



HEALTH CARE FUTURES IS COMMITTED TO PROVIDING LEADING EDGE THINKING RELATIVE TO KEY ISSUES THAT IMPACT OUR CLIENTS. HEALTH CARE FUTURES IS AN IDEA COMPANY PROVIDING VALUE-ADDED STRATEGIC THINKING TO LEADING HOSPITALS AND HEALTH CARE SYSTEMS, ACADEMIC MEDICAL CENTERS, AND LARGE MEDICAL GROUPS. FROM TIME TO TIME WE PREPARE A THOUGHT PIECE THAT ATTEMPTS TO ANTICIPATE A FUTURE "BIG PICTURE" IDEA, WITH THE INTENT OF BETTER PREPARING OUR CLIENTS TO SUSTAIN THEIR ABILITY TO ACHIEVE THEIR MISSIONS.

THIS PAPER IS INTENDED TO PROVIDE A SYNOPSIS OF THE MACRA LEGISLATION AND DRAFT RULES WITH THE FOCUS ON THE POTENTIAL IMPACT ON PHYSICIAN COMPENSATION APPROACHES FOR HOSPITALS, HEALTH SYSTEMS AND PHYSICIAN GROUPS. GONE ARE THE DAYS WHERE PROVIDERS JUST WORRY ABOUT CHECKING OFF A CPT CODE. REPORTING ON MYRIAD FACTORS IS AN INTEGRAL COMPONENT OF MACRA AND OTHER VALUE BASED PROGRAMS FROM OTHER PAYORS. WE WELCOME YOUR REACTION AND COMMENTS. IN ADDITION, IF YOU WOULD LIKE TO RECEIVE AN ELECTRONIC COPY OF THIS ARTICLE, WRITE TO US AT [INFO@HEALTHCAREFUTURES.COM](mailto:INFO@HEALTHCAREFUTURES.COM)

### Implications of Medicare Access and CHIP Reauthorization Act (MACRA) Legislation and Draft Rule on Physician Compensation Approaches.

Health Care Futures believes that the implementation of this MACRA legislation will have a material impact on how Hospitals, Health Systems and Physician Groups compensate physicians. There will be multiple measurements of underperforming or over-performing providers that should impact physician compensation models. Utilization of technology, outcomes, cost of the care and other metrics will be added to the traditional number of visit/net revenue generated.

MACRA was enacted in April 2015. (Please see the companion Health Care Futures Direct which summarizes this legislation and discusses some of our thoughts on the broader implications of MACRA on Physician Groups and Health Systems.) MACRA materially impacts how physicians and other related providers will be paid for services provided to Medicare recipients under Part B. "MACRA, MIPS, APM, CPIA, ACI, CEHRT". These are example new key acronyms that will impact physician and other provider compensation. CMS notes that MACRA is supposed to be a "Streamlined and Improved Program." The rules for the streamlined program required 960 pages in the Federal Register to explain the draft Regulations.

#### Major takeaways of MACRA proposed rule.

(As also discussed in our MACRA Health Care Futures Direct).

- **Time to start to adjust is now.** Reimbursement will be tied to performance 18 -24 months in arrears.
- **Not a pure volume generation model.** Provider reimbursement now will include many other factors beyond the number of CPT codes in a given day.
- **Team based care will impact reimbursement.** Physician reimbursement will be much more tied to how a team of professionals manage a patient.
- **Quality will continue to impact reimbursement.** Quality and outcomes will materially impact payments to Physicians and other Providers.
- **Cost of care will be more of a factor in how much physicians are reimbursed for the care provided.** Resources utilized to manage that care and achieve the outcomes

needed for other bonuses will impact Provider reimbursement. The level of impact will increase substantially over a short duration.

- **Complexities in physician reimbursement remain.** Granted there is more flexibility relative to certain aspects of the Provider reporting. However, this model is more complex for the Provider as CMS is trying to reward those with great outcomes at a lower cost and penalize those who do not share those attributes.
- **Smaller practices will be hurt the most.** It is fairly clear that CMS and others believe the brunt of the impact in terms of "lost reimbursement" will be borne by those smaller groups and practices that do have either the infrastructure or capabilities in house. We would suggest as have others, that this might be one of the nails in the coffin for small provider groups.
- **Other payors will follow suit.** We believe other payors who are still on pure per CPT reimbursement models will utilize components of MACRA in their future reimbursement approaches for physicians and other providers.

#### Implications on Physician Compensation Models.

Health Care Futures has worked with 15+ clients over the past few years helping to redesign compensation approaches for Physicians and other providers. These Hospitals, Health Systems and Physician Groups collectively employ nearly 8,000 providers. As is noted in the overview of our typical approach, a large sample size of the clinical physicians were involved in the redesign of these compensation approaches. Historically, there have been many drivers for organizations that are looking to update and redesign their compensation models. Some of these include the following.

- **Complexities in managing multiple compensation models.** This is especially the case with many of our Hospital and Health System clients. Typically these various compensation models are legacies of individual compensation negotiations as physicians were brought into employed arrangements with these organizations. As an example, one of our Health Care Futures

## Implications of Medicare Access and CHIP Reauthorization Act (MACRA) Legislation and Draft Rule on Physician Compensation Approaches, cont.

clients, prior to our assistance in developing an updated compensation approach, had over 140 compensation models in place for their approximate 1,000 employed physicians with dozens of other models in place for Advanced Practitioners (APCs). Managing this number of plans was an administrative nightmare. After our planning efforts were completed the number of Physician plans for this System dropped to under eight.

- **Compliance.** This is a material issue for Hospitals and Health Systems. The variances in compensation methods can create compliance issues for these Organizations.
- **Fairness.** As Hospitals, Health Systems and Physician Groups add Physicians to their mix, the compensation plans can become unfair at times within specialties and across specialties. Again this sometimes is a legacy of past negotiations for Hospitals and Health Systems. For Physician Groups, this issue can emanate from recruitment of tough to find specialties.
- **Models that do not reflect emerging issues.** A majority of the compensation approaches in place today for our Hospital, Health System and Physician Group clients are still based either exclusively or nearly so on production either as measured by wRVUs or net revenue generated. In addition, the approaches within Physician Groups, Hospitals and Health Systems relative to financial incentives or disincentives to utilize Advanced Practitioners varies tremendously.

**MACRA and Physicians Compensation Models.** The reimbursement from Medicare and other payors who may follow suit and/or develop similar approaches, impacts the amount of money available for Physician compensation and is less dependent than today on pure volume. Much is to be determined in terms of specifics of this legislation and how it is to be implemented by CMS. However in our view, there are some clear implications that will impact Physician Compensation Plans. These include the following.

- **Historical performance will drive future reimbursement for Physicians.** As an example, 2019 payments for Physicians will be driven off of 2017 data for the vast majority of the Physicians. It will take time for Physicians and other team members to change behavior to be able to be successful and not be one of those penalized under this new reimbursement approach. With 2017 months away, the changes in behavior and practices need to begin soon.
- **Team work will become important financially for the Physician.** The resources utilized will impact reimbursement for Physicians. This would be the case whether a Physician was part of the MIPS or the AMP track as cost of care over time will impact the available money for Physicians compensation either directly (MIPS) or indirectly (AMPs must take risk). (See companion Health Care Futures Direct for information on MIPS and APMs). The Physician will no longer be the sole determinant of reimbursement. Others will be part of the resource utilization – whether APCs, social workers or others.

- **Physician Groups and Health Systems can no longer ignore quality (as defined by others and by outcomes) as a determinant of whether a Physician is a positive or negative for the Group or System.** In the past, generation of large amounts of volume has generally been the definition of a winner or loser. This is no longer the case – Quality is here now.
- **Value Proposition is here.** Available dollars however are also impacted by overall value – taking into account many other factors including use of technology and cost of care. Compensation models should incentivize effective use of resources as this is a key determinant of available dollars by CMS and in the future from other payors.
- **Percentage of net revenue could become more prevalent again as a driver of physician compensation for Not for Profit Organizations.** Compensation for physicians in small private practices has historically based on the net revenue generated by the physician. Many large physicians groups still utilize this model today but the driver of net revenue will be impacted by MACRA. Most NFP Organization have been utilizing wRVUs as the exclusive or primary driver of compensation as opposed to net revenue. If net revenue is now to be materially impacted by quality scores, outcomes, use of technology and resource utilization then simpler compensation models that are again based on percentages of net revenue might become somewhat more prevalent and appropriate for some Hospitals and Health Systems.
- **Definition and Determination of Fair Market Value Compensation will need to evolve.** Medicare as the largest payor in this country has determined that defining work for a Physician no longer is solely derived from how many wRVUs, or CPT codes or revenue generated. Production as defined by these metrics is one factor, but not the sole determinate. Especially for Hospitals, Health Systems and NFP Physician Groups, this issue is something that in our view will evolve with legal counsel. However, we argue the definition needs to be expanded and Fair Market Value should include factors that CMS (and other major payors) believes are important in terms of the amount of money it is willing to spend for a given health issue. Items such as how well care is managed, how much shared savings may be generated and the like should be part of Physician compensation (upward and downward).
- **Data sharing will be key to successful compensation models.** Physician Groups, Hospitals and Health Systems will need to provide data on performance to providers that are accurate and as timely as possible. There can be many hurdles to address in seeking to achieve this obvious but critical objective. One of those hurdles is the fact it appears CMS will be reporting only annually on key components of these metrics such as resource utilization. Thus, how a Physician, or a Physician Group or a Health System is performing on this metric is not known until after the end of a reporting period. This provides for less opportunity for the providers to adjust.

**Health Care Futures Thoughts on Redefining Physician Compensation Models.** Health Care Futures has, as noted, been



## Implications of Medicare Access and CHIP Reauthorization Act (MACRA) Legislation and Draft Rule on Physician Compensation Approaches, cont.

involved in a number of provider compensation assignments over the last few years. Clearly the details of MACRA were not known to us or our clients as we were developing these plans. However observant professionals have noted the direction of CMS/ Congress and other payors toward value and more team approach to care. Quality metrics have been a part of the landscape for a few years but the concept of including outcomes over time, cost of care, and utilization of technology has become more important to the inflow of dollars given MACRA. We believed much of this was coming and thus have been working with our clients to better prepare for these changes. Money is clearly not the sole driver but it is a major incentive or disincentive for behavior. In our view, physician compensation plans should reflect the underlying concept of MACRA – Medicare is our largest payor in the US and other payors are either utilizing similar approaches or will be in the near term.

As Physician Groups, Hospitals and Health Systems work through a process of redefining their compensation approaches there can be a tendency to want to include every factor in the compensation model – throw everything into the model. This can result in an overly complex model that become frustrating for the physicians and difficult to manage for the Group or the Health System. The old adage – Keep It Simple Stupid or KISS has some merit. As an example, one of our clients wanted to include 3 Citizenship measures, one of which was whether the physician signed an annual conflict of interest form and wanted to include multiple gradients for various measures including citizenship. In our view, this created complexities that were not worth the outcomes desired. The compensation approaches and models we help to craft should, in our view, be able to be explained in a slow three floor elevator ride (we used to use two floors but it has become more complex as payors add complexities such as that outlined for MACRA).

### Thoughts on Primary Care Compensation today and in the near future.

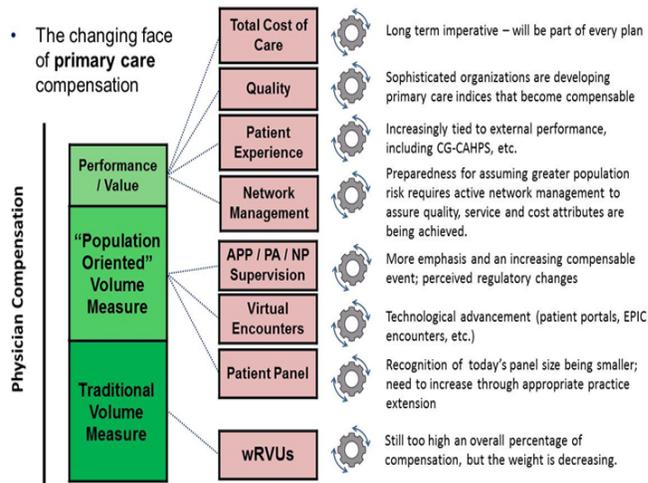
• **Today, the majority of primary care compensation models are broken and often misaligned.** Traditional wRVU based delivery systems fail to delegate and appropriately reflect population health.

- Physicians are incented to personally perform the majority of services – this is leading to increased burn out.
- Chronic and preventable conditions do not have appropriate penetration.
- Limited delegation of tasks.
- Perception of APCs as competitors to physician income.

• **A significant focus of redesign efforts is assuring primary care alignment with population-based initiatives.**

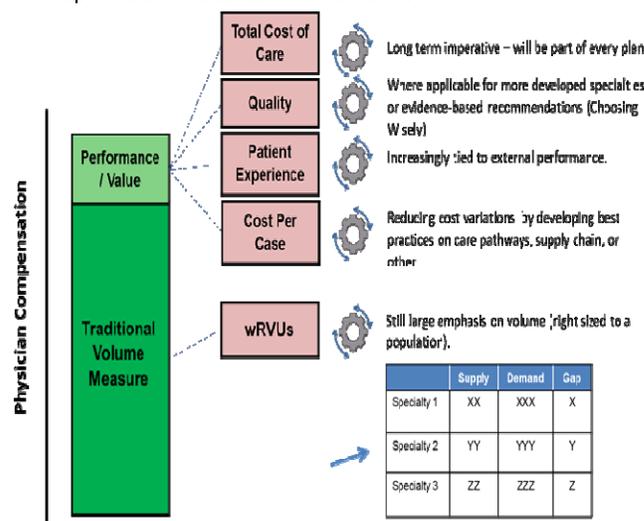
- Patient panel management.
- Technology/alternative encounters.
- Team-based care (incentives to grow panel through advanced practice practitioners).
- Population-based quality composite.
- Patient experience.

### Primary care quality is becoming integrated with Group and individual performance.



### Thoughts on Specialist Compensation in the near future.

• **Specialist compensation models may differ between procedural and medical specialties.** Clearly, these will be different quality and resource utilization metrics for various specialists. Some key attributes for near future specialist compensation model are noted below.



### Other sample topics to be addressed in compensation planning.

- **Citizenship.** Should good “citizenship” be a given or woven into the compensation model?
- **Patient experience.** Many progressive compensation approaches include a factor for the patient experience including patient satisfaction. However, CMS is not directly tying reimbursement to the patient experience.
- **Hospital based physicians.** Models for Primary Care and most Medical and Procedural Specialists will not work for Hospital based Physicians.

### Health Care Futures typical approach to Physician Compensation Redesign. Each situation is unique but we

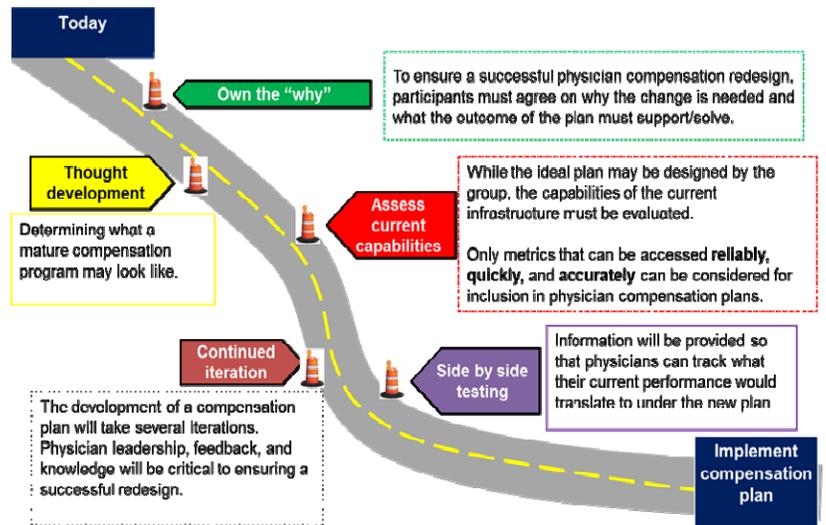
## Implications of Medicare Access and CHIP Reauthorization Act (MACRA) Legislation and Draft Rule on Physician Compensation Approaches, cont.

believe there are some givens relative to adjusting provider compensation plans.

- **As an Organization, this will be some of the most difficult work you will do.**
- **The level of process and change management is significant.**
- **The reasons for the need to redesign physician compensation models needs to be clearly articulated.** Hospitals, Health Systems and Physician Groups MUST be able to articulate to the physicians the “why”, along with an accompanying organizational vision. Absent achieving agreement on “why”, compensation redesign appears to physicians as an attempt to reduce compensation.
- **Physician leadership is mandatory and ownership is a must.** Physician engagement by line physicians is critical to eventual implementation of the compensation redesign that will be required. Some Physician Groups and Health Systems want to utilize a quick top down approach. We would argue the more successful redesign actively engages line physicians in the development of the plan. Clearly in organizations with 1,000 physicians all can't be surveyed or be part of the planning process. However, utilization of small teams of physicians who act as sounding board and eventually as proponents of the plans developed by the physicians has been proven to be the most successful track. It takes longer to develop the redesigned compensation plan to include line physicians but in our view the outcomes are far superior. Also, when we work through the systematic approach to compensation redesign we often see terrific ideas and concepts identified by the line physicians that were not suggested either by senior management or by us. In our view, to be successfully maintaining and growing the physician base the process of planning for the compensation redesign is as important as the outcome. *The right process leads*

to superior outcomes.

**Overview of the typical Health Care Futures Planning Process.** As we have noted, each situation is unique and we typically have a few extra curves on the typical roadmap outlined below.



**Conclusions.** The underlying premise of MACRA, that physicians and other providers will be reimbursed for care that is good value for the payor is something that we believe has been foreshadowed for a few years now. Value will matter and value is not only how many patients or even only the quality of the care provided. Whether one agrees or not with the known specific factors in the MACRA rules, at least now physicians and others have a clearer picture of how the largest payor in this country will determine payments to providers. MACRA should be an impetus for those Physician Groups, Hospitals and Health Systems who have not addressed adjusting their physician compensation plans to address value and outcomes to do so. Physicians are at the epicenter of an emerging team approach to delivering and managing health care in the US. As the epicenter, physicians should be involved in the development of compensation approaches that: promote fairness; incentive the attributes MACRA and other emerging reimbursement approaches are seeking to achieve; are financially sustainable for the Physicians Group, Hospital or Health System; and, meet fair market value compensation tests.

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