HSG | EMPLOYED PROVIDER COMPENSATION

STRATEGIES TO SUPPORT YOUR NETWORK'S EVOLUTION

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EMPLOYED PROVIDER COMPENSATION

INTRODUCTION

At HSG, we spend most of our time focusing on strategic and operational issues related to employed provider networks. We work with clients to build culture, improve operations, and reduce losses. Central to these activities, and foundational to the very existence of every employed group, are the providers themselves. In fact, a group's long-term success is incredibly dependent on having productive, engaged, and satisfied physicians and advanced practitioners (APs). Although there are many issues that affect providers, few are more impactful than compensation. That is why the most successful provider organizations make the development and execution of compensation strategy a top priority.

In this white paper we will focus on provider compensation strategy, specifically:

- The importance of having a compensation strategy that evolves with and supports the organization's progress toward an employed physician network that creates value and operates at high-performance.
- Best practices for provider compensation strategy, design, and implementation, including:
  1. **Introducing meaningful and aligned productivity incentives**
  2. **Incorporating broader, non-productivity-based incentives**
  3. **Building structures to incentivize team-based care**

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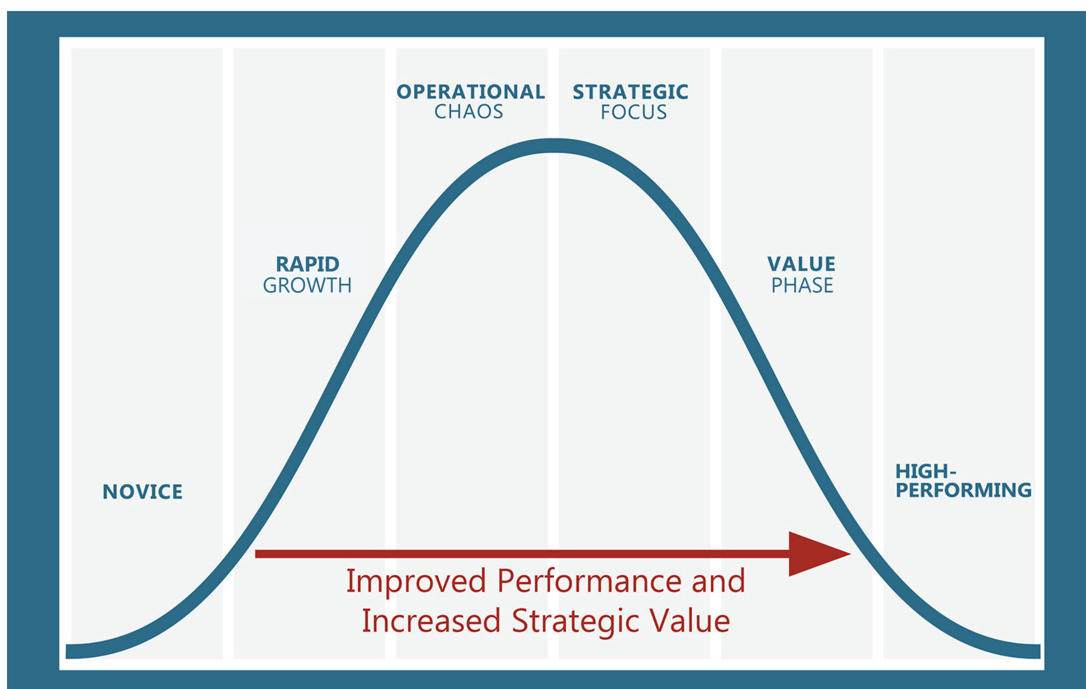
THE IMPORTANCE OF HAVING A COMPENSATION STRATEGY THAT EVOLVES WITH AND SUPPORTS THE ORGANIZATION'S PROGRESS

WHY CREATE AN EVOLVING COMPENSATION STRATEGY?

Since the Affordable Care Act (ACA) passed in 2010, consultants, healthcare leaders, and policy experts have been touting the transition to value. Pilot programs for **Accountable Care Organizations**, **Shared Savings Programs,** and **Bundled Payments** were launched after the ACA's implementation. These programs were designed to change the way hospitals and physicians provide care, manage patients' health, and generate revenue. Many experts advocated that organizations prepare for such programs by redesigning their physician compensation plans to reflect new reimbursement methodologies.

Therein lies the problem: **The speed at which markets and organizations have moved away from Fee-For-Service (FFS) towards value has been vastly inconsistent**. While several of our clients have aggressively pursued value-based strategies, many are still predominantly paid via FFS models. Additionally, organizations at varying points along this continuum face different strategic and operational challenges. Having observed and solved many of these challenges with clients, HSG has categorized commonalties into the **HSG Physician Network Growth Phases®** model shown below.



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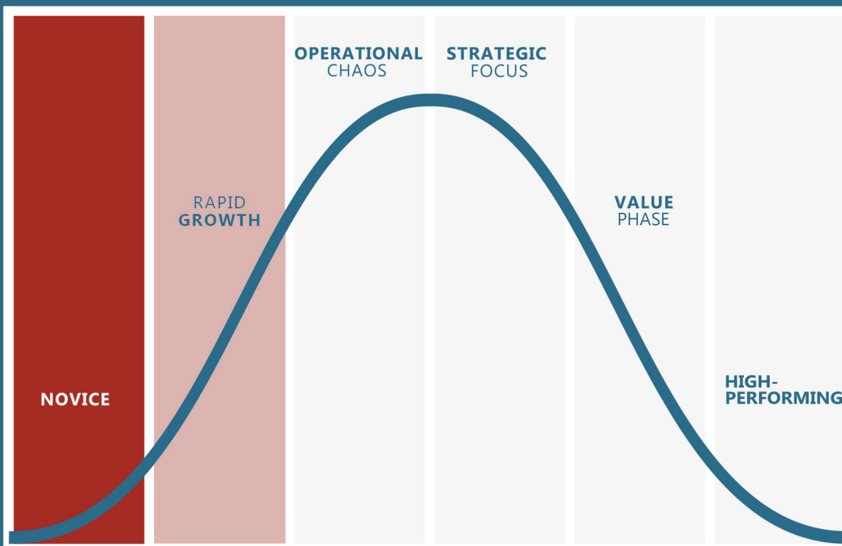
NOVICE INTO RAPID GROWTH

Because physician networks are commonly growing through acquisition, compensation arrangements are often implemented based on whatever it takes to get the deals done. For acquired practices that were struggling financially, this might mean a small premium over historic physician salaries. However, for acquired practices in highly competitive markets, physicians might receive large guaranteed salaries combined with signing bonuses and/or other incentive packages. In either case, the result is often a multitude of different types of arrangements, many of which may not align with productivity and therefore contribute to high physician network losses. Operating in this manner a few times in the early steps of a network qualifies as the **Novice Phase**. Do it enough and you are squarely in **Rapid Growth.**

Best practices for physician compensation during these phases include:

- Centralize physician deal-making to ensure all compensation arrangements are reviewed for compliance and Fair Market Value (FMV).
- Select compensation models that are easy to understand and administer.



Symptoms of a Physician Network in a Novice Phase or Rapid Growth

- Difficulty acquiring the management talent with actual practice management expertise that the network needs to stabilize operations.
- Inability to build revenue cycle capabilities and systems into the infrastructure.
- Not addressing the increasing infrastructure needs while facing mounting network financial losses.
- A lack of focus on management reporting, resulting in no reliable means to track key performance indicators.
- Nonexistent Physician Advisory Council to actively involve physician leaders in network operational efforts and decision-making, which would ultimately lead the effort to develop a group practice mentality, function, and culture.

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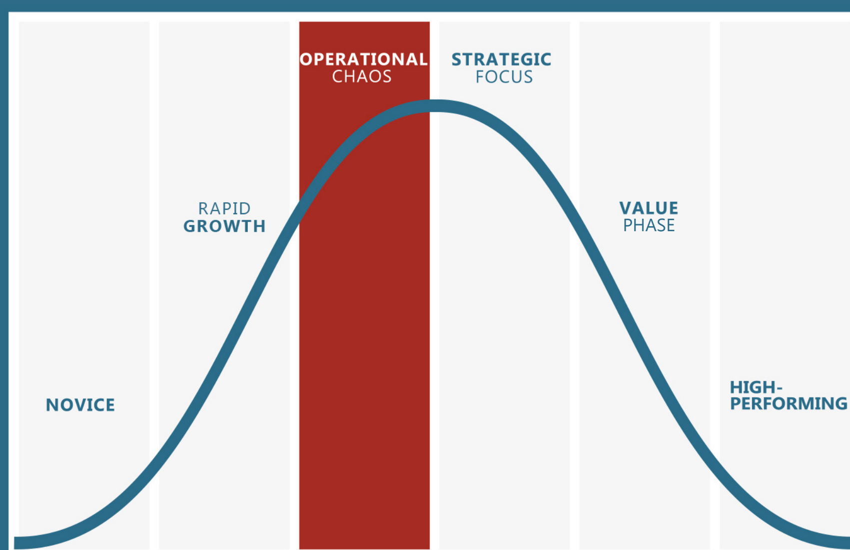
OPERATIONAL CHAOS

As organizations move through **Rapid Growth** and are flung into **Operational Chaos**, the compensation variability created in earlier phases will persist and create challenges for an already-taxed administrative staff. This variability also becomes an impediment to common culture and organizational initiates that require aligned incentives. Addressing these challenges is difficult; however, a lack of management infrastructure makes it difficult to focus on the development of a more cohesive compensation strategy. Therefore, networks in **Operational Chaos** should limit focus to standardizing and right-sizing compensation for providers where there is misalignment between compensation and productivity. This can address potential regulatory issues and help reduce practice losses, which are often a prime focus during **Operational Chaos.**

Best practices for compensation during these phases include:

- Focus efforts on physicians with large misalignment between productivity and compensation.
- Adjustments to base salaries or Work Relative Value Units (wRVU) rates/targets are recommended for physicians whose compensation percentiles exceed their wRVU percentiles by more than 10 points.
- Avoid temptation to embark on broad compensation strategy redesign. Groups at this stage lack sufficient management infrastructure and avenues for provider input. Failed attempts at compensation redesign will reduce administration's credibility and inhibit progress in future phases.



Symptoms of Operational Chaos

- Recent, rapid growth in employed providers and even faster growth in subsidies.
- Sense that finances are not sustainable, but not seeing a path forward.
- Management is used to do "everything" due to lack of resources, including recruitment and contract renewal/negotiation, which leaves local practice leadership to fend for selves amidst gaps in communication.
- Wide variation in practice operations.
- Revenue cycle not formalized due to lack of communication with practice administration.
- Coding variation, particularly under coding.
- Referrals leaking out of network.
- Variation of compensation models make it hard to measure effectiveness of compensation strategy or to provide right incentives at the network level.

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STRATEGIC FOCUS

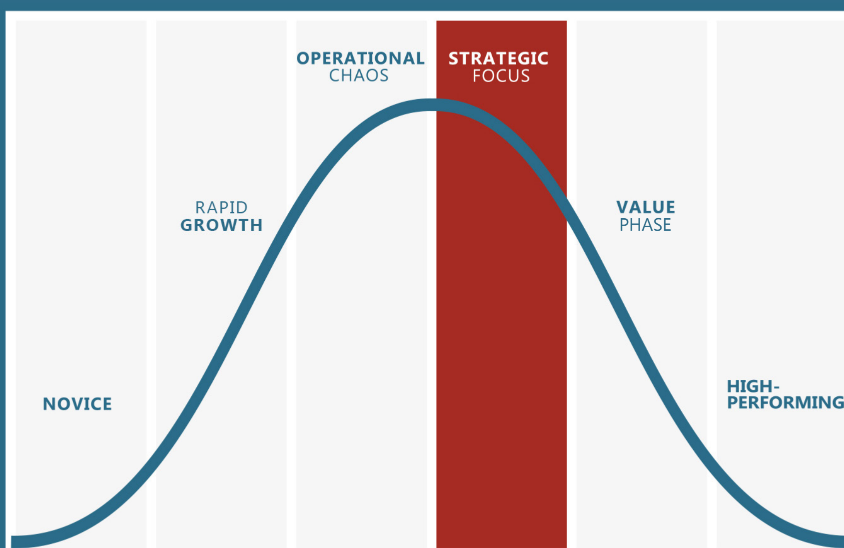
During the **Strategic Focus** phase, organizations are creating important foundational elements that will not only drive the group's success, but also play a key role in the compensation redesign process. These include:

- **A shared vision between providers and administration about the purpose and future of the group**
- **A strategic plan which flows from the shared vision and guides operations**
- **A robust management infrastructure supporting network operations and strategic decision making**
- **A physician leadership structure that allows providers to have a voice in the group's direction**

Once an organization lays these foundational elements, it becomes possible and necessary to adjust, standardize, and modernize its provider compensation structures. As the organization begins to think more strategically, it can develop concrete goals and objectives beyond the income statement. Organizational goals, for example, may include quality, patient satisfaction, access, team-oriented care, or other operational metrics. In order to ensure an organization's success in these efforts, all provider behavior must be aligned through a properly designed compensation and incentive structure. It is therefore necessary to create a compensation strategy that transitions disparate contracts into a unified framework for all providers.

Best practices for compensation during these phases include:

- Development of compensation strategy should include physician input via a subcommittee of the physician advisory council or other relevant physician leadership structure
- Compensation strategy should provide a unified framework for all providers
  - Common incentive methodologies for each category
  - Standardized base salary ranges and incentive rates within specialties
  - Similar term lengths, renewal mechanisms, and provisions for changes to compensation components
- As appropriate, Advanced Practice Providers should be incorporated into the same framework as physicians



Symptoms of Strategic Focus

- Ongoing investments in best practices and reducing variation.
- Ensuring appropriate referrals remain within the network along with a robust referral management process.
- Physicians are involved in group administration to drive clinical leadership.
- Chronically underperforming providers who have not been able to meet expectations in spite of assistance are removed.
- Ongoing initiative to tighten and build management capabilities.

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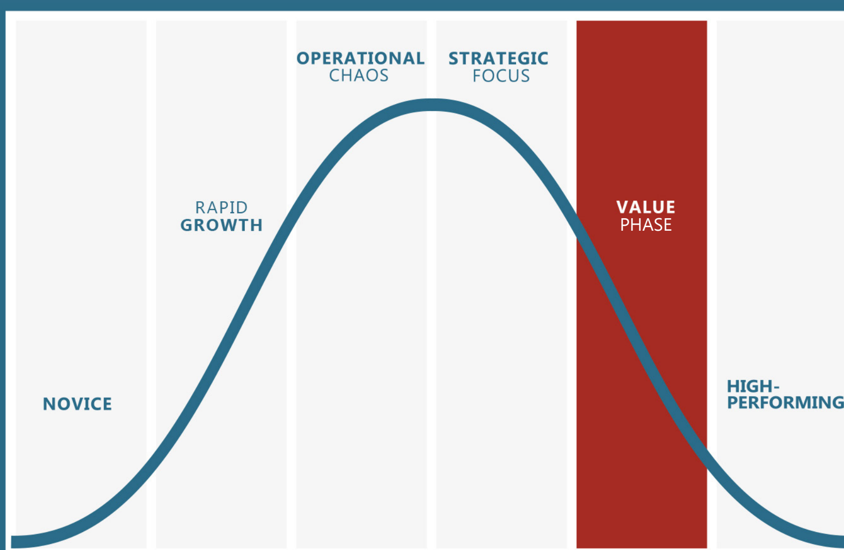
VALUE PHASE

As organizations move into the **Value Phase**, they develop the capabilities to collect, analyze, and distribute information related to quality measures. This allows for the organization to engage in value-based payment models that tie revenue to performance around these measures. It is therefore necessary for these organizations to update compensation models to reflect the emphases of the **Value Phase**.

Best practices for compensation during these phases include:

- Broaden incentives to increase the proportion of non-productivity-based metrics to include quality, patient satisfaction, patient access, team care delivery, and/or other operational measures
- Ensure the selection of these metrics is informed by provider input via a sub-committee of the physician advisory council or other relevant provider leadership structure
- Set the expectation that non-productivity metrics will evolve to ensure alignment with current and near-term risk
- Broaden incentives to align with team-based care delivery models
  - Evaluate group productivity incentives
  - Consider shifting quality and other incentives to be measured at practice or group level



Symptoms of The Value Phase

- Physician compensation redesigned to incorporate quality, operational efficiency, customer service, and teamwork.
- Clinical practice transformation is pursued in order to focus on bringing value-based capabilities to practices (PCMH, PCSP, etc.).
- Monitoring referral management to ensure business is staying inside the employed network.
- Ongoing Evaluation of opportunities in the market for getting value out of the cost and quality success your network is creating.
- The network is recognized in the market as an identifiable brand with strong customer service and high quality care.
- Ensuring the Physician Advisory Council has key roles in network decision-making processes.

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BEST PRACTICES FOR PROVIDER COMPENSATION STRATEGY, DESIGN, AND IMPLEMENTATION

This section provides additional details for three key areas that impact compensation planning across the entire network growth curve. Specifically,

1. Introducing meaningful and aligned productivity incentives
2. Incorporating broader, non-productivity-based incentives
3. Building structures to incentivize team-based care

UNDERSTANDING PRODUCTIVITY INCENTIVES BEYOND wRVUs

According to a commonly used industry survey report, up to 90% of all physician compensation plans involve some sort of productivity component. While a majority of these plans measure productivity based on wRVUs, a growing number of organizations are exploring alternative ways of measuring and rewarding productivity. The table on the next page outlines different approaches to measuring provider productivity.

ALTERNATIVE APPROACHES AND EMERGING TRENDS

Despite a variety of options for productivity measures, some systems have eschewed the idea of provider productivity incentives and, instead, converted to models with mostly fixed base salaries. In theory, this approach can absolve providers from worrying about volume and instead allows for greater emphasis on patient care and quality. Administration bears the burden of ensuring there is enough volume to support the providers' salaries and sustain operations. In order for this strategy to be successful, however, the following factors must be present:

- **Enough market demand to support the entire complement of providers**
- **Tight control over provider schedules**
- **Centralized access points that can efficiently distribute patients**
- **A strong management infrastructure that can monitor and adjust to volume fluctuations**
- **Willingness to remove providers or adjust base salaries, if needed**

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PROVIDER PRODUCTIVITY
WHICH APPROACH SHOULD NETWORKS IDEALLY USE?

APPROACH/ UNIT	DETAILS	IDEAL FOR
wRVUs	wRVUs are the most commonly used unit to measure and incentivize provider productivity. **Advantages:** • Generally easy to obtain and report data from most practice management systems • Prevalence of use leads to easily available benchmarks **Disadvantages:** • Occasionally not understood or trusted by providers • Must ensure wRVU values are properly adjusted based on coding modifiers	Organizations in any phase of the Network life cycle who want an easy to administer productivity system
Revenue/ Collections	Although popularity has declined, some organizations still find success using productivity incentives based on provider revenue. **Advantage:** • Incentivizes providers to support or improve front-end revenue cycle operations **Disadvantages:** • Providers could be penalized if payer mix is unfavorable • Inefficient revenue cycle processes will cause provider dissatisfaction • May be hard to administer	Organizations in the novice or growth phases that operate in demographically favorable markets with a strong payer mix
Visits/ Procedures	Similar to wRVUs, visits or procedure counts allow for direct measurement of provider workload. **Advantage:** • Easily understood and relevant to provider daily duties **Disadvantages:** • Visit counts may not be suitable for proceduralists • Difficult to account of varied procedure mix	Rarely recommended
Panel Size	Most commonly used in primary care models, panel size can measure the number of patients under a provider's care. **Advantage:** • Mitigates the risk of visit/procedure churning • Allows providers to focus on providing appropriate care **Disadvantages:** • Can be difficult to define or calculate • Lack of use makes comparison to survey data difficult	Organizations in the Value or High Performing phases which have significant revenue tied to shared savings or capitation.

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INCORPORATING NON-PRODUCTIVITY BASED INCENTIVES

Tying compensation to quality, patient experience, or efficiency is no easy task. Unlike productivity, where there is a limited number of metrics, there exists a deluge of potential value-based indicators. These measures fall into many different categories, with each category having subsets based on specialty, measure design, and/or endorsing agency. Successfully navigating this complex landscape often requires robust IT systems, dedicated quality analysts, and ample clinical leadership. Organizations without these resources will undoubtedly struggle when attempting to implement complicated quality incentive plans. Therefore, it is critically important to ensure that your organization's compensation strategy utilizes an approach that is aligned with your organization's position along the **HSG Physician Network Growth Phase®** continuum.

ORGANIZATIONS IN THE GROWTH PHASE OR EARLY STAGE OF OPERATIONAL CHAOS

It may not make sense to prioritize quality incentives. These networks likely have an abundance of operating issues that will bear lower hanging fruit. Additionally, these networks are less likely to have a management infrastructure that can successfully select, implement, and report on quality metrics. Failed attempts in these efforts will cause frustration with providers. This frustration will not only have near-term consequences but may also provide a barrier to the organizations future attempts to improve and implement quality incentive programs.

ORGANIZATIONS MATURING THROUGH OPERATIONAL CHAOS AND ENTERING STRATEGIC FOCUS

These organizations should be laying the groundwork for a compensation strategy that includes basic non-productivity-based components. Compensation strategy should include a ramp-up in both the complexity of measures and amount of compensation at risk. In the early stages, organizations should start easy and start slow:

Starting Easy

Focus on measures that are easy to track and manage so your organization can build quality measurement capabilities at a realistic pace. Start with measures physicians feel they can influence directly. For example, it may be better to start with process oriented measures.

Starting Slow

Compensation is a touchy subject and if quality-based incentives are new to your organization, your providers will probably feel hesitant about these changes. Plan to increase quality dollars with time to allow management and physicians to identify issues before large dollar amounts are at risk. This also ensures that the amount of compensation dedicated to quality measures does not exceed the rate at which your physician reimbursement is transitioning from FFS to value. Some HSG clients have pursued a slightly more conservative approach with their move to value-based compensation, deciding to measure and report quality metrics to their providers a full year or more before tying them to their group's compensation. Either approach is ultimately fine. The key takeaway is that it is best for all involved to ease into value and quality-based compensation incentives.

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VALUE PHASE ORGANIZATIONS

During transition from **Strategic Focus** and throughout the **Value Phase**, organizations are building upon their abilities to manage populations, understand total cost of care, and measure outcomes. These abilities provide an important foundation to quality-focused provider compensation strategies. Specifically, organizations in this phase should:

- **Begin to move from process-based measures toward outcome measures.**
- **Incorporate appropriateness measures as defined by initiatives like ACIM, Specialty Societies, or ChoosingWisely.org.**
- **Combine cost and outcome measures to measure the value of care being delivered.**
- **Ensure that non-productivity-based measures align with risk-based contracting incentives.**

Regardless of your network's maturity, you must understand the clinical processes that contribute to a particular measure. You don't want to implement a measure that the physician cannot control or at least influence. That's why HSG recommends using an inclusive approach when adding non-productivity-based incentives to compensation plans. Clients are more likely to have success when they involve providers in selecting clinical quality measures. Physicians are uniquely qualified to tackle clinical issues; they have relevant ideas and opinions regarding the usefulness and practicality of key measures. Additionally, this should be an iterative process and new measures should be evaluated and selected to stay current with the organizations current and near-term plans.

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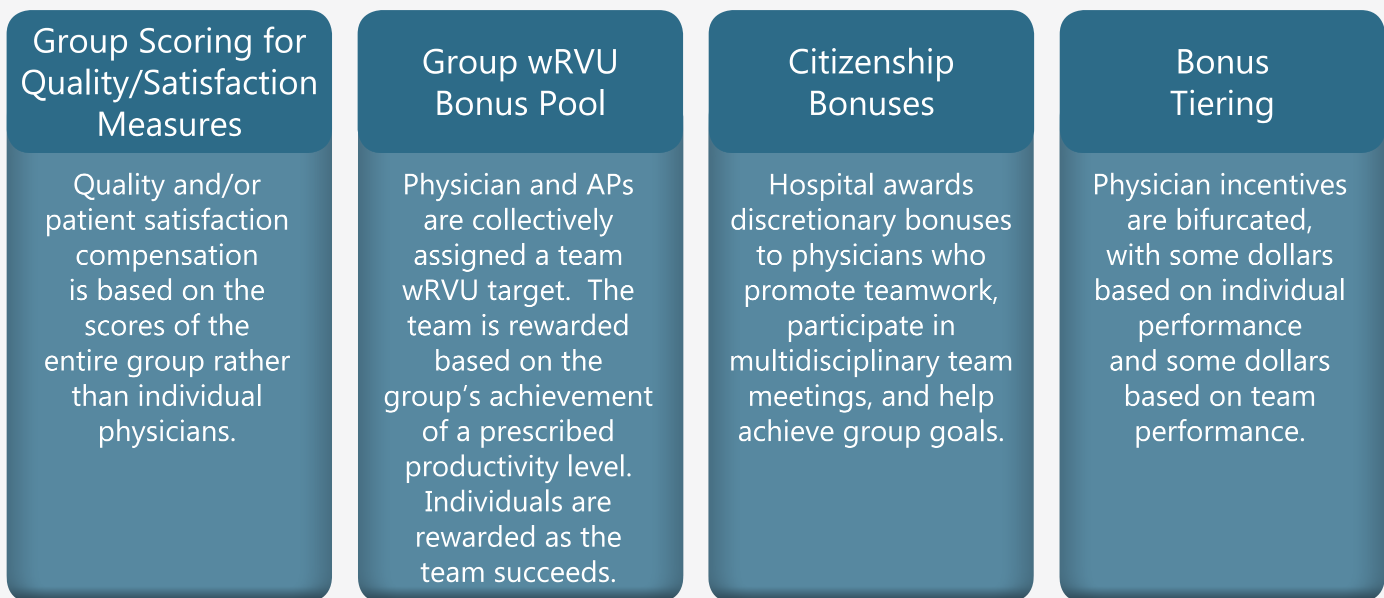
BUILDING STRUCTURES TO INCENTIVIZE TEAM BASED CARE

As previously stated, organizations in the **Value Phase** should consider reformatting incentives to align with the delivery of team-based care. This is particularly necessary for hospital-based, medical, and surgical specialties that require a high degree of collaboration and hand-offs among the physicians. The table below details four different approaches to setting up team-based incentives as part of the physician compensation strategy.

Example Approaches to Team-Based Incentives



In addition to considering incentives for the physician team, it is equally important to consider incorporation of APs into the care team. As organizations move throughout the growth phases and into value, the ability to recruit, retain, and maximize the effectiveness of APs remains a critical competency.

Growth Phase organizations must use APs to supplement physician supply in constrained markets. Many organizations in Operational Chaos are deploying APs to right-size their provider complement and alleviate practice losses. For groups in the Strategic Focus phase, APs are being incorporated into practice model redesigns to improve patient access and reduce variation across practices. Regardless of an organization's position in the **HSG Physician Network Growth Phases®** model, compensation plans must allow for and encourage providers to collaborate and work together. The accompanying table outlines various approaches to AP compensation.

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AP COMPENSATION
WHICH APPROACH SHOULD NETWORKS IDEALLY USE?

APPROACH	DETAILS	IDEAL FOR
Straight Salary	Straight salaries are still the most common method of compensating APs due to ease of understanding and implementation.	Organizations in the Novice, Growth and Operational Chaos phases.
Salary Plus Individual Productivity	These models measure and reward for wRVUs that are produced directly by the AP. *One variation, for example, could set a wRVU target and reward the AP for each wRVU produced above the target.*	Organizations in the Strategic Focus and Value Phases This approach is more suited to APs working in primary care settings as they are more likely to maintain their own panels and bill directly for their services.
Salary Plus Group Productivity	These models measure the productivity of the entire care team and reward the APs if the group is collectively productive. *One variation, for example, could pay a bonus equal to 10% of AP base salary if group wRVUs exceed an established target.*	Strategic Focus and Value Phase Organizations This approach is best suited for APs in collaborative specialty practices who may not directly produce wRVUs but allow for increased physician productivity.

We Build High-Performing Physician Networks so Health Systems can Address Complex Changes with Confidence.

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CONCLUSION

In the business-world, incentives are commonly utilized and are widely known to increase loyalty, productivity, and morale. In the healthcare industry, we are at times slow, if not completely resistant, to adapting successful business philosophies, strategies, and tactics. In reality, the same incentive-based compensation schemes that work in manufacturing, retail, and other industries, can and will work in healthcare. Our physicians and APs are not only our most critical frontline healthcare providers, but they are the daily leaders of our healthcare delivery teams. When our physician and AP incentives are aligned with our goals, together we can achieve the high-level of productivity, provider engagement, customer satisfaction, and efficient practice operations that we all want for our networks. Savvy network leadership also recognizes that the previous incentives they had in place may not be the same incentives they need to successfully move their organization into the future. When you are ready to move your organization to the next phase of its development, HSG can help you design and implement a physician and AP compensation model that will get you there.

GETTING STARTED

We want to help create a provider compensation strategy that will allow your organization to be successful. HSG can work with you to design a process that properly evaluates the status quo, establishes goals for the new plan, and then systematically builds, tests, and implements the new compensation plan with collaboration from key stakeholders. The table below outlines the basic building blocks of a successfully compensation strategy development process. HSG can provide guidance and/or hands-on support during any step of the way. Please reach out to discuss how HSG can help your organization develop a successful compensation strategy.

	Discovery Phase	Building Phase	Testing & Implementation
Key Questions to be Answered	What are the goals of the new compensation plan? When do the current contracts expire and how will this impact implementation? Will physicians need education on the market forces driving the need for a new compensation plan?	What compensation methods are considered to be best practice? What are advantages and disadvantages of different methods? Which methods will work with our group?	How will the selected compensation affect each physician? Will the plan be financially suitable for the organization? When and how will the plan be rolled out across the physician groups?
Action Items	Contract review, including cataloging expiration dates and key parameters. Interviews/discussion with key stakeholders. Data review and benchmarking analysis.	Research and presentation of best practices. Facilitation of educational sessions. Facilitation of collaborative meetings designed to evaluate and select options for each major plan component.	Financial modeling at physician and organizational levels. Creation of a roll-out timeline based on contract review dates. Creation of regular transition reports showing performance under future plan parameters.

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ABOUT THE AUTHORS

Eric Andreoli

MBA

Director

Email: EAndreoli@HSGadvisors.com
Office: (502) 814-1193
Cell: (502) 322-2087

Eric Andreoli is a Director at HSG. In this role, he supports a variety of projects including strategic planning, operational assessment, due diligence, and physician compensation. He draws from a technical background to provide rigorous data analysis and practical solutions to complex problems.

Prior to obtaining an MBA from the Kelley School of Business at Indiana University, Eric worked as a research assistant at IU Health in Indianapolis. He holds a Bachelors of Science in biotechnology from Indiana University.

Neal Barker

MBA

Partner

Email: NBarker@HSGadvisors.com
Office: (502) 814-1189
Cell: (502) 386-9821

Neal D. Barker joined HSG in 2001 and became a partner in 2015. He came to the firm with several years of managed care and physician practice experience. Neal served as a provider relations representative and physician credential coordinator for a 2,000-member Independent Practice Association and fulfilled various roles within primary care and dental practices. Today, he provides clients with expertise and leadership in: physician practice mergers and consolidations; physician practice operational improvement; physician network development; physician employment and practice acquisition; physician compensation (including independent and employed, medical directorships, and call pay); physician-hospital alignment strategies (including professional service and co-management arrangements) and strategic planning for both hospitals and physician groups.

A member of the American College of Healthcare Executives, Neal holds a Bachelor's Degree in Biology and a Master's Degree in Business Administration with a concentration in Healthcare Administration from the University of Louisville, Louisville, Ky. He also serves as HSG's representative with the Indiana Hospital Association.

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info@HSGadvisors.com