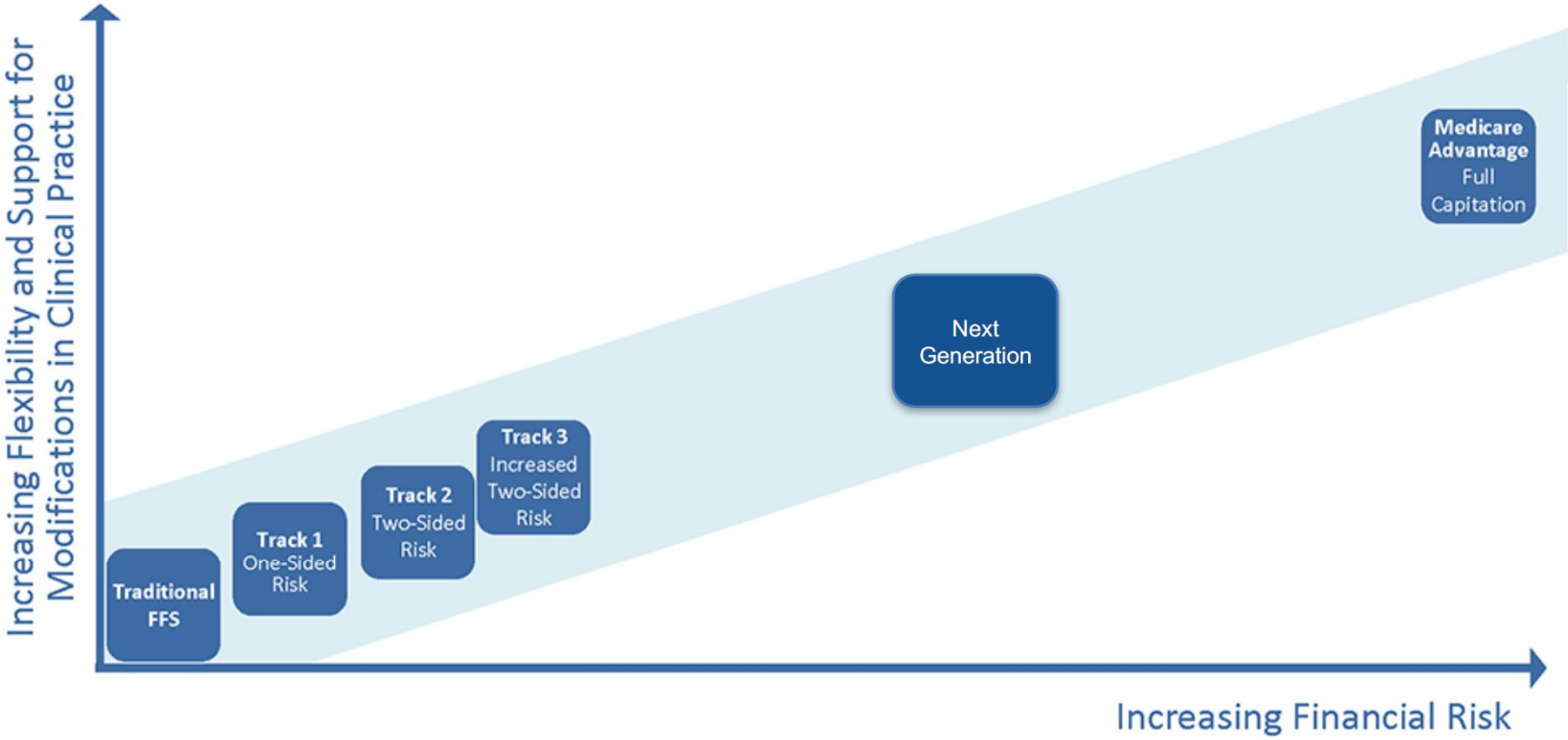
Powerful ideas for a healthier world

ACO Overview

Track	Overview	2016 Participants	Length of contract	Sharing Rate
1	Included in original MSSP, designed to enhance care coordination, improve quality, lower costs	412	3 years (may remain for up to 6)	Up to 50%
1+	Voluntary for Track 1, new MSSP participants. Some downside risk, less than Track 2/3. On-ramp to risk.	Begins in 2018		
2	Adds downside risk	6	3 years	Up to 60%
3	Added to MSSP in 2016. Takes successful MSSP/Pioneer elements, adds higher shared savings and greater risk.	16	3 years	Up to 75%
Next Gen	Next Gen aims to transition providers from fee-for-service to capitation. Next Gen ACOs must operate under outcomes-based contracts with other purchasers by the end of the first performance period.	21	3 years w/ option for 2 additional years	Arrangement A – up to 80% Y1–3, 85% Y4–5; Arrangement B – Up to 100%

ACO Overview



Source: S.L. Kocot, R. White and M. McClellan. "The Revised Medicare ACO Program: More Options...And More Work Ahead." *Health Affairs Blog.*

ACOs: Value and Payment

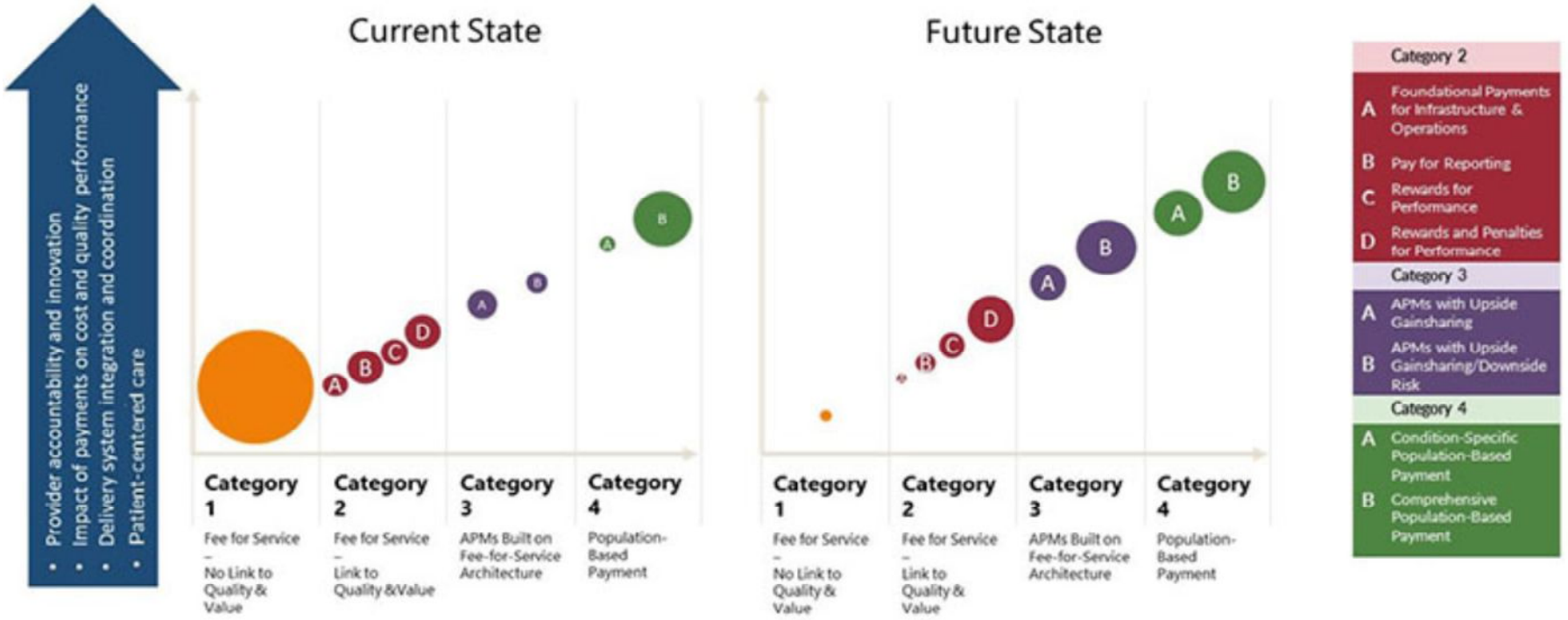
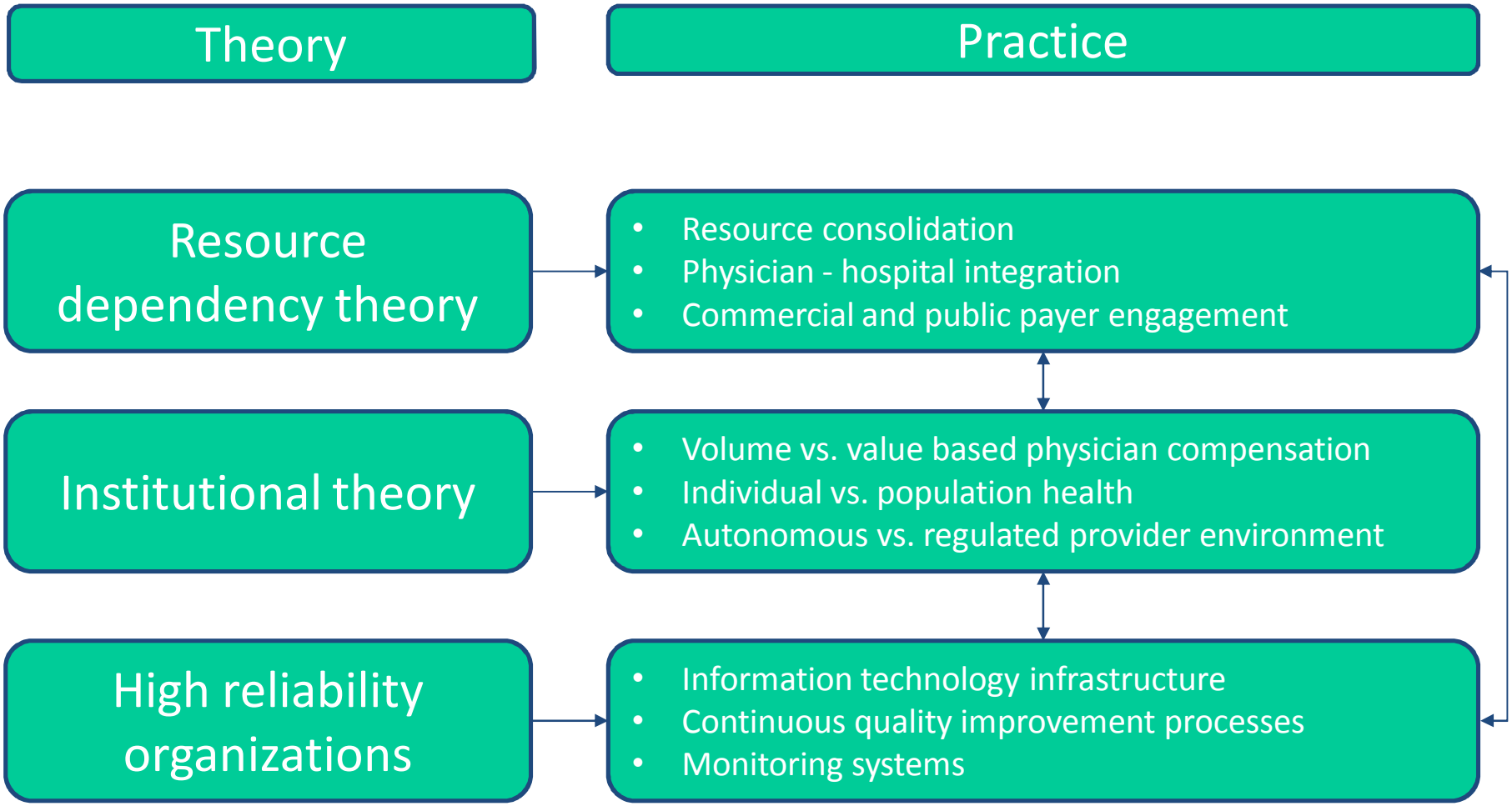
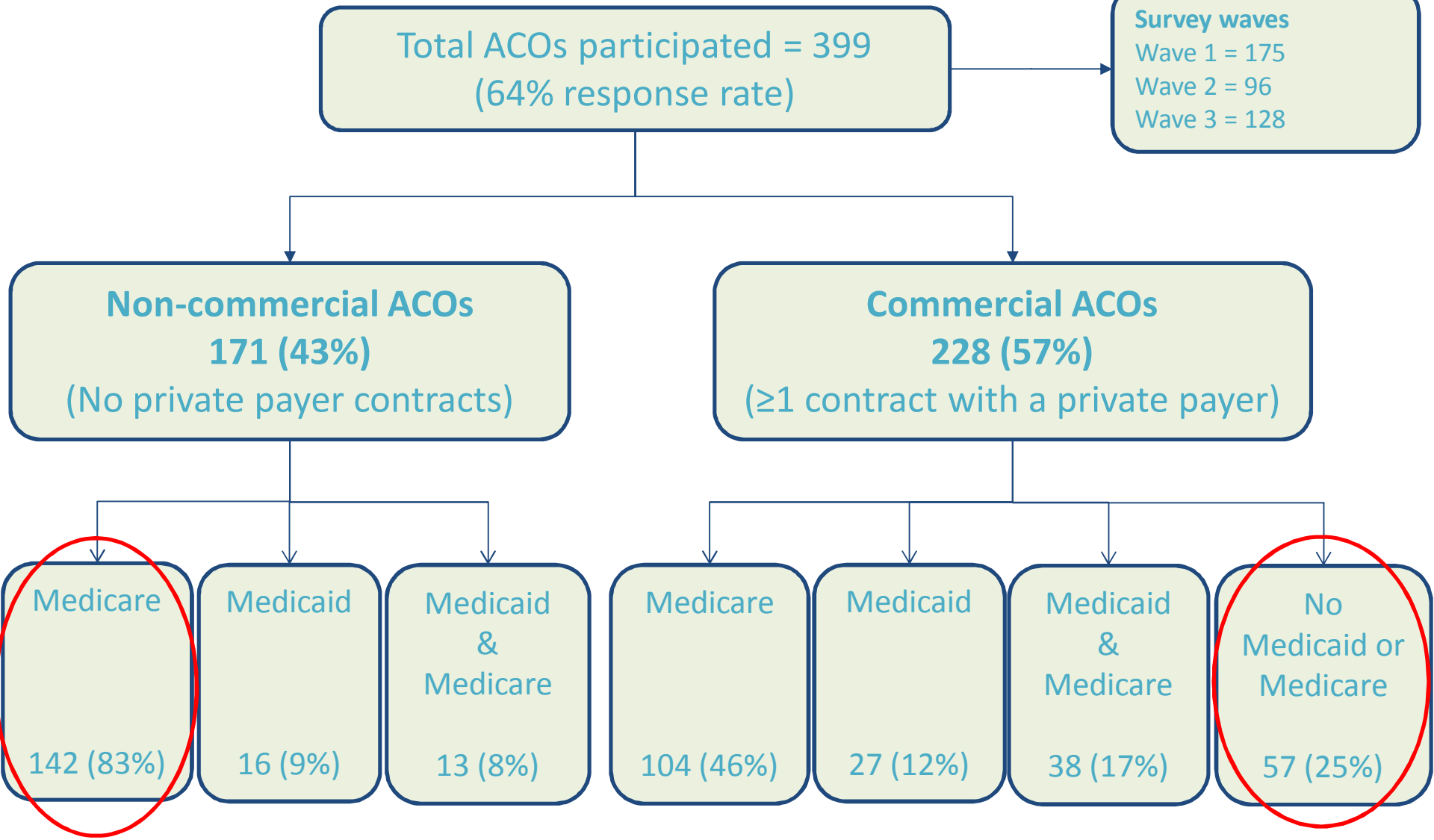


Figure 1. The circles in this graphic estimate the relative degree of payment model activity in each category and do not represent exact figures or percentages.

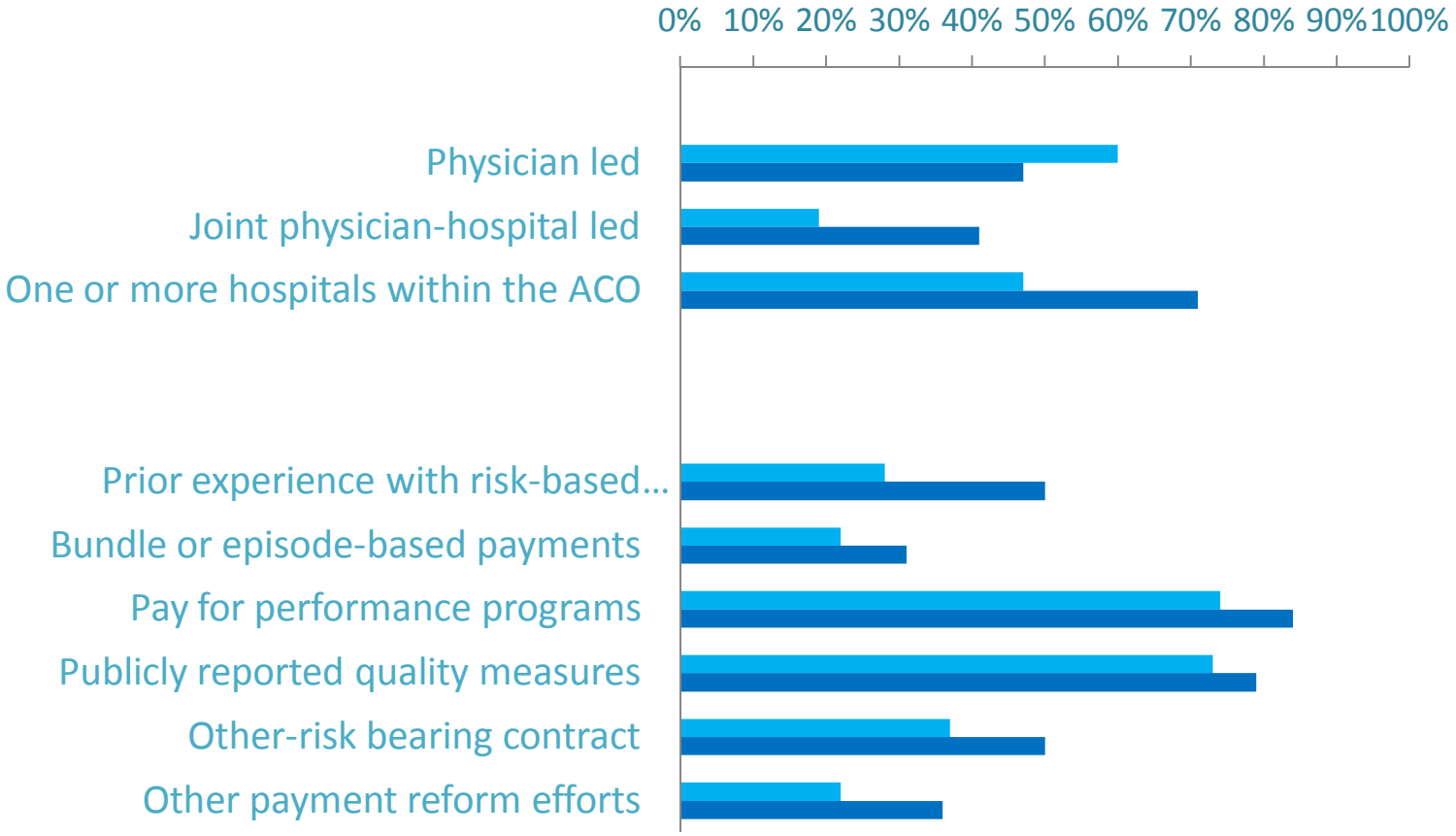
Theories of Organizational Change



ACO Survey Sample



ACOs: Results– Structure



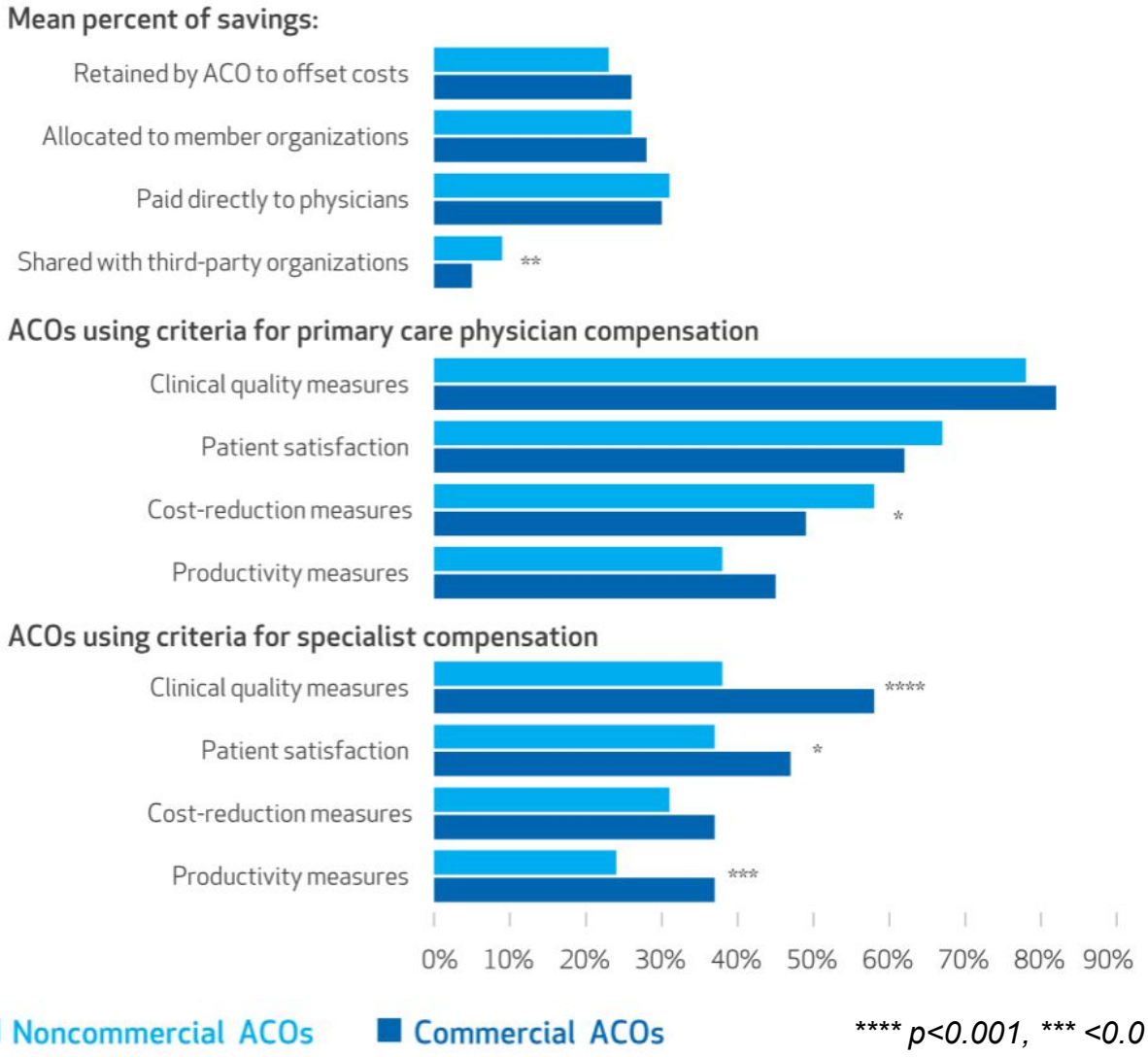
Noncommercial ACOs (n =171)

Mean Medicare beneficiaries
n=14,347

Commercial ACOs (n =228)

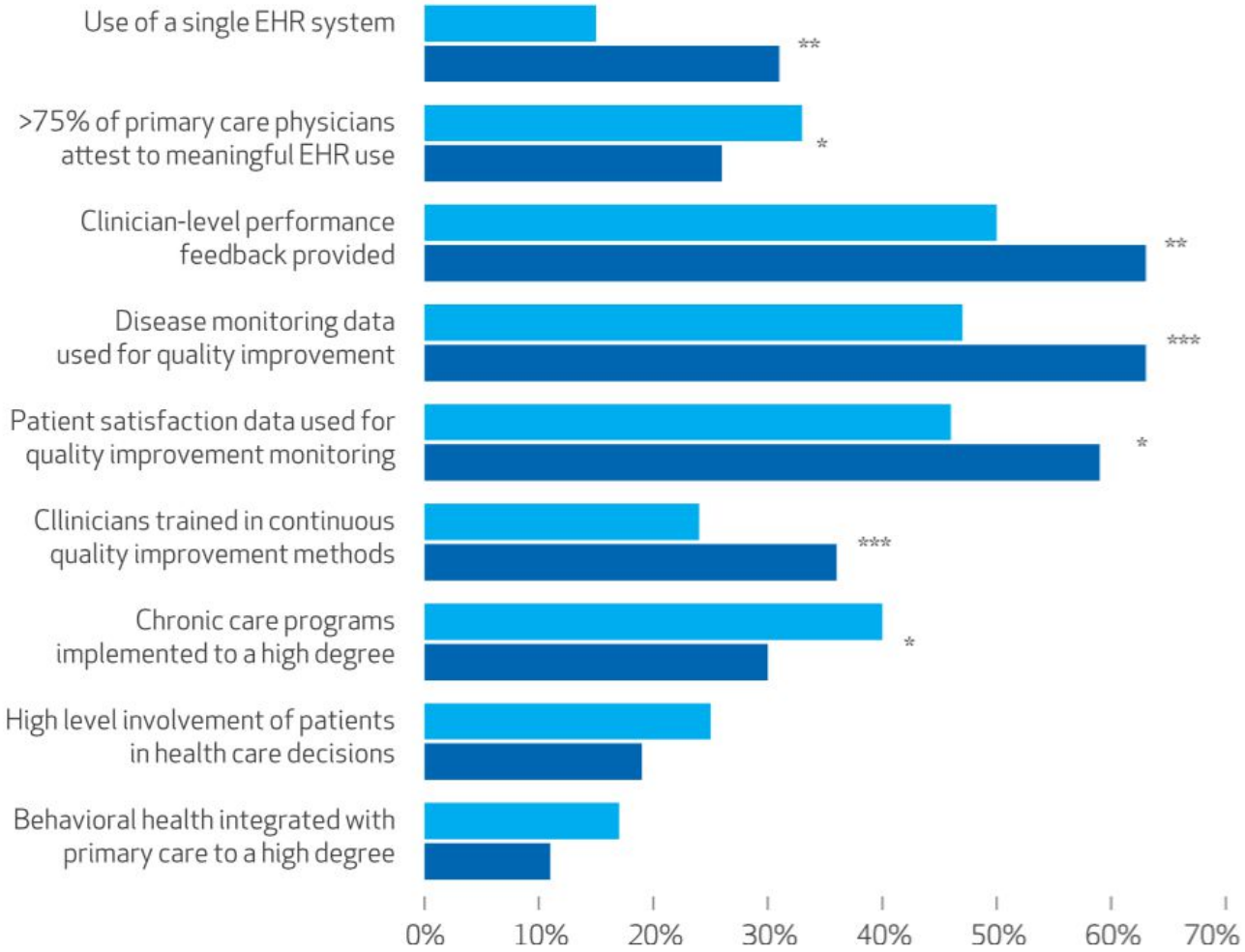
Mean Medicare beneficiaries
n= 19,061

ACOs: Results– Provider payment



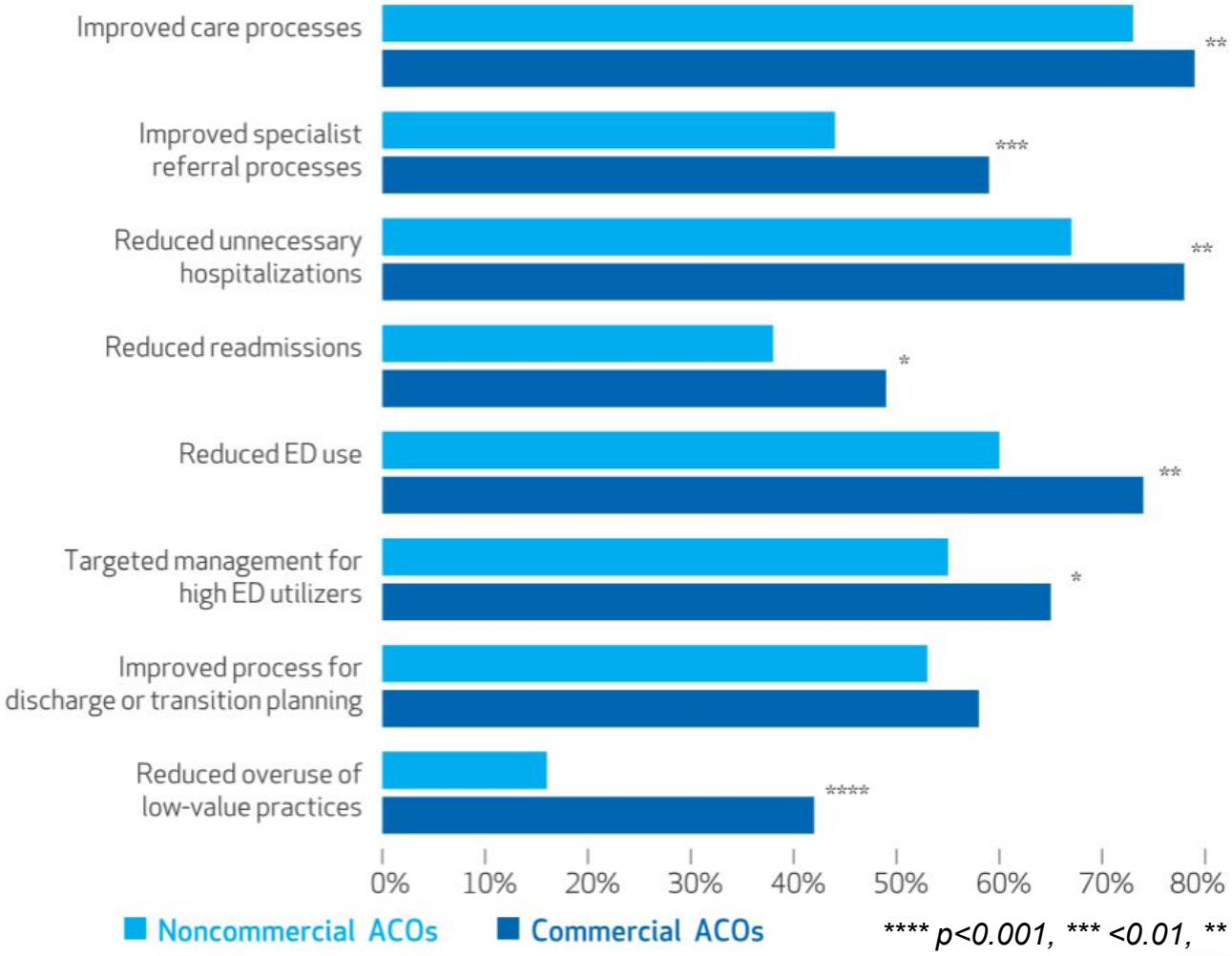
**** p<0.001, *** <0.01, ** <0.05, * <0.10

ACOs: Results – Quality processes



**** p<0.001, *** <0.01, ** <0.05, * <0.10

ACOs: Results – Efficiency processes



**** p<0.001, *** <0.01, ** <0.05, * <0.10

Policy implications

- Size matters – are ‘super ACOs’ the most viable option?
- Smaller ACOs are more reliant on public funding to stimulate delivery system reform
- Public payers are mitigating risk to stimulate involvement but is this sustainable?
- Infrastructure limitations are major barriers that will require additional investment
- Organizational mapping instruments may be useful for assessing reform preparedness & progress

Acknowledgements

- Commonwealth Fund
- Meredith Rosenthal – Harvard TH Chan School of Public Health
- Carrie Colla – Dartmouth Institute for Health Policy & Clinical Practice
- Co-authors - Maddy Phipps-Taylor, Courtney Stachowski, Lei-Sien Kao, Valerie Lewis, Steve Shortell, Meredith Rosenthal, Carrie Colla

Advanced Alternative Payment Models (APMs)

MIPS APM Reporting (APMs in MIPS 'unless or until')

- A group is defined by clinicians billing under one Tax Identification Number (TIN)
- For 2017, ACOs and Next Generation ACOs report quality via GPRO and are scored based on the performance year, but they report MIPS improvement activities and ACI measures
  - Improvement activities weighted at 20% and ACI at 80%
- Non-ACO MIPS APMS: Improvement activities at 25% and ACI at 75%
- Submit via the CMS web interface (GPRO): must register as a group by June 30, 2017
- Deadline: March 31, 2018 for performance year 2017 for qualified registry, QCDR, EHR, GPRO, and attestation

Alternative Payment Models (APMs)

MIPS APMs

(No 5% Bonus)

Partially-Qualifying APMs

(No 5% Bonus & MIPS Choice)

Advanced APMs

(5% Bonus)

Advanced APM Requirements

Advanced APMs must meet the following requirement:

- Be a CMS Innovation Center model
- Use Certified EHR Technology (CEHRT)
  - For 2017 50% of QPs would need to use CEHRT
- Base payments for services on qualify measures comparable to those in MIPS
- Be a Medical Home expanded under Medicare Innovation Center **OR** require participants to "bear more than nominal financial risk for losses"
- ECs will be notified of their APM status before the end of the performance year
- CMS will take three "snapshots" during the performance period: March 31, June 30, and August 31 to identify qualifying participants (QPs) – not only at December 31 as originally proposed

Advanced APM Requirements

- To Quality for the 5% APM incentive Payment for participating in an advanced APM during the payment year you must receive certain percentage of payments for covered professional services or see a certain percentage of payments through the Advanced APM.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Advanced APM Risk Requirements: 2017 - 2019

- Final rule defines risk in 2 ways for 2017 and 2018:
- Whichever is lower of:
  1. Revenue-based standard: “8% of the average estimated total revenue of participating APM entities” (2017 and 2018 only)
  2. Benchmark-based standard: “3% of expected expenditures for which an APM entity is responsible” (page 1493)

  (For episode payment model expected expenditures means the target price for the episode)

- CMS is not finalizing its proposed marginal risk and medical loss ratio requirements
- Revenue standard will likely disqualify most potential episode payment models
- CMS finalizing risk requirements for “other payers” at 30% of expected expenditures, MLR no greater than 4%, and potential risk at least 4% of expected expenditures

CMS "Pre-Approved" Advanced APMs

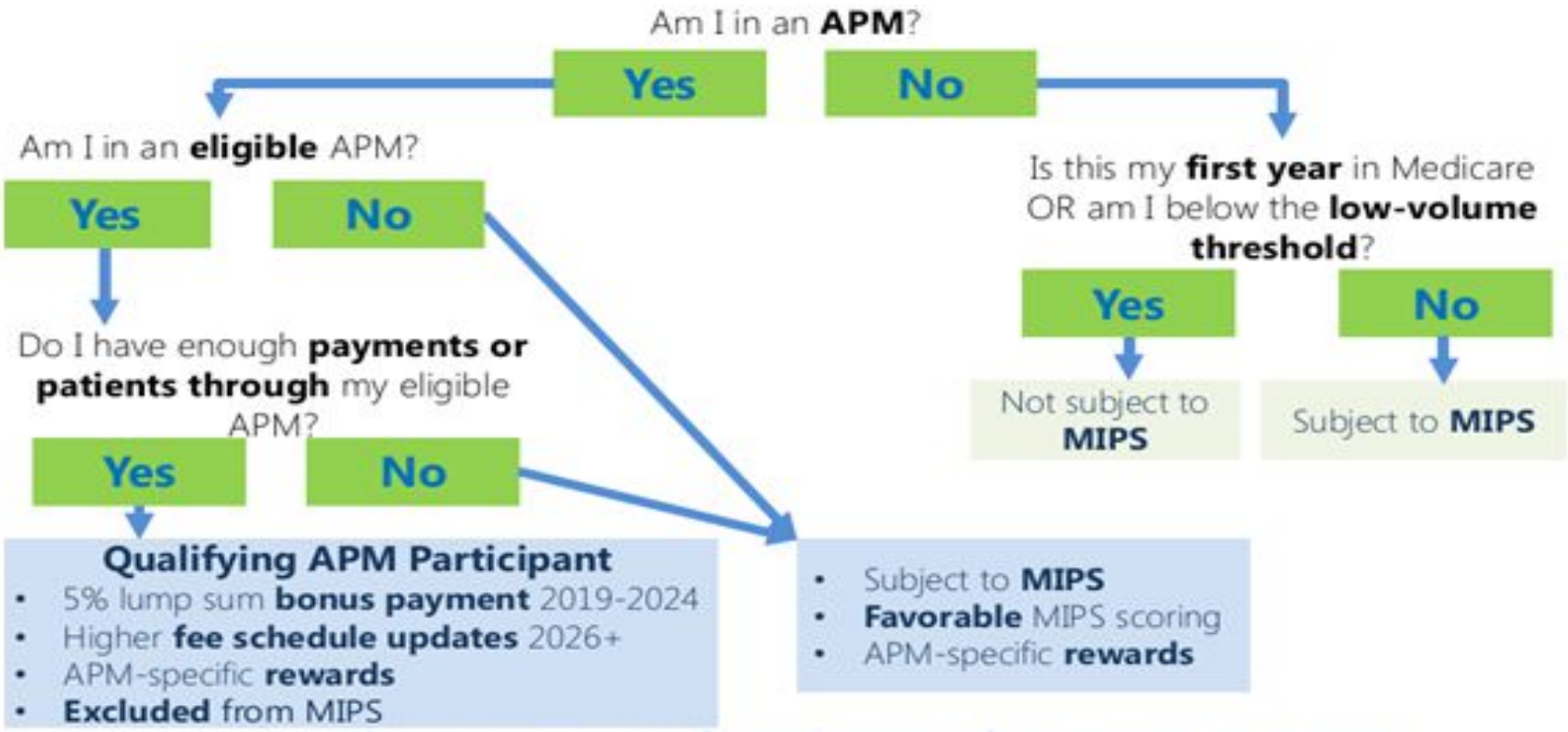
2017 Performance Year

- ACO Track 2 or 3 (MSSP)
- ACO Next Generation demonstration
- Comprehensive ESRD Care demonstration (CEC)
- Comprehensive Primary Care Plus demonstration (CPC+)
- Oncology Care model (two-sided risk track available in 2018)
- Select tracks in the Comprehensive Care for Joint Replacement (CJR), Cardiac Episode Payment Models (EPMs), future voluntary bundled payment programs
- **CMS will publish complete list before January 1, 2017**
- **This list will be updated on an ad hoc basis – will not go through formal rulemaking process**

2018 Performance Year and beyond

- ACO Track 1+
- Episode (bundled) payment models to be determined

MACRA/MIPS Decision Tree



Bottom line: There are opportunities for **financial incentives for participating in an APM,** *even if you don't become a* **QP.**

Source: CMS Website

Advanced APMs: Patient Centered Medical Homes

CMS largely finalized PCMH proposal

- Certification is expanded to include comparable specialty practices and those certified by a national, regional, or state program, private payer or other body
- Must meet 4 of 6 criteria including care coordination across the medical neighborhood
  - Example: Patient and caregiver engagement or shared decision-making
- Beginning in 2018 a medical home is defined as 50 or fewer eligible clinicians in the organization through which the PCMH is owned or operated (this means in 2017 criteria does not apply)
- If medical home meets general APM risk standards organizational size is moot
- Medical home owes or forgoes at least: risk amounts for Part A and B revenue:
  - 2.5% in 2017
  - 3% in 2018
  - 4% in 2019
  - 5% in 2020
- Bonus only pertains to Medicare Part B Payments

ACO Track 1+

- CMS “exploring development” of ACO Track 1+ model to begin in 2018
- Would be voluntary for ACOs currently participating in Track 1 of the Shared Savings Program or ACOs seeking to participate in the Shared Savings Program for the first time
- Payment model that incorporates more limited downside risk than in Tracks 2 and 3
- Would include sufficient financial risk to qualify as an Advanced APM
- Will include regional benchmark criteria
- CMS does not believe uncompensated care can be considered a monetary loss
- CMS will announce additional information about the model in 2017

APMs: Bonus Payments

- 5% of aggregate amounts paid for Medicare Part B professional services from proceeding year across all billing TINs associated with the QPs NPI
- Payment made no later than 1 year from end of the incentive payment base period (as soon as 6 months possible)
- Payment made to QP's TIN. Multiple TINs will split payment proportionally
- CMS estimates $333 million to $571 million in Advanced APM bonus payments in 2019

Selecting MIPS vs. Advanced APMs

Before you make a decision:

- Know your providers
- Know your tolerance for change
- Know your current performance
- Know your data capabilities
- Know your patient population
- Know your options

Transitioning to an Advanced Alternative Payment Model

Transition to Advanced APM

MIPS → APM → Advanced APM

- Engage your physicians
- Understand the Criteria of Advanced APMs
- Identifying the appropriate Advanced APM
- Know your data capabilities
- Application and selection process

Transitioning to an Advanced APM

Understand the Criteria of Advanced APMs

- Revenue and/or patient population percentage thresholds
- Certified EHR technology
- Meet or exceed MIPS quality metrics
- Medical Home Model expanded under CMS Innovation Center authority; or require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses:

	Nominal Risk Criteria	What Does This Mean?
1	**Minimum Loss Rate:** A threshold to trigger losses no greater than 4%	The APM contract must require the APM entity to assume responsibility for losses once spending reaches 4% or less above expected expenditures
2	**Marginal Risk:** Loss sharing of at least 30%	APM Entities must share with the payer in at least 30% of the losses in excess of the expected expenditures
3	**Stop Loss:** Maximum possible loss of at least 4%	APM entity's maximum potential losses can't be capped lower than 4% of the total expected expenditures

Transitioning to an Advanced APM

Identifying the appropriate Advanced APM

- Program restrictions
  - Geographic
  - Group size
- Financial Risk aversion
- Operational capabilities
- Care advancement alignment

Transitioning to an Advanced APM

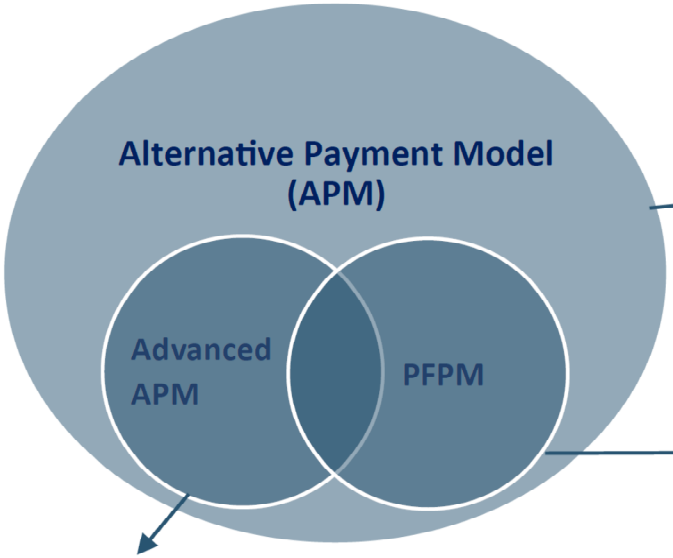
Data Capabilities

- Population health capabilities
  - Do you know who your sickest patients are?
- Data Collection and Integration
  - Identifying the data sources for each of the ACO measures
  - Data integration into single platform
  - Ensure security
- Presentation of the data
- Operationalize data

Model Design Factors

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

What type(s) of Alternative Payment Model(s) will you designing?



Alternative Payment Model (APM)

- Innovation Center Models (other than a health care innovation award)
- Demonstration under the Health Care Quality Demonstration Program
- Medicare Shared Savings Program
- Demonstration under federal law

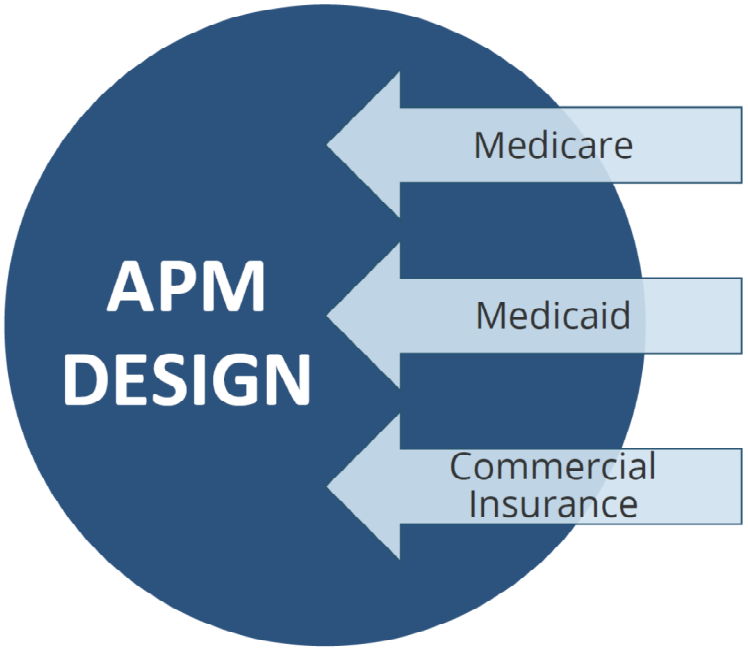
Physician-Focused Payment Model (PFPM)

- Is an Alternative Payment Model
- Includes Medicare as a payer
- Physicians or other eligible clinicians play a core role in implementing the payment methodology
- Targets quality and costs of services eligible clinicians provide, order, or significantly influence

Advanced Alternative Payment Model (Advanced APM)

- Is an Alternative Payment Model
- Requires Participants to Use Certified EHR Technology
- Bases payment on quality measures comparable to those in MIPS
- Participants Bear More than Nominal Financial Risk, **OR**
- APM is a Medical Home Model Expanded under Innovation Center authority

How does your Alternative Payment Model align with other payers and CMS programs?



Leveraging Investments*

Are enough payers participating in the model or aligned with your proposal to create a strong business case and supportive business relationships for providers to participate?

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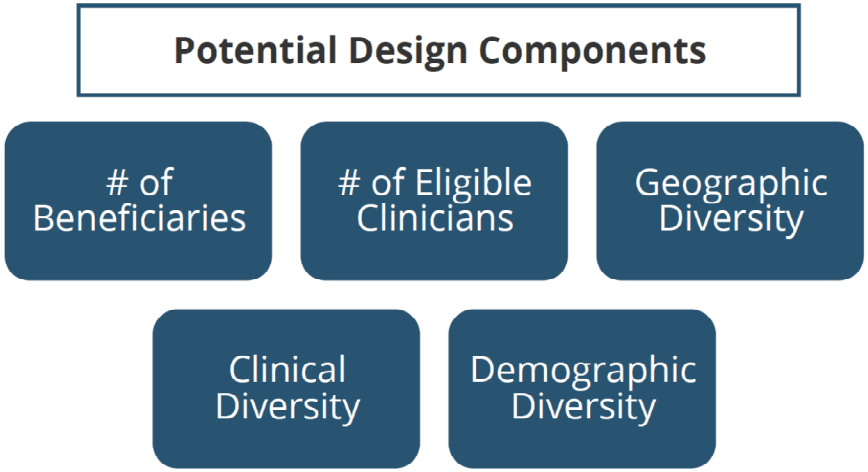
What is the scale of your Alternative Payment Model?



Scale*

What is the anticipated size and scope of the APM in terms of health care services? What is the burden of disease or illness on the target population in terms of morbidity and/or mortality? Who are the APM Entities-the entities participating in the APM (for example, Physician Group Practices)?

How is improved clinical quality or better patient experience of care measured under your Alternative Payment Model?

Quality Domains

- Clinical Care
- Safety
- Care Coordination
- Patient and caregiver experience
- Population health and prevention

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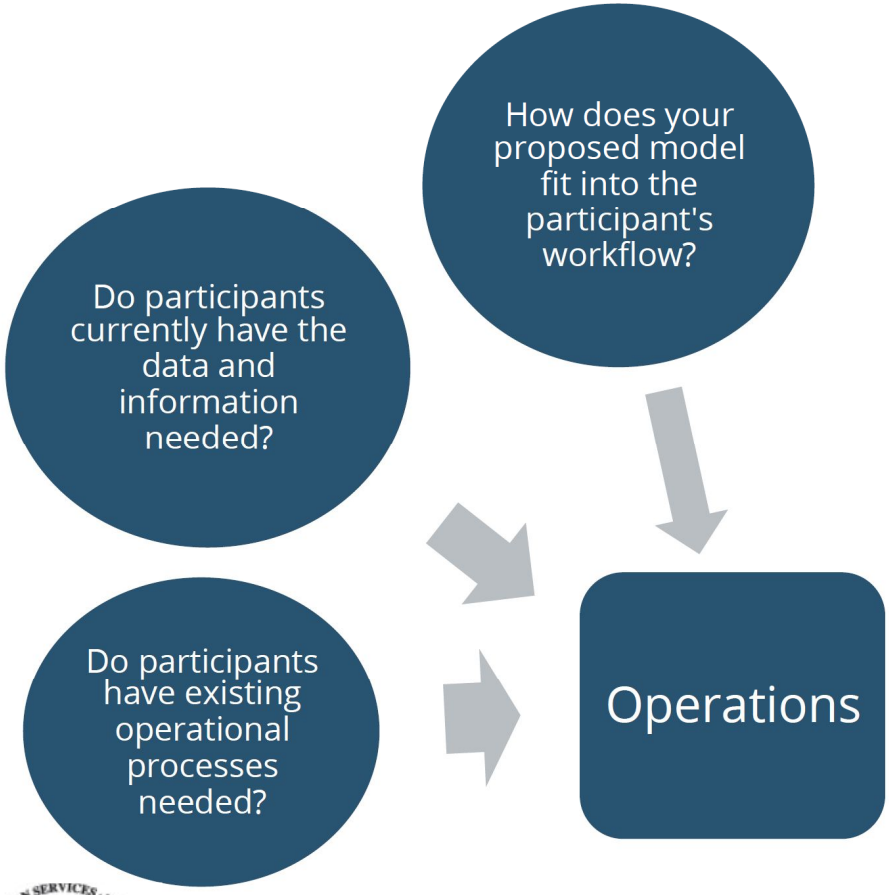
How easy would it be for participants to implement your Alternative Payment Model?



Operational Feasibility

How easy would it be for participants to build systems, processes, and infrastructure necessary to operationalize the APM?

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Quality Payment Program Next Steps

Next Steps for Providers

- Take advantage of your “transition year” (2017) to evaluate your goals
- Engage key stakeholders who will be involved in identifying, tracking and reporting performance measures
- If you’re ready, align your physician compensation arrangements with your organization’s desired track and performance measures
- At a minimum, develop a placeholder that allows for periodic identification of performance measures and incentives
- Stay up to date on CMS developments – this is rapidly changing
- For more information, see: https//qpp.coms.gov/education

AMGA
Advancing High Performance Health

AMGA Consulting

The Journey to Population Health and Value Based Care

Howard B Graman MD, FACP

MACRA Summit

November 30, 2016

AMGA Consulting Biographies

Howard B. Graman, MD, is a Vice President with AMGA Consulting. He has spent the majority of his career as a physician executive with extensive experience in clinical transformational change and leadership in large, multispecialty physician practices. Prior to joining AMGA Consulting, he was CEO of PeaceHealth Medical Group with over 900 providers and 100 practice locations. Additional roles included Chair, Department of Primary Care and Regional Medicine, Carilion Clinic and Medical Director of Carilion Medical Group, as well as Executive Director, Cleveland Clinic and Chair, Board of Directors, Cleveland Clinic Hospital (Weston, Florida).

Earlier in his career, he was professor of medicine at University of Vermont and was a commissioned officer in the National Health Service Corps. He has been actively involved in governance at AMGA and has been an invited speaker at leadership retreats for many member organizations. He completed undergraduate studies at City University of New York, his medical degree at SUNY – Downstate, and a residency in internal medicine at the University of Michigan.

Presentation Goals

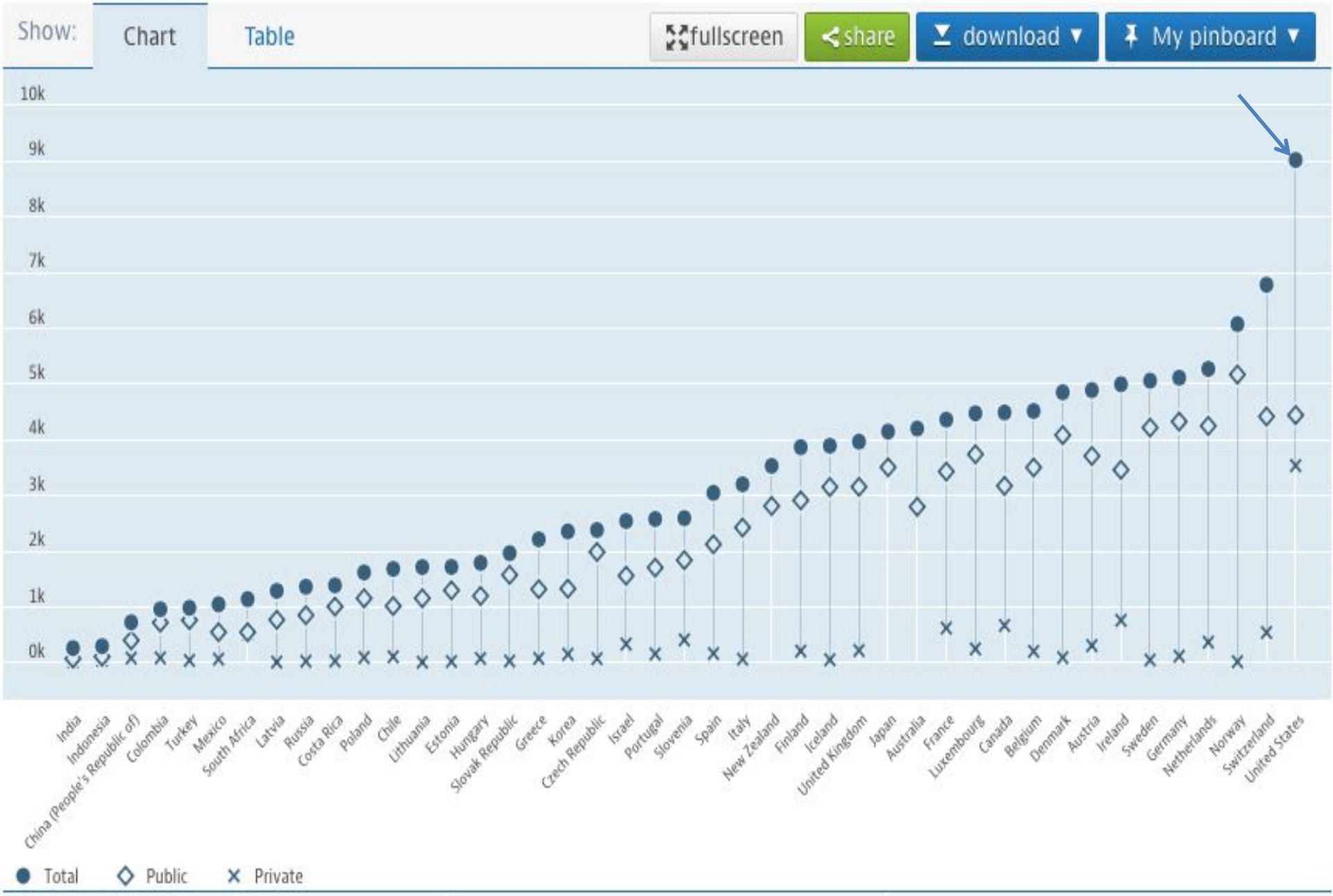
1. State the case for value
2. Describe five key organizational domains to be addressed to ensure success as an APM
3. Emphasize the necessity of physician engagement in supporting and leading the journey

$$\text{Value} = \frac{\text{Quality} + \text{Experience}}{\text{Cost}}$$

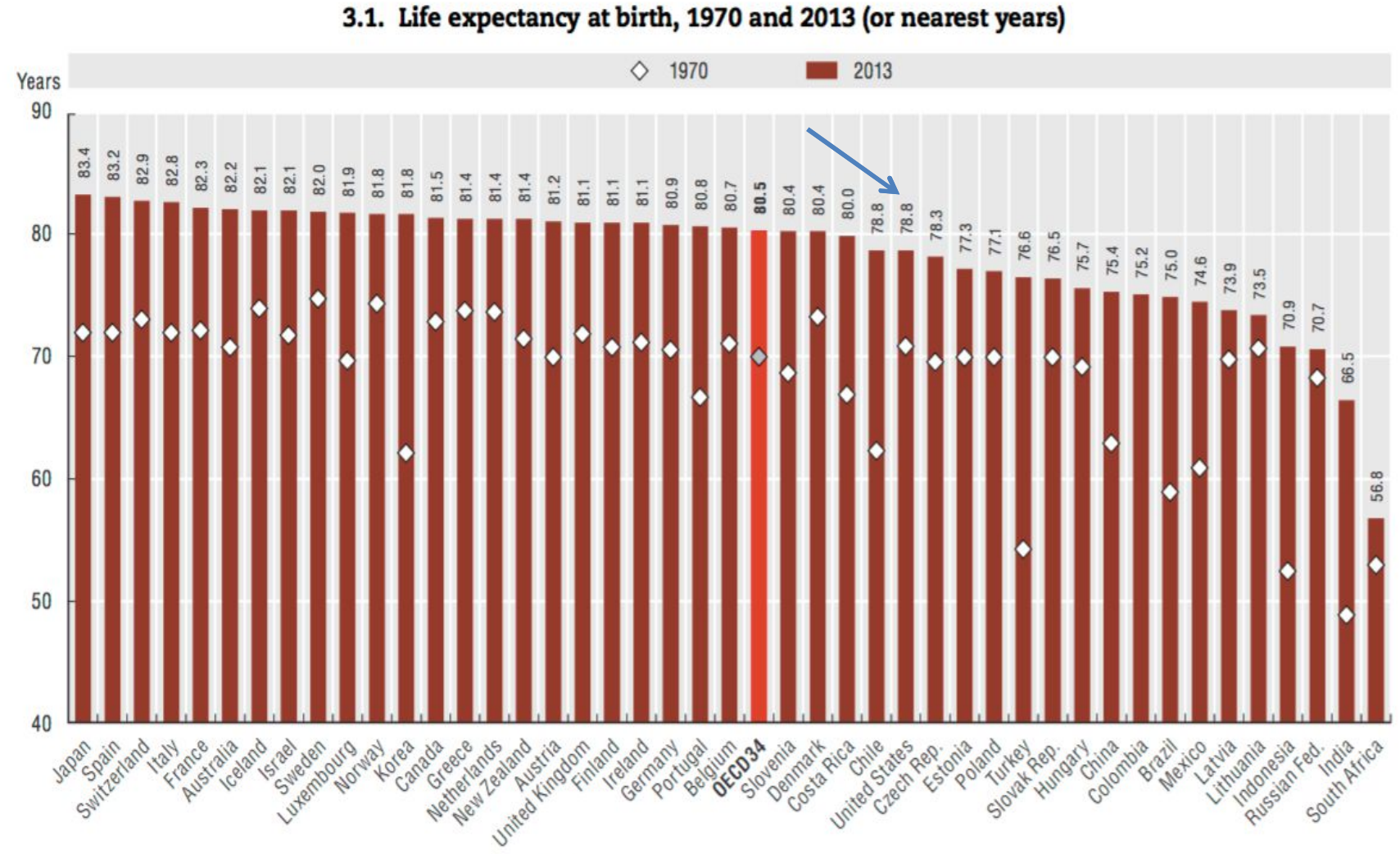
Health spending

Total / Public / Private, US dollars/capita, 2014

Source: Health expenditure and financing: Health expenditure indicators

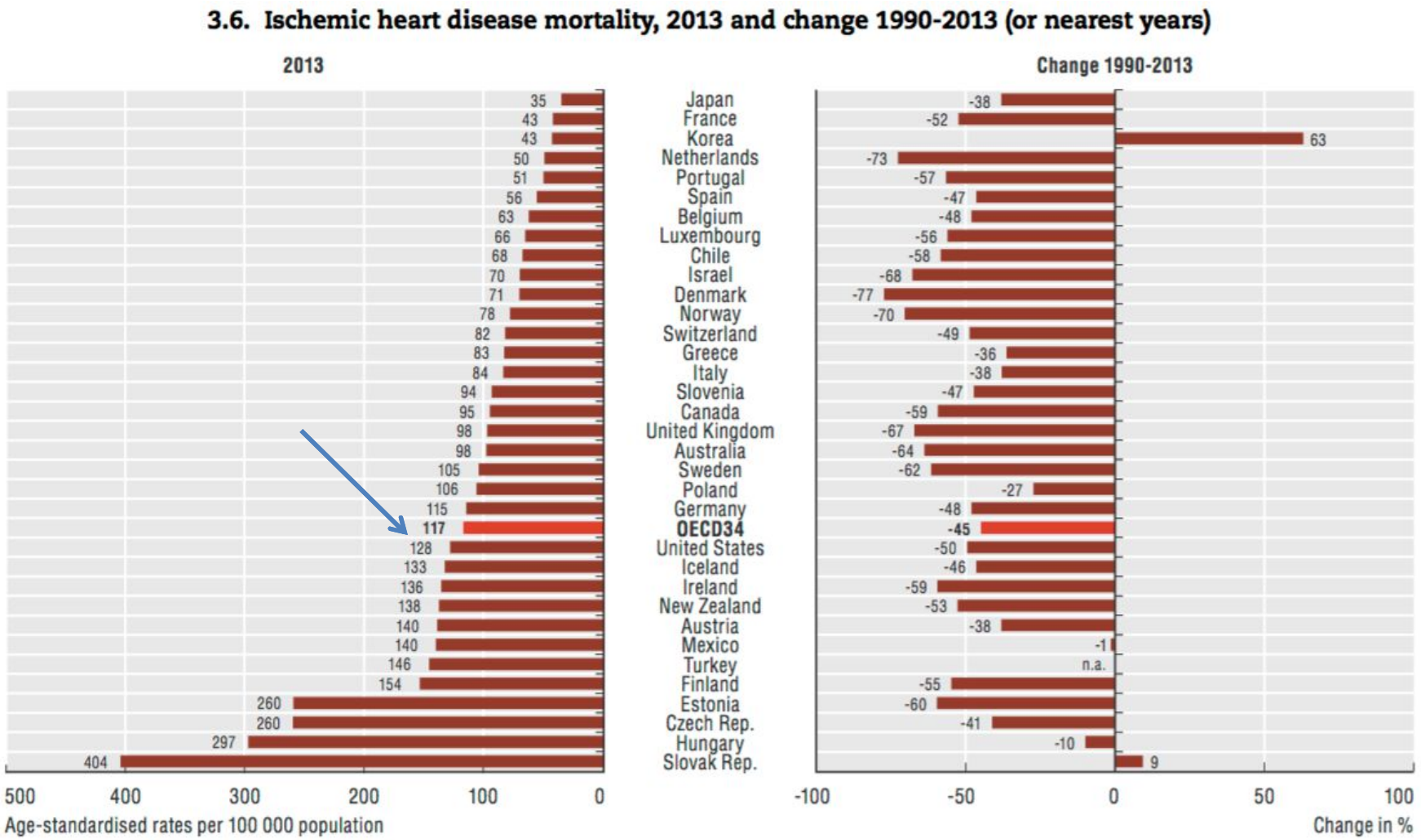


Life Expectancy



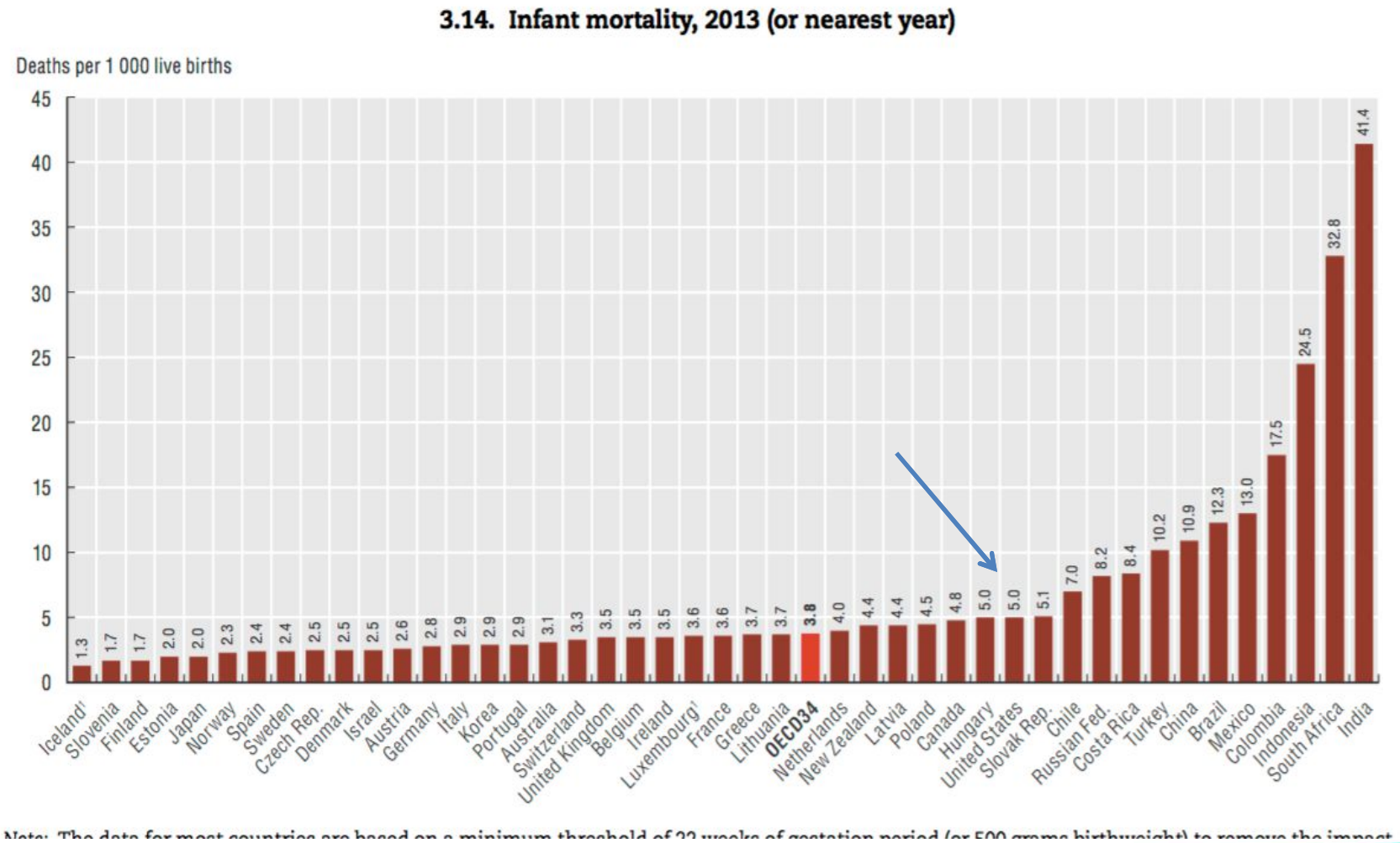
Source: OECD Health Statistics 2015. http://dx.doi.org/10.1787/health-data-en.

Heart Disease Mortality



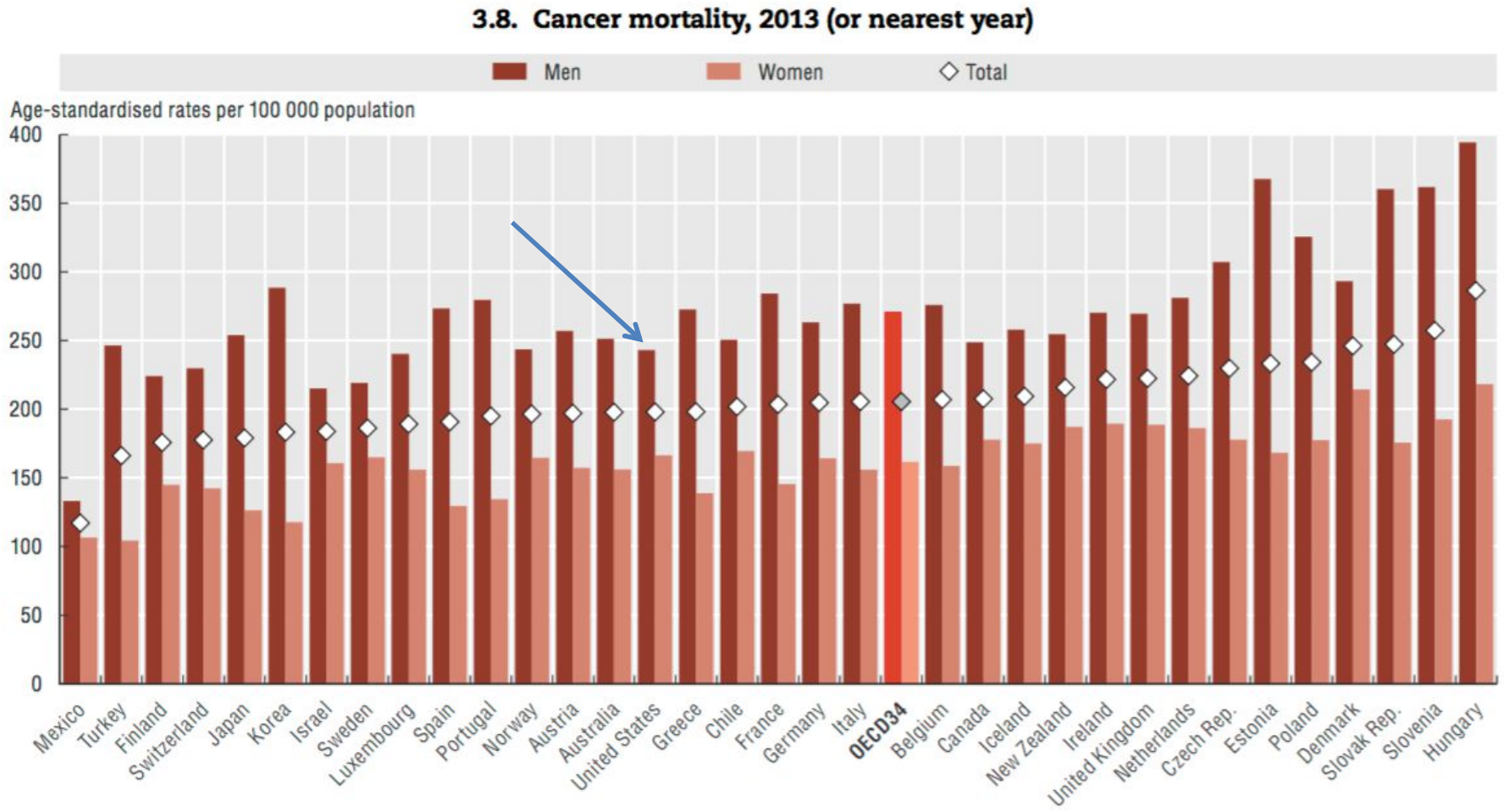
Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

Infant Mortality



Note: The data for most countries are based on a minimum threshold of 22 weeks of gestation period (or 500 grams birthweight) to remove the impact

Cancer Mortality



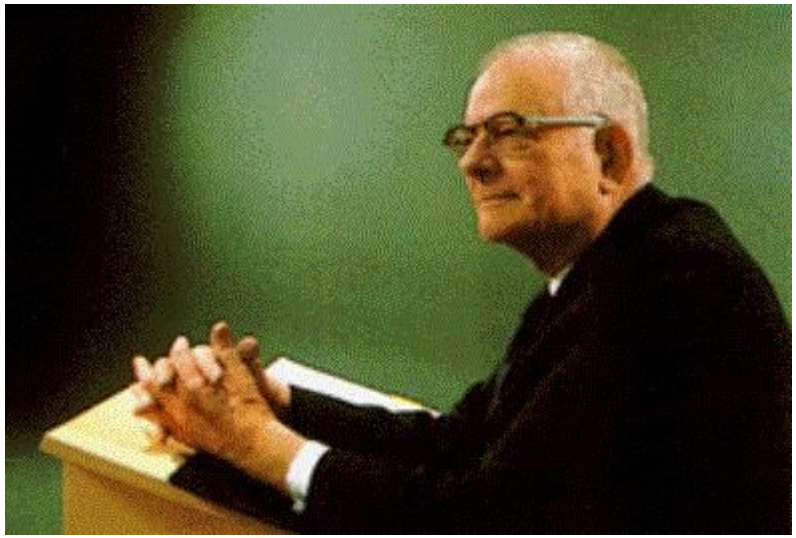
Why is Healthcare so Expensive

The determinants of cost:

1. Price
2. Utilization

Where is the waste?

“Uncontrolled variation is the enemy of quality”



Dr. W. Edwards Deming

Low Back Pain

Worsening Trends in the Management and Treatment of Back Pain

John N. Mafi, MD[1]; Ellen P. McCarthy, PhD, MPH[1]; Roger
JAMA Intern Med. 2013;173(17):1573-1581

From 1999-2010 advanced imaging for non neurologic LBP increased by 57%

- **Conclusions and Relevance**: Despite numerous published clinical guidelines, management of back pain has relied increasingly on guideline discordant care. Improvements in the management of spine-related disease represent an area of potential cost savings for the health care system with the potential for improving the quality of care.

Pap Smears

Doctors in U.S. Overuse Pap Smears
Release Date: March 20, 2012 | By Milly Dawson, Contributing Writer
Research Source: The Milbank Quarterly

KEY POINTS

In the U.S., women received three to four times the number of Pap smears over a period of three decades as women in the Netherlands, yet the two countries' cervical cancer mortality rates were similar.

Colon Cancer Screening

Overuse of Screening Colonoscopy in the Medicare Population

James S. Goodwin, MD; Amanpal Singh, MD, MS;
***Arch Intern Med.* 2011;171(15):1335-1343**

38% exceeded recommended frequency

- **Conclusions:** A large proportion of Medicare patients who undergo screening colonoscopy do so more frequently than recommended. Current Medicare regulations intending to limit reimbursement for screening colonoscopy to every 10 years would not appear to be effective

Knee Arthroscopy for OA

A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee

J. Bruce Moseley, M.D., Kimberly O'Malley, Ph.D.

N Engl J Med 2002; 347:81-88 July 11, 2002

- **Conclusion:** In this controlled trial involving patients with osteoarthritis of the knee, the outcomes after arthroscopic lavage or arthroscopic débridement were no better than those after a placebo procedure

A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee

Alexandra Kirkley, M.D., Trevor B. Birmingham, Ph.D.

N Engl J Med 2008; 359:1097-1107, September 11, 2008

- **Conclusion:** Arthroscopic surgery for osteoarthritis of the knee provides no additional benefit to optimized physical and medical therapy

Arthroscopic Partial Meniscectomy versus Sham Surgery for a Degenerative Meniscal Tear

Raine Sihvonen, M.D., Mika Paavola, M.D., for the Finnish Degenerative Meniscal Lesion Study (FIDELITY) Group

N Engl J Med 2013; **369:2515-2524 December 26, 2013**

- **Conclusions:** In this trial involving patients without knee osteoarthritis but with symptoms of a degenerative medial meniscus tear, the outcomes after arthroscopic partial meniscectomy were no better than those after a sham surgical procedure.

Knee arthroscopy is performed on about 700,000 people in the US every year for OA and/or meniscus injury, at about $5,700 per procedure, for a total cost of 4 billion dollars

CT Scans in the Emergency Department

Adherence to PIOPED II Investigators' Recommendations for CT Pulmonary Angiography

Presented at: the American Thoracic Society meeting, May 16, 2011, Denver, Colorado

Results: 55% ordered without meeting criteria

- **Conclusion:** Nonadherence to recommendations for CT pulmonary angiography is common **and** exposes patients to increased risks, including potential false-positive diagnoses of pulmonary embolism.

Pre Operative Stress Testing

Overuse of preoperative cardiac stress testing in Medicare patients undergoing elective non cardiac surgery

Sheffield KM[1], McAdams PS

Ann Surg. 2013 Jan;257(1):73-80

BACKGROUND:

The American College of Cardiology/American Heart Association guidelines indicate that patients without class I (American Heart Association high risk) or class II cardiac conditions (clinical risk factors) should not undergo cardiac stress testing before elective non-cardiac, nonvascular surgery.

- **CONCLUSIONS:** In a 5% sample of Medicare claims data, 2803 patients underwent preoperative stress testing without any indications. When these results were applied to the entire Medicare population, we estimated that there are over 56,000 patients who underwent unnecessary preoperative stress testing. The rate of testing in patients without cardiac indications has increased significantly over time

Autonomy, Waste and Harm

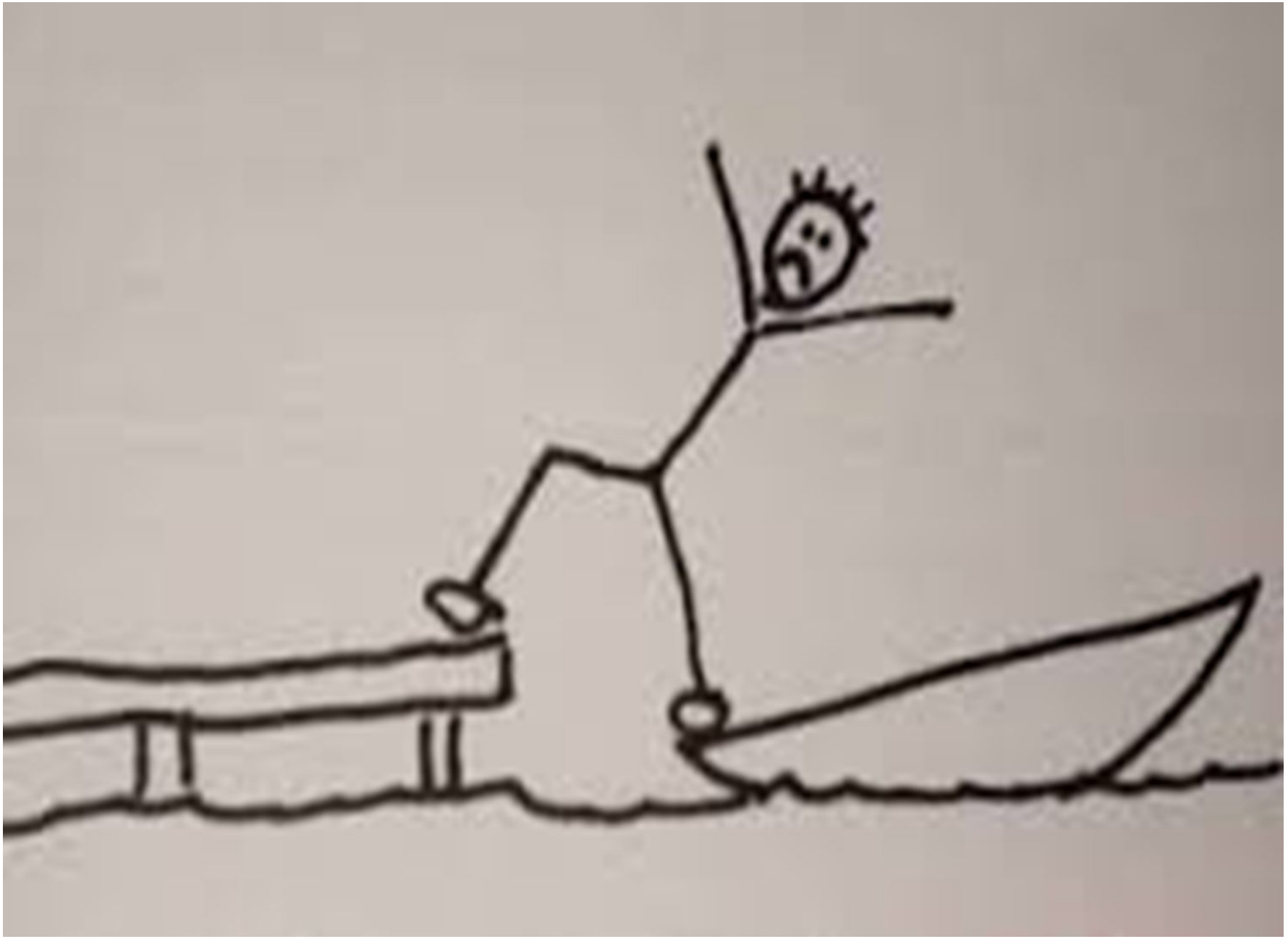
American medical culture has not yet come to a point where adherence to evidence based guidelines and consensus driven preventive care are the expected norm.

"Do the right thing.
It will gratify some
people and astonish the
rest."

-*Mark Twain*

The 5 Domains of Change

1. Cultural Preparation
2. Data/Technology Acquisition
3. Care Model Redesign
4. Compensation Plan Changes to Reflect Value-Based Care
5. Payer Contracting Alignment



1. Cultural Preparation

Two Leadership Scenarios:

1. Denial – based: Little/no prep for value

2. Visionary: Articulate the transition from V to V

2. Data/Technology Capabilities

- Clinical Care Data
- Business Systems
- Telemedicine/remote monitoring

Clinical Data

- EMR Capabilities:
  - Point of care tools – HM and BP alerts, order sets, decision support (Radiology, Choosing Wisely)
  - Care management tools – registries, Healthy Planet
  - Robust patient portal – results, self scheduling/check-in, bulk messaging
- Quality reporting
- Predictive modeling
- External benchmarking

Business Data

Provider Specific

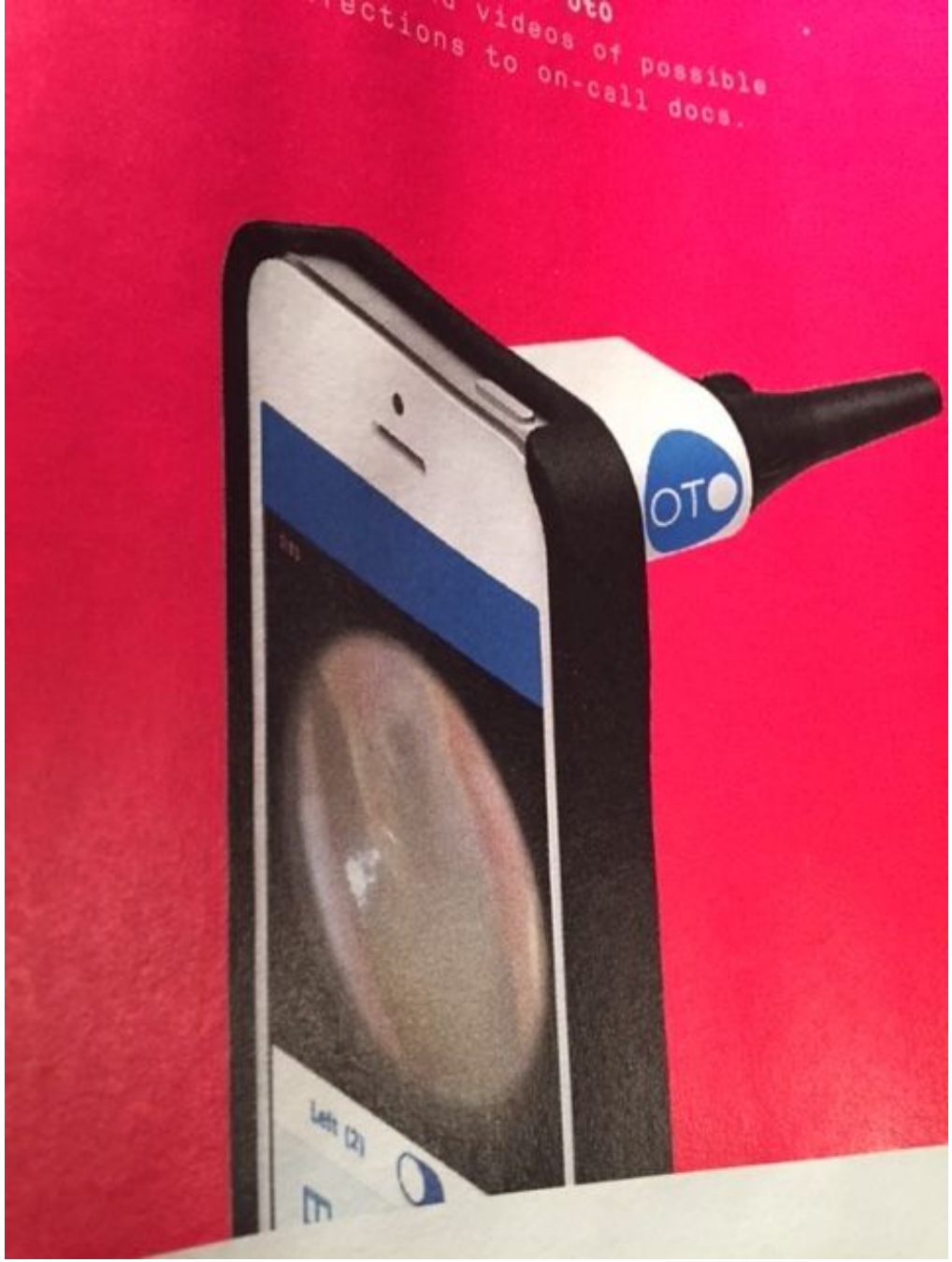
- Panel size
- Prescribing patterns - generic vs. brand
- Utilization of high cost imaging
- ED visits and admissions/readmissions
- All claims – internal and external
- Cost data for bundled payments

The burden of good data…….

managing outliers

Telemedicine

- Patient visits – low acuity 70% resolved
- Physician to physician consultations
  - Routine – quick questions
  - Emergent – stroke/TPA decisions
- Care coordination/home care monitoring


videos of possible
ections to on-call docs.
OTO

3. Care Model Redesign

- Isolated transaction  Our patient all the time
- PCMH as core functional unit
- Team - based care with delegation by provider
- Everyone works to top of license
- Richer staffing ratio

Primary Care Clinic Model

(6 providers: 4 MDs, 2 Midlevels)

Chronic Active Primary Care

Panel Size – (36 month)
1 MD (2800)
.5 Midlevel (980)

Total Patient Population:
15,120

CMA – indirect patient care

Flow Manager – paired with provider to maintain care flow

Health Coach – new patient visits, Annual Wellness visits

Resource RN – Cardiac, Pulmonary & Diabetic

Patient

Provider (6)

Central Medical Assistant (3)

Flow Manager (6)

Health Coach (2)

Resource RN (2)

Patient Access Representative (3)

Rotational Medical Group

Dietician

Pharmacist (centralized refill)

Pharmacist

Behavioral Health

PHMO Resources

Disease Mgmt (telemonitoring)

Social Worker Centralized

Case Manager Centralized

APM Functions to Improve Quality and Reduce Cost

- Tight transitions of care management

  Home – Hospital – Rehab* – SNF – Home – Hospice
- Oversight of post acute care by **employed** providers
- Specialty Clinics for high risk diagnoses associated with readmissions (CHF, COPD)
- Intense RN care coordination (**Sickest 5% incurs 50% of cost**)
- Adherence to care guidelines/order sets

4. Comp Plan Changes

- Most still production based
- Add value metrics: 5 - 20% total comp:
  - Quality, Patient experience, Growth, Panel size, MU/ACI, Citizenship, ACO performance
- Draw quality metrics from MIPS/ACO menu
- Move from process to outcome metrics asap
- Provide comfortable run-up of reporting before comp affected (6-12 months)

5. Payer Contract Alignment

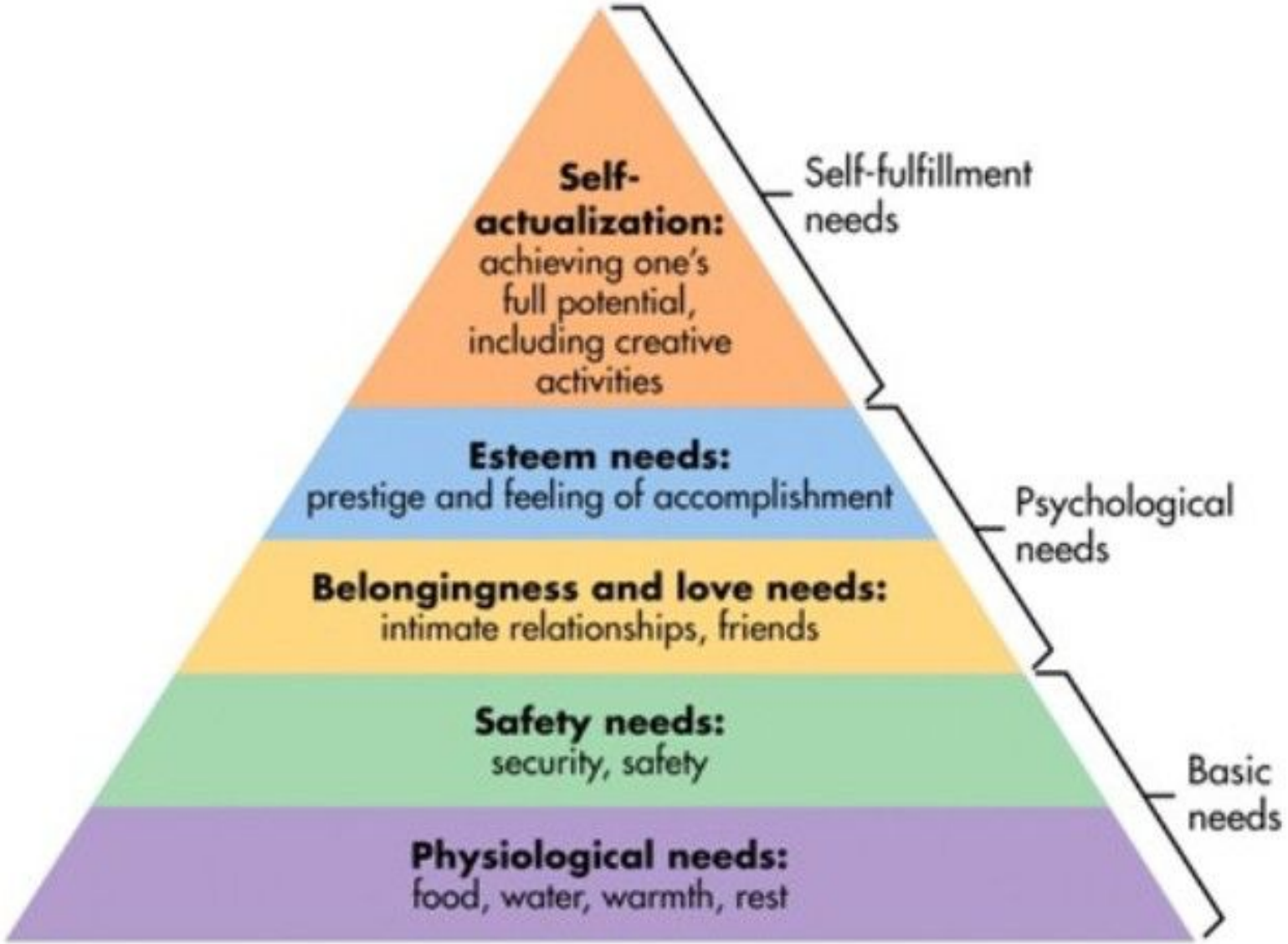
- Medicare 85% tied to value by 2018
- ~30 - 40% revenue at risk
- Negotiate for PM/PM PCMH support
- Enter pathway to ACO 2 - sided risk
- Climb the commercial payer food chain

  - Start your own plan

  - Develop a payer partner relationship with a pathway to risk

Focusing on Providers to Insure Successful Transition to Value

- Meet providers' basic needs
- Incorporate team - based care
- Consider "Care Coordination Agreements"
- Develop your physician leaders


Self-actualization:
achieving one's full potential, including creative activities
Esteem needs:
prestige and feeling of accomplishment
Belongingness and love needs:
intimate relationships, friends
Safety needs:
security, safety
Physiological needs:
food, water, warmth, rest
Self-fulfillment needs
Psychological needs
Basic needs

How does this translate for providers?

- Space/exam rooms/tools
- Staffing to allow delegation and team-based care
- Modern EMR with adequate training, optimization and point of care tools
- Reasonable balance of autonomy with system needs to promote professional satisfaction

Daniel Pink – **A**utonomy

Mastery

Purpose

Team - Based Care

- Doesn't come naturally – must be taught/reinforced
- Delegation is key skill
- Everyone works to top of license
- Allows provider to use expertise where most needed

Care Coordination Among Providers

- Primary care and specialty together construct “Care Coordination Agreements”
- Agree on approach to most common problems mutually managed
- Agree on: How much done by PCP
  Threshold for referral
  W/u prior to specialty visit
  Who does follow up care once stable

Develop Physician Leaders

- Clinical excellence does not always translate into leadership skills
- Skills include:
  - Articulating a vision
  - Conducting:
    - Meaningful performance reviews
    - Crucial conversations
    - Effective meetings
  - Developing emotional intelligence
  - Organizing an effective leadership cascade

Effective Leadership Cascade

- Avoids “voltage drop”
- Promotes 2 –way communication
- Consistency of message – same agendas across organization
- Allows for performance management
- Facilitates spread of care guidelines
- Lead providers are held accountable

Support Leadership Growth

- Masters level degree programs
- External physician leadership courses AAPL
- Internally provided leadership academies
- Formal mentoring by seasoned leaders within your organization

Provider Compensation: Aligning Pay with Desired Outcomes

Presentation Roadmap

- Perspectives on Work RVU Production
  - Why the Market is Changing
  - How the Market is Changing
- Approaches to New Compensation Models
  - Early Incremental Models
  - Intermediate Models
  - Advanced Models

Speaker Biography

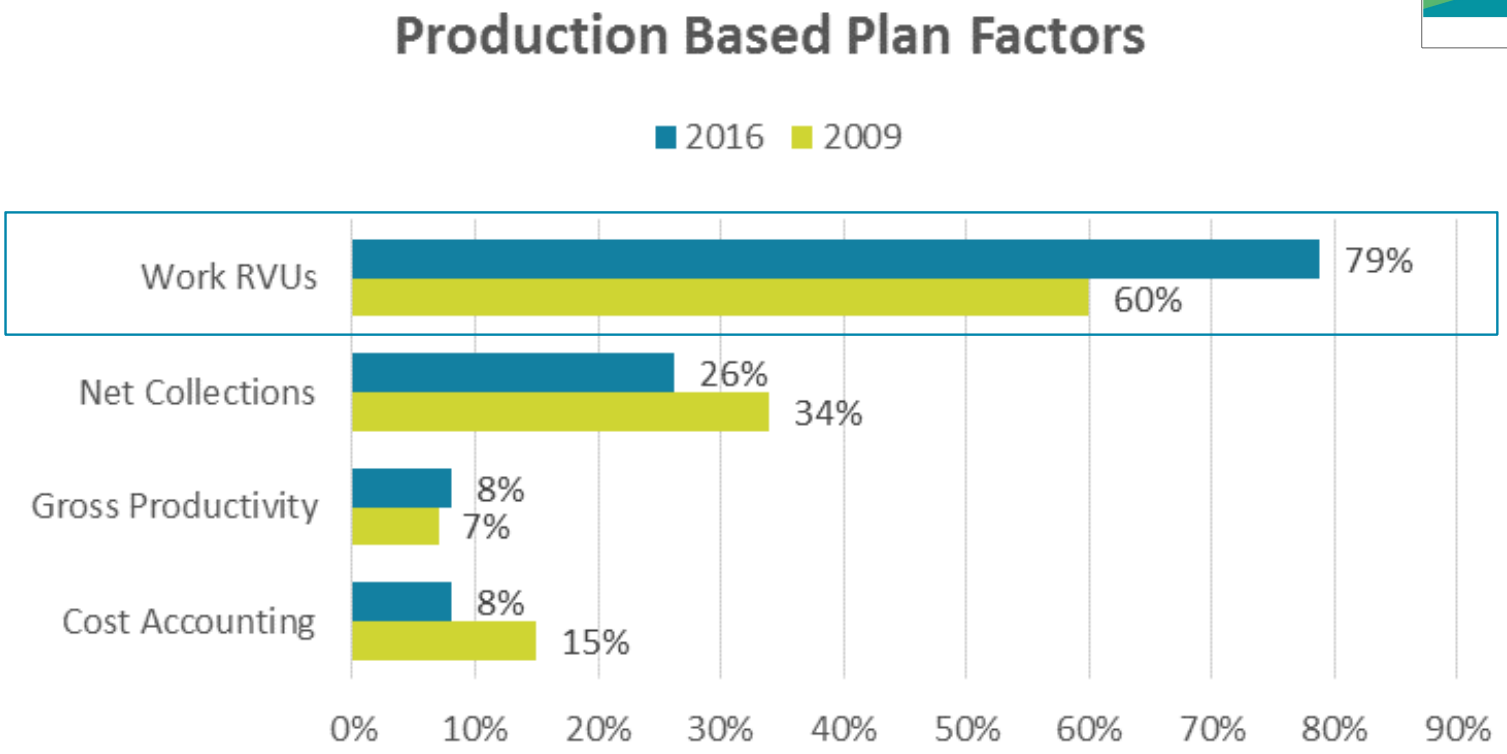
Wayne Hartley is a Vice President with AMGA Consulting. He has worked in the healthcare industry for 20 years, beginning in operations and later focusing on consulting in the physician services area. His operational roles were in large, integrated delivery systems including Allina Health in Minneapolis, and HealthEast in St. Paul, MN, where his responsibilities included physician practice management, clinical service line development, and revenue cycle improvement. He has served as director of professional revenue at Fletcher Allen/University of Vermont. Prior to joining AMGA, his consulting experience included positions with two leading physician services consulting organizations.

Perspectives on Work RVU Production

Perspectives on Work RVU Production

- For many years, work relative value units (wRVU) have increased in popularity in physician compensation plans
- **Work RVUs have several benefits:**
  - Payer/reimbursement neutral
  - Measure "work effort" or intensity of various visits/procedures
  - E&M/CPT codes are equally weighted across specialties
  - National benchmarking is possible through provider compensation surveys
- **At the same time, wRVU can bring some distinct disadvantages:**
  - May promote focus on productivity
  - Place emphasis on volume over value (volume over patient satisfaction)

Perspectives on Work RVU Production

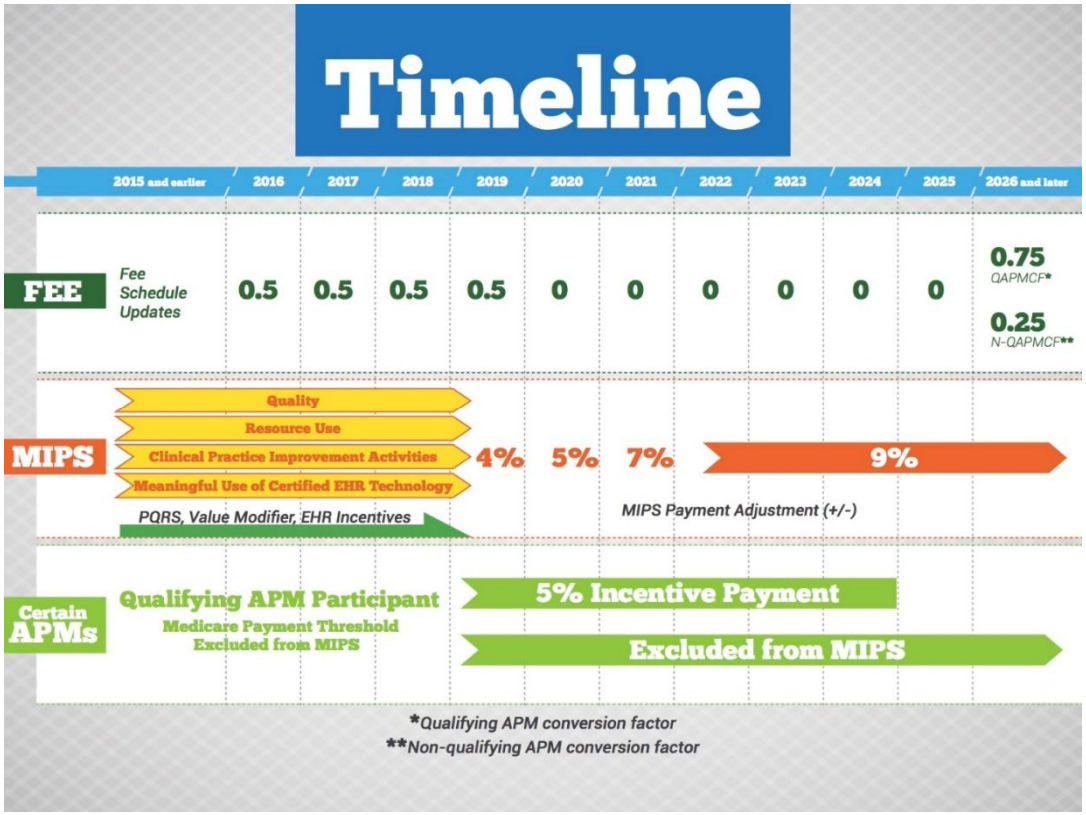


Why the Market is Changing

Reimbursement at the federal and local levels is changing:

- MACRA: MIPS and APMs
- ACO Models
- Shared Savings Programs
- Employer-Driven Contracts

The focus is on VALUE so we advise compensation plans align with general value-based principles – not program specifics



How the Market is Changing

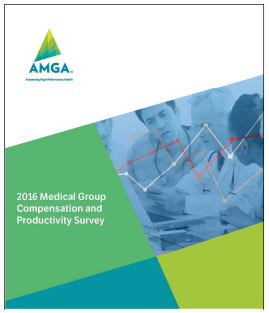
According to the 2016 *AMGA Medical Group Compensation and Productivity Survey*:

- In **2009**, about **41%** of groups responded that some amount of their physician compensation was based on the achievement of value-based metrics (VBM)
- By **2016**, about **60%** of groups responded that some amount of their physician compensation was based on the achievement of value-based metrics (VBM)

Is any portion of your compensation at risk based on achievement of goals?

If so, does this fact impact your priorities and actions?

How the Market is Changing



Value-Based Pay as a Percent of Total Compensation

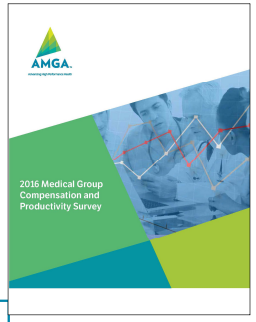
Specialty Type	Physician FTEs	
Overall	All Groups	6.7%
Primary Care	Less than 150	5.9%
	150 to 300	6.2%
	More than 300	9.4%
	All Groups	7.0%
Radiology/ Anesthesiology/ Pathology	Less than 150	5.1%
	150 to 300	6.7%
	More than 300	9.0%
	All Groups	7.0%
Specialists	Less than 150	5.2%
	150 to 300	6.4%
	More than 300	7.4%
	All Groups	6.2%

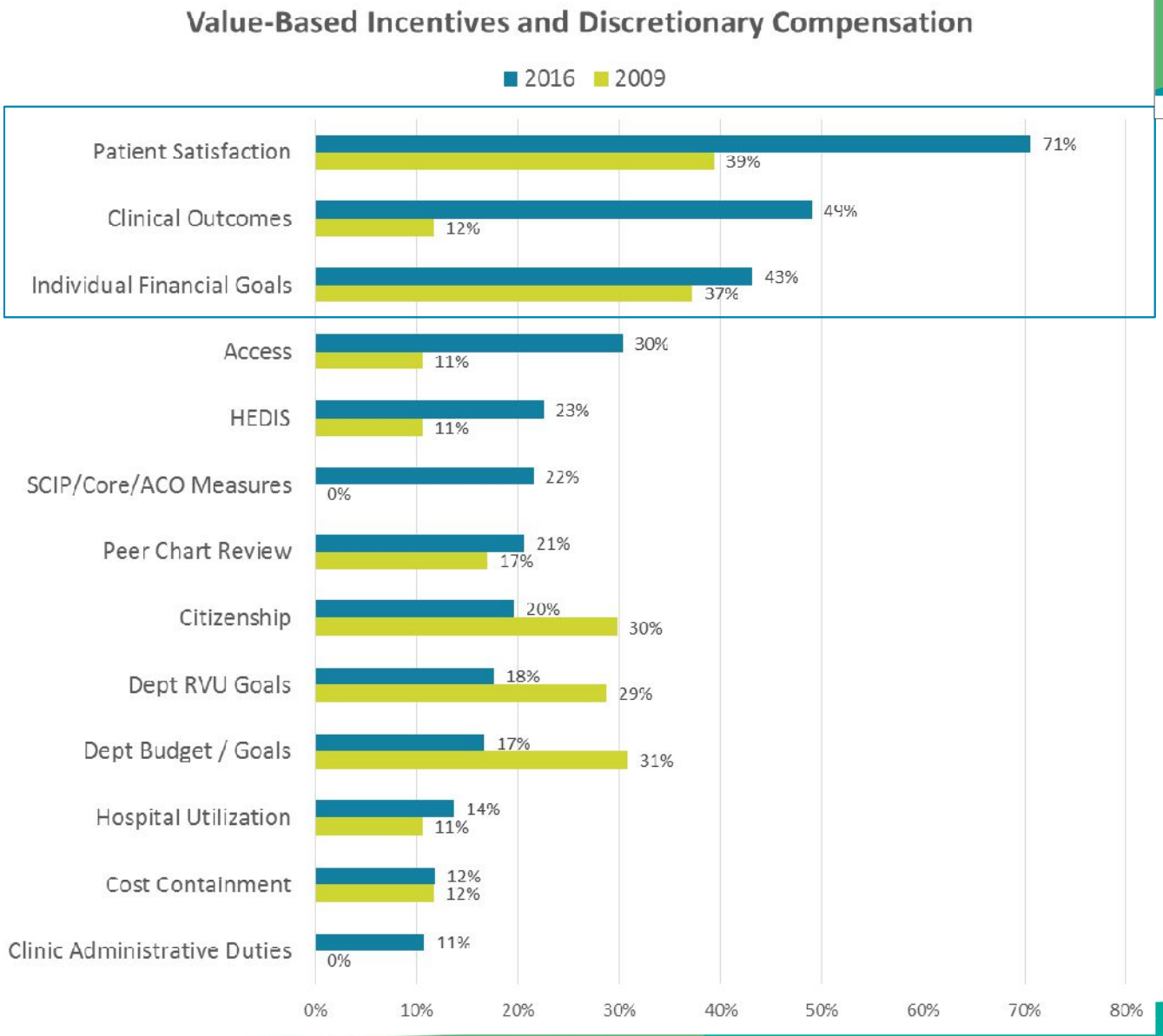
1.0% 2.0% 3.0% 4.0% 5.0% 6.0% 7.0% 8.0% 9.0% 10.0%

Percent Quality and Discretionary Pay

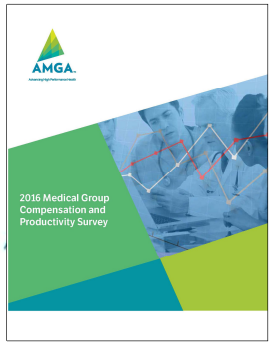
*Only includes groups that reported quality or discretionary compensation represented some amount of total cash compensation.

How the Market is Changing





Value Does Not Mean Comp Reduction…



Weighted Average Change in Median Values by Specialty Type from 2015 to 2016

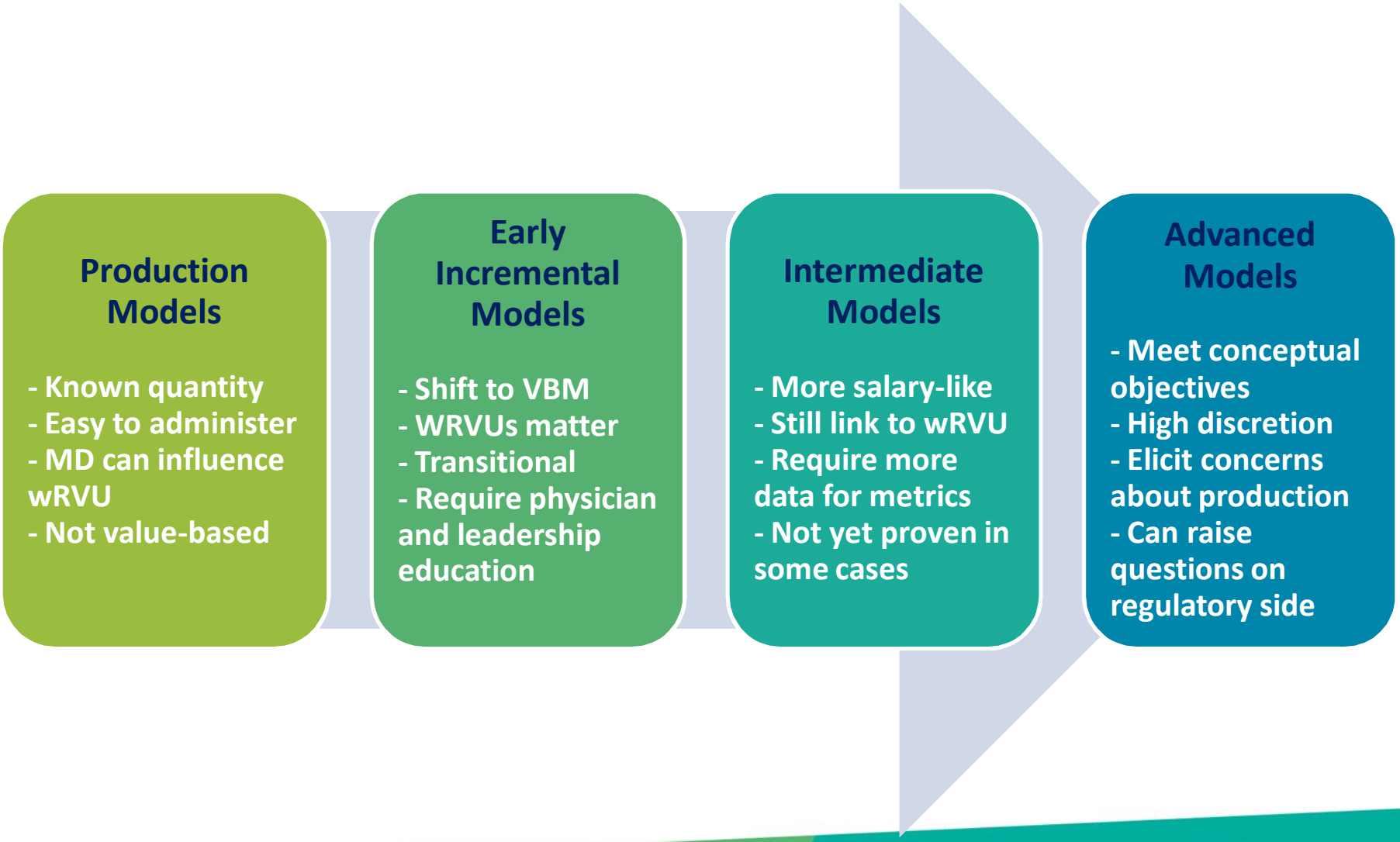
Primary Care	Median Comp Change '15 to '16	3.7%
	Median wRVU Change '15 to '16	-0.3%
	Comp/wRVU Change '15 to '16	3.4%
Medical Specialties	Median Comp Change '15 to '16	2.9%
	Median wRVU Change '15 to '16	0.3%
	Comp/wRVU Change '15 to '16	1.2%
RAP Specialties	Median Comp Change '15 to '16	1.3%
	Median wRVU Change '15 to '16	2.8%
	Comp/wRVU Change '15 to '16	-2.4%
Surgical Specialties	Median Comp Change '15 to '16	3.6%
	Median wRVU Change '15 to '16	-0.4%
	Comp/wRVU Change '15 to '16	2.7%
Other Health Care Providers	Median Comp Change '15 to '16	3.2%
	Median wRVU Change '15 to '16	-1.7%
	Comp/wRVU Change '15 to '16	2.2%

Approaches to New Compensation Models

Approaches to New Compensation Models

- Models that move away from wRVU have been emerging slowly
- 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
- However, the rate of change in the market appears to be ***accelerating***
- If you start earlier, you will have more time for a ***thoughtful transition***

Approaches to New Compensation Models



Approaches to New Compensation Models

Your *compensation philosophy* should guide your direction with redesign:

Core Principles

The following core principles have been established to provide guidance in development of the Valley Medical Group Compensation Program.

Fairness

- The compensation program will be understandable and predictable: the formulas for compensation will be published.
- Core work expectations will be defined in advance for all program participants and expected as part of membership in the group. These expectations may cover access, production, call, administrative committee contributions and other factors.
- Levels of compensation will vary with work effort and outcomes.
- Compensation approaches may vary across specialties where supported by market practice or organizational needs.

Market Competitiveness

- Compensation will be competitive at the national level and, in recognition of our unique market, may consider regional variations.
- The compensation program will support recruitment and retention which promotes patient access to services for our community.

Affordability and Sustainability

- The compensation program must be synchronized with healthcare reform and position the organization for success in a population health model.
- Given current market direction, value-based metrics will be part of the plan for all participants (e.g. patient satisfaction, clinical quality and efficiency.)
- At a minimum, value-based metrics will account for _(proportion)_of compensation.
- The overall program must be affordable for the organization, which includes alignment between work effort and pay levels.

Team Orientation

- The compensation program will support the Valley Medical Group care model.
- In a value-based environment, effective patient care requires a coordinated effort across the care continuum.
- Compensation will support teamwork as achievement of desired outcomes is often a function of the work of many.

Compliance

- Compensation methods and overall pay levels will be administered in a manner that meets all applicable regulatory requirements.
- Periodic review will be conducted and could result in compensation changes to support compliance.

AMGA thanks Valley Medical Group, Paramus, NJ, for permission to use this information.

Early Incremental Models

Early Incremental Models

- Intentionally simple 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 – setting a path for change
- NOT an ultimate strategy
- If you want to make a compensation plan change now and ***not*** re-visit it in a couple of years, consider a more advanced model

Early Incremental Models: Adjusted Conversion Factor

85% Production/15% Incentive

Production
$40.80 / wRVU

→ Earned based on wRVU production
Paid through a draw with "true ups"

Incentive
$7.20 / wRVU

→ 25% Patient satisfaction
75% Quality and other value-based metrics
Paid at year end (could draw a portion)

- Involve physicians in the process, especially incentive design
- Some will view this approach unfavorably as a withhold
- Recognize the model is transitional; production is still the driver of pay

Early Incremental Models: Additional Quality Incentive

Current Formula	New Formula		
100% Production	Production + 10% Quality		
Family Medicine* $48.00 / wRVU	Quality/Incentive up to 10%		
If 5,000 wRVU: $240,000	$240,000 x .10 = $24,000	=	Up to $264,000 or $52.80 per wRVU

- This approach is additive; it is not a ***withhold***
- May need to lower the per wRVU starting point if larger incentive % desired
- At $52.80 per wRVU, compensation per wRVU is ~64th percentile

*Approximately market median values

Intermediate Models

Intermediate Models

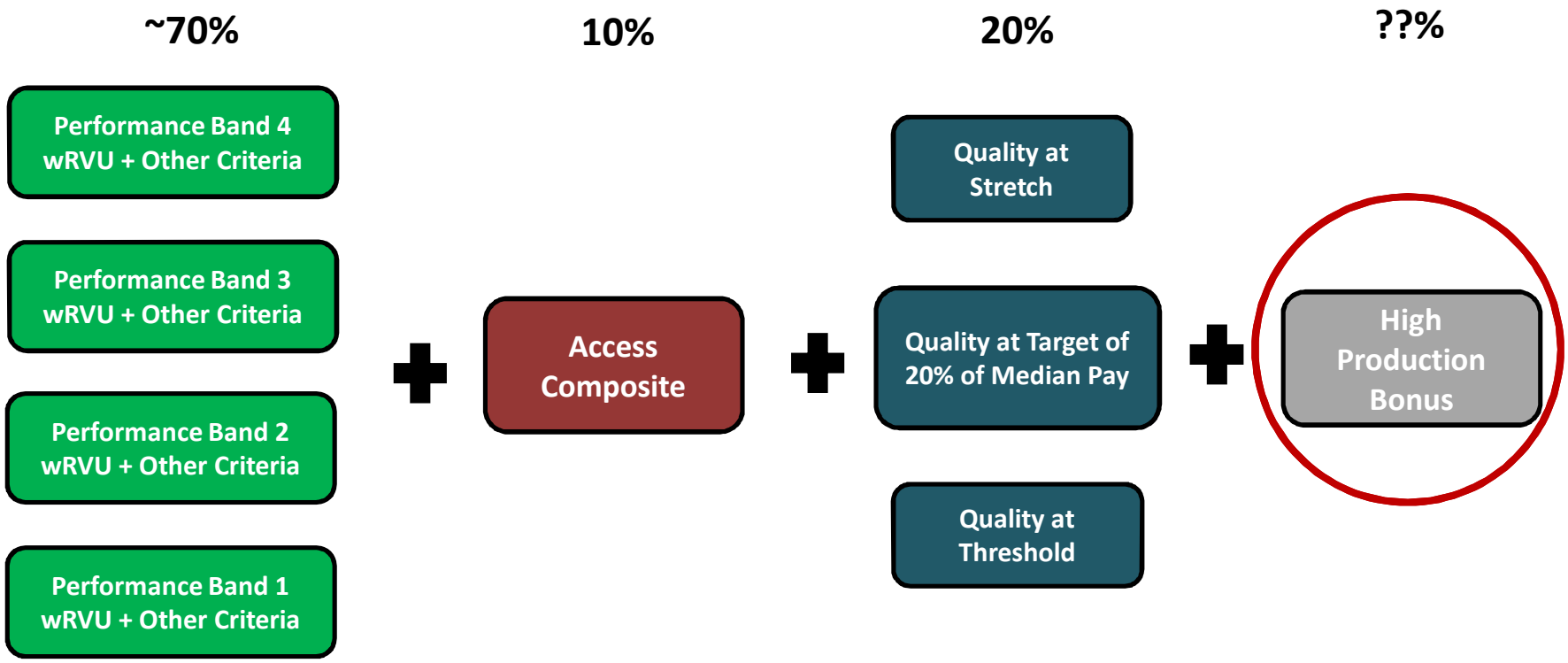
- These models are more complex; they address VBM in a more substantial way
- May work best for organizations that accept a mandate for change from production-based models
- Intended to shift thinking away from ***each and every wRVU***
- Assume production remains a factor in the future (even as a proxy for access)
- May line organizations up well for panel size or salary models
- Call for a shift in thinking regarding issues like 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 and low cost

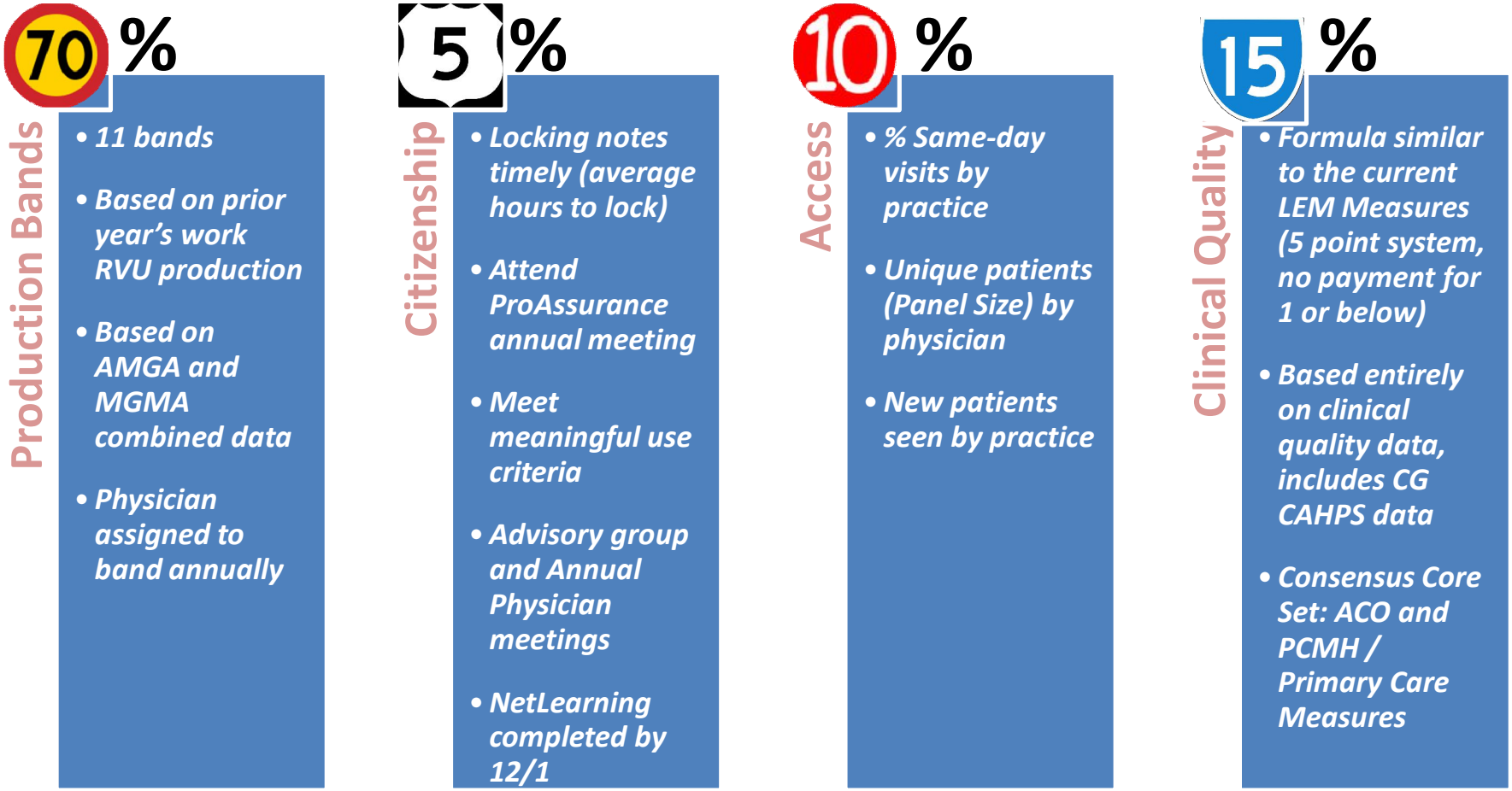
Intermediate Models: Conceptual Design



Intermediate Models: Refining Philosophy and Plan Design

Driving Forces		Potential Actions
Risk-based reimbursement is a local market reality	→	Compensation models should include *more emphasis* on quality, coordination, and efficiency with less emphasis on each wRVU
Current weight of value-based metrics (VBM) is too low		
Current formulas tend to have a large production component	→	Develop models that maintain access targets
Some physicians produce below their specialty's 30th percentile	→	Set minimum work expectations
Fairness and provider engagement are critical	→	Allow some autonomy with VBM; provide market-based pay

Intermediate Models: Incentive Design



AMGA thanks Roper-St. Francis Physician Partners, Charleston, SC, for permission to use this information.

Intermediate Models: A Transitional Approach

Three-Year Transition Plan

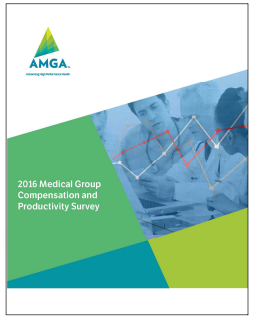
Incentive	Stage One	Stage Two	Stage Three
Access	5%	7.5%	10%
Clinical Quality	10%	12.5%	15%
Citizenship	5%	5%	5%
TOTAL	**20%**	**25%**	**30%**

If moving to 30% at risk represents too much change from current state but it is your eventual goal, consider implementing the plan in stages.

Intermediate Models: Plan Administration Considerations

- Setting Tiers prospectively or retrospectively
- Managing physicians whose performance/productivity falls
- Establishing absolute “max” on compensation (“other compensation,” regulatory)
- Measuring and reporting results on quality and other “at risk” metrics
- Implementing and managing a compensation “draw” if needed
- Re-adjusting the plan to the market each year (a role for the Compensation Committee)

Intermediate Models: Panel Size Considerations



Specialty No	Specialty	Group Count	Provider Count	25th Percentile	50th Percentile	75th Percentile
1110	Family Medicine	41	1,608	1,457	1,823	2,290
1115	Family Medicine With Obstetrics	11	138	1,356	1,741	1,990
1210	Internal Medicine	41	1,154	1,379	1,808	2,315
3115	Nurse Practitioner – Primary Care	22	328	790	1,223	1,737
1320	Pediatrics and Adolescent – General	36	684	1,508	1,926	2,431
3182	Physician Assistant – Primary Care	16	169	756	1,363	1,825

- 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.*

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 a medical group that is mature enough to manage **increases** or **decreases** in compensation over time as productivity and performance vary
- Must be well socialized with physicians as non-production pay becomes more substantial
- Can promote more teamwork
- Less “formulaic” which will require education of your business advisers such as legal, compliance, and FMV consultants

Advanced Models:
Modified Salary-Based Approach

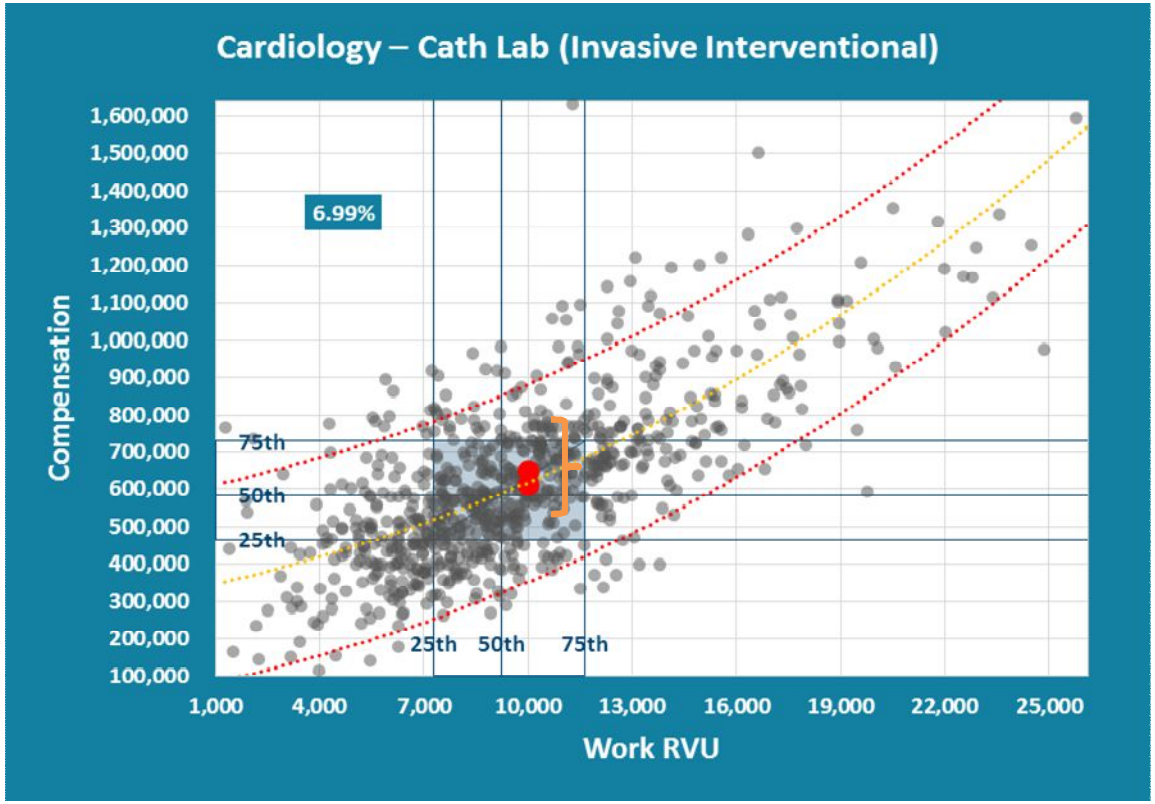
- Consider a model that is **75% Base Salary** and **25% Incentive Compensation**
- Set a Target Total Cash Compensation level (total salary)
- Determine the approach to allocate Incentive Compensation
- Develop the Plan Administration guidelines

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 Models: Modified Salary-Based Approach



- For a full-time interventional cardiologist with 10,000 wRVU, consider a range of reasonable pay
- Consider potential reductions in productivity

AMGA Cardiology-Cath Lab 2016 Percentiles				
Clinical Comp	Work RVU	Comp %ile	wRVU %ile	Comp/ wRVU %ile
$650,000	10,000	63	60	54
$615,000	10,000	56	60	46

AMGA Cardiology-Cath Lab 2016 Percentiles				
Clinical Comp	Work RVU	Comp %ile	wRVU %ile	Comp/ wRVU %ile
$650,000	9,500	63	54	63
$615,000	9,500	56	54	53

…and salary could be adjusted down for the next year

Advanced Models: Modified Salary-Based Approach

For Incentive Compensation, set the guidelines perhaps with some discretion:

Incentive Compensation Total is 100%	
Patient Satisfaction	**10% to 15%**
Clinical Quality and Efficiency	**60% or more**
Access/Citizenship	**15%**
Discretionary*	**Up to 15%**

*Subject to Chair or CMO approval

The weighting can be adjusted to align with your payer-related performance targets.

Advanced Models:
A Salary-Based Approach

The Plan Administration Guidelines might include:

- There will be 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 Department Chairs 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

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

Closing Thoughts

"It is not the strongest of the species that survives, Nor is it the most intelligent, It is the one most responsive to change"

-Charles Darwin

AMGA Consulting

Thank you!

Request White Paper or Group Practice Journal Article:
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AMGA is forming a MACRA Collaborative if you are interest in learning more about this initiative email:
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