Urology Group Compensation and Ancillary Service Models in an Era of Value-based Care

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Changes involving the health care economic landscape have affected physicians' workflow, productivity, compensation structures, and culture. Ongoing Federal legislation regarding regulatory documentation and imminent payment-changing methodologies have encouraged physician consolidation into larger practices, creating affiliations with hospitals, multidisciplinary medical specialties, and integrated delivery networks. As subspecialization and evolution of care models have accelerated, independent medical groups have broadened ancillary service lines by investing in enterprises that compete with hospital-based (academic and nonacademic) entities, as well as non–physician-owned multispecialty enterprises, for both outpatient and inpatient services. The looming and dramatic shift from volume- to value-based health care compensation will assuredly affect urology group compensation arrangements and productivity formulae. For groups that can implement change rapidly, efficiently, and harmoniously, there will be opportunities to achieve the Triple Aim goals of the Patient Protection and Affordable Care Act, while maintaining a successful medical-financial practice. In summary, implementing new payment algorithms alongside comprehensive care coordination will assist urology groups in addressing the health economic cost and quality challenges that have been historically encountered with fee-for-service systems. Urology group leadership and stakeholders will need to adjust internal processes, methods of care coordination, cultural dependency, and organizational structures in order to create better systems of care and management. In response, ancillary services and patient throughput will need to evolve in order to adequately align quality measurement and reporting systems across provider footprints and patient populations.

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Independent practice • Collaboration • Value-based care • Specialization • Compensation

The ever-changing health care economic landscape has affected the workflow for community-based physicians attempting to organize their practices in order to provide effective services and, simultaneously, structure their compensation arrangements with fairness and mutual agreement within the partnership. In response to the Patient Protection and Affordable Care Act (ACA), along with the imminent payment changes forecasted, physicians have consolidated into larger practices, often creating affiliations with entities such as hospitals, multidisciplinary medical specialties, and integrated delivery networks. As subspecialization and evolution of care models have accelerated, independent medical groups have broadened ancillary service lines by investing in enterprises that compete with hospital-based (academic and nonacademic) entities, as well as non–physician-owned multispecialty enterprises, for both outpatient and inpatient services.

This market adjustment to value-based compensation has long been anticipated. In 2012, Sullivan, Cotter, & Associates released a survey of 424 health practitioners who predicted that physician compensation would increasingly incorporate factors such as quality outcomes, preventative care, cost savings, and patient satisfaction.[1] They also predicted that physician incentives tied to the above metrics were only 3% to 5% of total physician compensation in 2012, but would increase to 7% to 10% within a few years.[1] Additional surveys by health care consulting firms suggest that the differential trend of employed physicians, receiving payment via salary, versus independent physicians, being compensated on volume, is narrowing. A survey of 182 health care organizations by the Hay Group released on October 17, 2011, found that 66% of physician groups have incorporated quality measures into incentive programs for physicians.[2]

In a June 2012 Allscripts Healthcare Solutions survey of 204 hospital executives, 73% agreed that physicians needed to shift from volume- to value-based compensation immediately; 39% of these executives expected one-fourth of total revenue to be linked to value-based metrics within the next 5 years. Another 17% noted that it would comprise up to one-half of their revenue moving forward.[3]

In urology groups nationwide, a minimal percentage of reimbursement for ancillary service compensation is linked to value-based care. The goal of the Catalyst for Payment Reform, an employer coalition, is to have 20% of payments be value based by 2020.[4]

Urology groups that have efficiently transitioned to value-based compensation models have several common business and cultural consistencies: (1) a thorough understanding of how value-based payment models benefit their practice (an education around the shifts that the Medicare Access & CHIP Reauthorization Act [MACRA], Merit-based Incentive Payment System [MIPS], and Alternative Payment Models [APMs] will bring to their medical business success); (2) leadership with an innovative attitude in moving their compensation toward these models, augmenting a partnership culture of collaboration and cohesion; (3) a group-wide understanding of how, when, and where compensation transitions will take place, predicated upon education and communication from the physician and nonphysician leadership; and (4) ongoing educational guidance to assure continuity of care and uptake of any new, innovative quality metrics or payment methodologies as regulatory and legislative developments evolve.

Urology groups struggling to adjust to alternative compensation models often fail for the following reasons: (1) lack of group education regarding the inevitable reimbursement changes; (2) an inherent culture of negativity or cynicism based upon historic experiences; (3) inhibited open communication, which obviates vetting of model differential discussion and leads to backroom dissention; and (4) failure to adequately survey or ensure communication guidance, with attendant leadership avoidance, which culminates in a dearth of evolution, thus fostering discontent.

MACRA, MIPS, and APMS

On April 27, 2016, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule creating significant adjustments to Medicare. The new MACRA payment model was created to replace

the Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula. At the time of this writing, the SGR has been replaced with a new, value-based reimbursement system called the Quality Payment Program. This quality payment model is divided into two tracks: MIPS and the Advanced APMs. This newly minted payment algorithm means that each Medicare Part B clinician is in MIPS, an Advanced APM, both, or neither (continuing with a regular fee-for-service [FFS] model). Based upon current projections, CMS predicts that most Part B clinicians will be subject to MIPS, as MIPS is effectively the "new default" for Part B, whereby clinicians may be exempt from MIPS only under very specific conditions.[5]

As groups rework their respective compensation structures in preparation for the ACA and alternative payment model implementation, they must first work to comprehend the new payment models and implications. MIPS, the first track, will combine elements of Meaningful Use, the Physician Quality Reporting System, and the Value-based Payment Modifier. An additional program, called Clinical Practice Improvement Activities, is focused on ways to improve care coordination, beneficiary engagement, and patient safety. This track and subsequent payment implications will be the default track for eligible professionals unless the practice is already part of a qualified APM.

The MACRA track also affords a urology group the opportunity to qualify for APMs. Eligible professionals who receive at least 25% of their Medicare Part B payments through a qualified APM may qualify under this track. Eligible professionals who are a part of the APM track will receive an annual 5% lump-sum bonus payment in addition to being excluded from the requirements of MIPS.[6]

Ancillary Services

Ancillary and integral services, which may range from diagnostic radiology, in-office pathology, therapeutic radiation oncology, ambulatory surgery services, to clinical trial research, have become an essential part of urology group models as a vital clinical requirement for quality care. These services complement traditional clinic visits and surgical procedures, and thus must be appropriately reviewed and evaluated for each health care business model as payment structures evolve. Ancillary services tend to be classified under three distinct service categories: diagnostic, therapeutic, and custodial. With the MACRA/MIPS and APM adjustments, many urology groups are rethinking their current ancillary service and compensation structures in order to effectively position themselves for a productive future of quality initiatives and optimal patient delivery methods.

As new payment structures unfold, urology groups will need to adjust their ancillary services toward models hinged on shared revenue quality metrics, blended compensation metrics, and patient satisfaction metrics. Legacy arrangements with volume-based financial structures will need to be replaced by the value-based paradigm of shared clinical decision-making pathways, consistent patient outcomes, and synergistic partner collaboration.

Value-based Care

Most urology group leaders understand that, given the incoming legislative payment models and value-based reform, legacy FFS compensation structures are destined for obsolescence. Instead of rewarding volume-based patient care, new value-based payment models will seek to reward quality metrics in terms of cost, quality, and outcome measures. If not strategically outlined and planned, these largely untested models have the potential to upend urology stakeholders' traditional patient care and business models and drive suboptimal, and possibly incorrect, behavior across medical practices. Although some urology leaders are actively preparing for the transition to value-based care, others are hesitant and are taking more of a "wait and see" approach, electing a reactive versus a proactive strategy.

The reluctance to make this shift is understandable, because the level

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of political, cultural, and financial investment in changing compensation models can be substantial, and the current FFS payment structure is still the predominant methodology. Nonetheless, mandated variables for establishing value-based strategies are now clearly delineated within MACRA (ACA). Therefore, practice leadership should recognize that elucidating the optimal ancillary service and compensation models is not merely predicated upon choosing a binary compensation plan (eg, make more money, make less money), as quality metrics and performance improvement must be incorporated in order to successfully navigate MIPS or APM. Moreover, group leaders must invest the time to implement a comprehensive process, leveraging their existing partnership agreement and practice data in conjunction with a positive group culture, and thus create a multistep solution geared toward rewarding the most appropriate patient care and quality-centered outcomes.[7]

When considering how to effectively operate under the new payment algorithms, urology groups should analyze their market position, current revenues, and core capabilities. Leadership and all practice stakeholders should work together to better understand how the value-based models work, including associated incentives, risks, and potential financial impacts to their respective health care footprint. Urology leaders who ask difficult questions in order to address outdated and legacy-based compensation structures will gain early advantages that will enable them to compete more effectively in the future. When the imminent reimbursement market shift toward value-based patient care models arrives, those who have not done their due diligence will be significantly disadvantaged.[8]

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Models for Transition to Value-based Care

Best Practices: Clinical/Financial/Operational Considerations

There are five strategic steps that urology groups should implement in order to prepare for compensation models that can thrive under MACRA requisites, including ancillary service structures. These are outlined below.

Leadership Must Articulate a Vision. The first step is to recognize central goals and articulate a strategic vision to meet those goals. As an example, one urology group had a vision of forming a value-based prostate cancer center in order to coordinate partner compensation and treatment algorithms under one central model of care. One of the urology group's stakeholders said, "It became clear to us last year that we needed to focus our comprehensive efforts on this specific group of patients in order to lessen variance in care patterns among providers and achieve the appropriate quality outcomes."

Maintaining a focused vision throughout the adjustment process and coordinating compensation under this vision is essential for keeping physicians on track when they face obstacles. "We deeply believed it was possible to make this happen," commented another urology partner. "At multiple places during this process, we ran into barriers, and we just stayed with it, never letting up, and finally some of those barriers broke down. The net effect was that the vision we held onto materialized over time. The trust that was built throughout the process helped to move our group toward the next evolution in value-based care metrics and evolved payment models for all of our ancillaries."

As the urology group moved from vision to articulation of a new shared advanced prostate center, group leaders had to address questions, including the following:

- Are we currently achieving our performance goals? How will we continue to meet them as we move toward shared revenue and value-based ancillary service partnerships?
- Does our current compensation plan incentivize the right physician behaviors? What parts can be adjusted now and which parts should be adjusted over time?
- What market shifts do we anticipate that could break down or build up the new compensation structure?
- What is our vision for the group in this new reality?
- How will our business model evolve to fulfill our mission?
- Is our leadership prepared to hold our partners accountable as we shift to value-based care?
- Do we have the right leadership team and culture to lead us into the future of health care innovation, MACRA, and alternative payment discussions?

Form a Multidisciplinary Leadership Group in Order to Manage and Measure the Depth of Group Culture. Compensation structures and ancillary services in value-based care models are typically

predicated on integration of care, which relies on the collaboration of multiple partners in a group-wide effort. In planning for a shared-resource prostate cancer center, urology physicians can work to create a multidisciplinary committee that includes medical, surgical, and radiation oncologists, radiologists, pathologists, physician extenders, and key staff.

Group leadership who make it a priority to meet regularly to discuss how they can best deliver care to their prostate cancer patients develop stronger shared decision-making processes, structures, and culture. "Our meetings and the commitment of the core team drive progress," reports the physician leader of this group.

In creating a successful multidisciplinary group, urology group leaders need to address detailed questions, including the following:

- Do we have a unified medical group culture?
- Do our physicians trust our leadership and administrative capabilities?
- Which executives will lead the redesign of our compensation process?
- Are all of our leaders able to stand on principle with respect to compensation change?
- Which clinicians should be involved to build consensus across the group?
- What role should they play in developing and approving the model?
- How will administrative and physician leaders work together to secure physician buy-in at every level?
- What are our nonnegotiable points in changing our group philosophy toward ancillary services and compensation metrics?
- What are our unique organizational and market considerations?
- What can we learn from external best practices within our urologic peer group?

Identify Metrics. To deliver excellent care, urology groups need to determine baseline performance metrics and the measures that they will use to define improvement across their ancillary services, as well as in their compensation structures. In addition to developing internal quality standards, urology groups should use national benchmarks from LUGPA, the American Urological Association, and the Medical Group Management Association, along with individual consultants to pressure test their center of excellence shared compensation programs. Benchmarking performance against national standards enables the multidisciplinary leadership team to compare metrics with other groups and specialties across the country.

Specific questions need to be addressed in the quantification and rollout of metrics prior to the launch of an adjusted compensation strategy, including the following:

- Which metrics should be tied to incentives to support our vision?
  - Individual: productivity, quality, service, patient experience, expense management, access, panel growth and management, group leadership, group citizenship?
  - Collective: team-based care, group goals?
  - Strategic: consistent with the group's strategic goals and vision?
- Can we calculate the potential impact on individual compensation and model various scenarios?
- Can we incorporate tracking mechanisms to ensure the ongoing effectiveness of the plan for providers and for the organization?
- Can we adjust the model for unintended consequences?
- Can we validate and benchmark the chosen metrics?
- Do we anticipate any changes in operations and work flow to enhance quality of data capture?
- Do we have the expertise to build the proper algorithms in order to adjust our care models effectively?

Develop a Data Collection System. After identifying metrics, urology groups must develop a comprehensive data collection system in order to organize data in a way that allows for accurate reporting to urology group partners, strategic associates, and accountable care organizations.

According to a physician from one large urology group, this step was one of the most difficult, and was compounded by the group's earlier adoption of an antiquated electronic medical system that many partners found to be challenging and ineffective. One challenge was that even though the urology group already tracked certain data, the group was not necessarily maximizing data extraction and analysis capabilities. Each multidisciplinary team had to go back through 3 years of data in order to align it with current metrics to better quantify and qualify partner prescribing behavior, as well as short- and long-term goals.

Urology groups should address the following questions related to their data collection system:

- How will we report performance and compensation data?
- Do we have the necessary technology infrastructure?
- Do we have a mechanism for gathering all of the required data from multiple sources?
- Can we ensure the integrity of data?

- Can we dedicate sufficient resources (staff and other) to get the model up and running in a reasonable period?

Redesign Processes to Match Vision and Compensation Goals. Creating a value-based ancillary service care model requires leaders to re-evaluate their entire delivery system of care using newly prioritized metrics. For effective implementation, one urology group reviewed its prostate cancer care model and then redesigned processes to improve clinical, quality, and patient satisfaction outcomes in accordance with their new vision.

One key takeaway from process redesign was that prostate cancer patients often waited too long for scheduled follow-up visits during asymptomatic disease progression. The multidisciplinary team redesigned the intake process, which included improving communication between different clinical care providers, and thus established more rigorous and team-based communication pathways. This redesign reduced the "time to treatment plan," which resulted in increased patient volume for more effective care and subsequent improved patient satisfaction surveys.

The new compensation-clinical model, with the attendant physician behavior change, was implemented by addressing key questions in order to focus on change management. Questions highlighting the process redesign consisted of the following:

- How will we transition physicians to the new model?
- What are the pros and cons of an immediate vs phased approach to adoption?
- Will there be a pilot or will our group "go live" with the new metrics all at once?
- Is our timeline consistent with market changes?
- How will we onboard new physicians under the revised model?
- How will we communicate the redesign to our physicians?
- What are the critical issues to address: strategy and vision for the redesign, pathway and expectations, timeline, support mechanisms?
- Which communication channels will we use at each stage?
- What forums will we have for physician feedback and iteration?

Long-term Commitment: Having Vision

As urology groups evolve toward value-based care metrics, many are experimenting with variations and combinations of four main types of value-based payment models. Many groups have moved strategically from a 90% FFS:10% shared structure toward a more balanced shared compensation structure. These models are swiftly evolving from a baseline of 60% FFS:30% shared to 20% FFS:80% shared, and beyond. Although compensation percentages vary across independent urology groups, innovative, forward-thinking groups are shifting their culture, along with compensation percentage strategies, to reward partners who embrace quality, collaborative, and comprehensive outcomes as opposed to simply compensating for volume-based efforts.

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Opportunities abound for urology groups to embrace, rather than fear, the incoming payment algorithms and adjustments. Groups can choose from a plethora of innovative models in order to select a model best suited for their specific circumstances, which could include some of the following concepts:

1. **Shared Savings.** A urology group can still be paid using a traditional FFS model, but at the end of the year, total spending is compared with a value- or quality-based metric, goal, or target. If the urology group's spending is below the target, it can share some of the difference with partners and/or members as a bonus toward value-based care. Urology groups that have employed shared savings targets have recognized greater synergies toward overall quality, cost, and performance goals. By creating common objectives across urology group footprints, hinged on metrics such as patient satisfaction, quality initiatives, or practice citizenship, groups can distribute bonuses and make payments to partners based on criteria more in line with the imminent value-based payment algorithms.
2. **Bundles.** Instead of paying separately for ancillary services, physician visits and procedures, and other urologic services, payments can be bundled for services linked to a particular condition, reason for treatment, and/or period of treatment for chronic disease states (eg, newly diagnosed prostate cancer, overactive bladder syndromes). With bundled payments, a urology group can keep the revenues it saves through

reduced spending on some components of care included in the comprehensive payment amount. When designing a bundle, urology group leaders should look at nuanced areas in which cost is at a premium and/or quality is a recognized suboptimal variable. For example, one urology group tracked biopsy complication rates with a goal of lessening the infection complication rate and thus reducing hospital admissions in collaboration with their local payor. Another group tracked emergency room patient visits for complicated urinary tract infections and negotiated a bundle around lessening overall urinary tract infection complication rates across all physicians within their practice footprint. Well thought-out, bundled payments with a reduction of cost can be a strategic way to achieve urology group partner alignment to shared clinical and economic goals, while reducing pathway inconsistencies, detrimental outlier behavior, and suboptimal outcomes, and still maintain coordination of care.

3. **Shared Risk.** In addition to, or in conjunction with, sharing savings, a urology group can employ a shared risk strategy. Shared risk governs when a urology group or specific urologists spend more than the value-based metric target. When this model is deployed, a group of physicians must repay some of the difference as a penalty toward the overall algorithm of care. Urology groups who have exercised a shared risk structure have recognized savings through shared risk bonuses, penalties, or incentives. Some urology groups are finding synergies in employing shared risk algorithms with certain payors, Clinically Integrated Networks (CINs), or Integrated Delivery Networks (IDNs) in their respective market places. Other groups are using the shared risk model to govern their performance against national benchmarking standards. Some of the newer payment pilots (eg, the Oncology Care Model) have a shared risk component to their remuneration model. Based upon current performance within these pilot models, it appears that shared risk opportunities are, and will remain, popular going forward.
4. **Global Capitation.** With a capitated model, a urology group receives a per-patient, per-month (PP/PM) payment intended to pay for a patient's care, regardless of what urologic services they use. Global capitation structures can be comprehensive or they can be by therapeutic condition or type. Urology groups have employed global capitation models across strategic partnerships with payors, CINs, IDNs, or Accountable Care Organization structures. Many urology groups have found PP models and PM models to be beneficial for certain patient types or therapeutic conditions. When negotiating a global capitation model, urology

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MAIN POINTS

- The looming and dramatic shift from volume- to value-based health care compensation will assuredly affect urology group compensation arrangements and productivity formulae. For groups that can implement change rapidly, efficiently, and harmoniously, there will be opportunities to achieve the Triple Aim goals of the Patient Protection and Affordable Care Act, while maintaining a successful medical-financial practice.
- Urology groups struggling to adjust to alternative compensation models often fail because of a lack of group education regarding the inevitable reimbursement changes, an inherent culture of negativity or cynicism based upon historic experiences, inhibited open communication, and failure to adequately survey or ensure communication guidance.
- Successful transition to a value-based compensation model requires a thorough understanding of how value-based payment models benefit their practice; leadership with an innovative attitude; a group-wide understanding of how, when, and where compensation transitions will take place; and ongoing educational guidance.
- Implementing new payment algorithms alongside comprehensive care coordination will assist urology groups in addressing the health care economic cost and quality challenges that have been historically encountered with fee-for-service systems. Improving a comprehensive payment and quality approach to care is a necessary step for implementing value-based care metrics.

groups should consider their overall payor mix, patient visits, and patient demographics. Carefully negotiating these types of agreements with strategic entities can be highly beneficial when both parties are in agreement concerning the comprehensive cost of care per patient, as well as the overall benefit to coordinating the structure of PP/PM care. By employing capitation models strategically, urology groups can recognize a globally driven, value-based solution, while employing a bottom-line orientation toward cost control.

In summary, implementing new payment algorithms alongside comprehensive care coordination will assist urology groups in addressing the health care economic cost and quality challenges that have been historically encountered with FFS systems. Improving a comprehensive payment and quality approach to care is a necessary step for implementing value-based care metrics. Despite many urology group leaders' desire for a quick, tactical approach to adjust their health care economic structure, merely adjusting payment models is not the only disruptive change that groups must undertake. Urology group leadership and stakeholders also need to adjust internal processes, methods of care coordination, cultural dependency, and organizational structures to create better systems of care and management. In addition, ancillary services and patient throughput need -1- to evolve to adequately align quality measurement and reporting systems across provider footprints and patient populations.

Of note, change and payment model evolution cannot happen instantaneously. To be effective, a transition process is needed for urology groups to process the new value-based paradigms. Rather -2- than immediately moving toward a value-based structure, urology groups must invest time and energy, and emphasize streamlined communication in order to undo ingrained formulae. Although a phased approach in order to transition to a value-based model and its unique philosophical culture could take longer than many group leaders might desire, the sustainability and success of a carefully and strategically addressed realignment will afford long-term success. ■

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Author Queries

AQ1. Ref #2: link to correct article?
AQ2. Ref #5: link to correct article?
AQ3. Approve or edit Main Points as necessary.