Building a Sustainable Compensation Strategy

Best Practices for Employed Provider Compensation

Ohio Hospital Association 2021 Annual Conference

Tuesday June 8, 2021
10:00-11:00 AM ET

Company **Overview**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Headquarters: Louisville, KY

Formed: 1999

Focus: Health Systems and Physician Network Strategy and Execution

Physician Strategy

Driving a common strategic focus with engaged physicians.

Physician Leadership

Identifying and engaging strong physician leaders is integral to the network's development and success.

Performance Improvement

Improving the performance of employed physician networks.

Network Integrity

Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

Physician Compensation

Aligning physician compensation with health system and employed network goals.

Building a Sustainable Compensation Strategy

- Understand the importance of having a compensation strategy that evolves with and supports your organization's progress toward value and high-performance.
- Recognize the impact of provider compensation on recruitment, retention, and alignment success.
- Identify and implement best practices for provider compensation strategy including balancing productivity and non-productivity-based incentives, selecting appropriate rates, and building structures to incentivize team-based care.

Building a Sustainable Compensation Strategy Description and Behavioral Outcomes

Description

The long-term success of any employed medical group is dependent on having productive, engaged, and satisfied physicians and advanced practitioners. Although there are many issues that affect providers, few are more impactful than compensation. It is therefore critical for organizations to develop and execute a sustainable compensation strategy.

Behavioral Outcomes

1. Participants will understand the importance of having a compensation strategy that evolves with and supports your organization's progress toward value and high-performance.
2. Attendees will be able to implement best practices for provider compensation strategy including balancing productivity and nonproductivity-based incentives, selecting appropriate rates, and building structures to incentivize team-based care.

Behavioral Outcomes Supporting Points

1. Understand how trends in the healthcare industry are impacting provider compensation.
2. Review common components of successful provider compensation programs.
3. Utilize examples and case studies to demonstrate best practices for provider compensation design and implementation.

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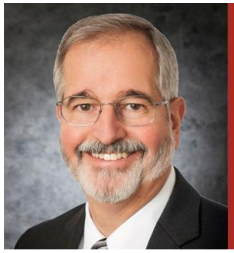
- Market Development and Growth Strategy
- Network Integrity and Patient Capture
- Compensation Planning



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Expertise in:
- Physician Leadership and Governance
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- Compensation Planning

Evolution of Compensation Strategy

Key Question:
What factors are pushing organizations to reevaluate provider compensation?

Three major trends driving this need:

1. Payer factors
2. Market and competitive factors
3. Internal factors in response to prior two

Payer Factors: Shifting Dollar Allocations by Service

CMS is shifting dollars towards office visits and away from procedures

Changes introduces in the 2021 Medicare Physician Fee Schedule (MPFS)

- **Conversion Factor decreased by 3% to $34.89**
- **wRVU credit increased for many E/M codes**
- **Office E&M coding changes**
- Telehealth services
- Scope of practice
- Communication Technology-Based Services (CTBS)
- Remote Physiologic Monitoring (RPM)
- Clinical Laboratory Fee Schedule (CLGS)
- Appropriate Use Criteria (AUC)
- Rebase and revise FQHC Market Basket
- Medicare Shared Savings Program (MSSP)

These changes significantly impact organizational revenue

CPT	CY2020 wRVU Value	Proposed Rule CY2021 wRVU Value	Percent Change
99202	0.93	0.93	0%
99203	1.42	1.6	13%
99204	2.43	2.6	7%
99205	3.17	3.5	10%
99211	0.18	0.18	0%
99212	0.48	0.7	46%
99213	0.97	1.3	34%
99214	1.5	1.92	28%
99215	2.11	2.8	33%

Specialty Impact (selected)

Specialty	Medicre Allowed Charges (mil)*	CY2021 MPFS Final Rule Combined Impact	Legislative Impact – CY2021**	Changes in wRVU credit CY 2021 MPFS Final Rule	Differences in % change wRVU v. reimbursement
Cardiology	$6,871	1%	3%	9%	6%
Critical Care	$378	-7%	-1%	2%	3%
Endocrinology	$508	16%	13%	21%	8%
Family Medicine	$6,020	13%	11%	19%	8%
Gastroenterology	$1,757	-4%	2%	6%	4%
General Surgery	$2,057	-6%	0%	6%	6%
Heme/Onc	$1,707	14%	13%	19%	6%
Infectious Disease	$656	-4%	0%	3%	3%
Internal Medicine	$10,730	4%	6%	11%	5%
Nephrology	$2,225	6%	11%	16%	5%
Neurology	$1,522	6%	7%	12%	5%
Neurosurgery	$811	-6%	0%	5%	5%
Orthopedic Surgery	$3,812	-4%	2%	7%	5%
Otolarngology	$1,271	7%	8%	14%	6%
Psychiatry	$1,112	7%	8%	12%	4%
Pulmonary Disease	$1,654	1%	3%	7%	4%
Rheumatology	$548	15%	13%	22%	9%
Urology	$1,810	8%	9%	15%	6%
Total	**$97,008**	**0%**	**4%**	**11%**	**5%**

* As displayed in CY2021 MPFS Final Rule

** Combined Impact without G2211 in CF & with an additional 3.75% CF Increase

Payer Factors: Increasing Value Dollars

CMS is increasing the proportion of dollars linked to quality and value . . And commercial payers are mimicking

CMS Quality Payment Program - 2017

Merit-Based Incentive Payments	Advanced Alternative Payment Model System
• Performance Year 2021 parameters (Payment Year 2023) • Maximum +/- 9% change in reimbursement rates based on performance • Additional performance excellence % for high performers	• Qualifying Participants in a qualifying Advanced APM achieve a 5% lump sum payment (5% of previous year's Medicare Part B reimbursements)

Hospital Value Based Purchasing Program - 2013

- Withholds hospital Medicare payments by 2%
- Those reductions fund value-based incentive payments to hospitals based on their performance in the program.
- Applies the net result of the reduction and the incentive as a claim-by-claim adjustment factor to the base payment amount.

Measure categories include:
- Mortality and complications
- Healthcare-associated infections
- Patient safety
- Patient experience
- Efficiency and cost reduction

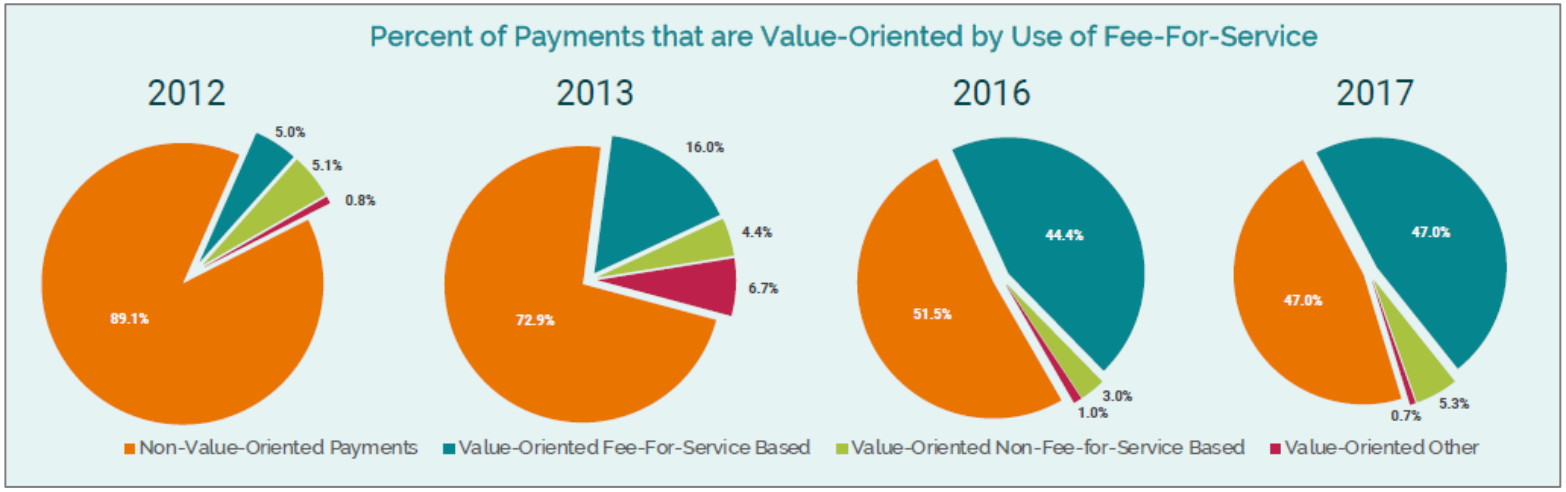
Payer Factors: Increasing Value Dollars

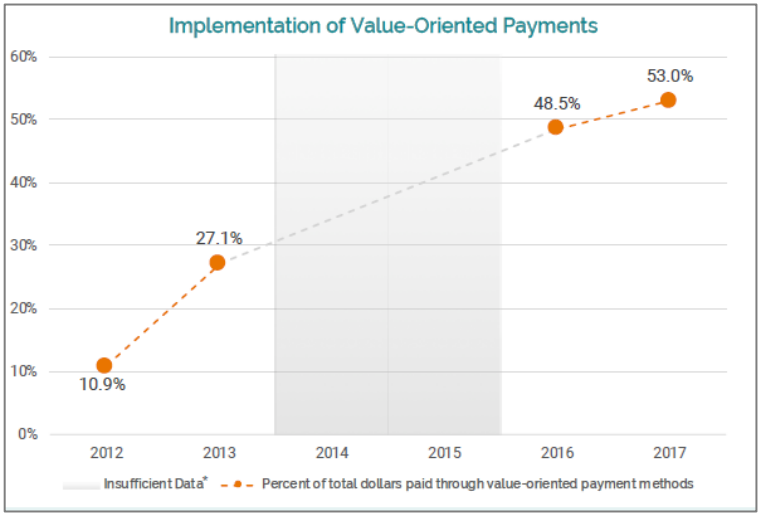
National Scorecard on Commercial Payment Reform

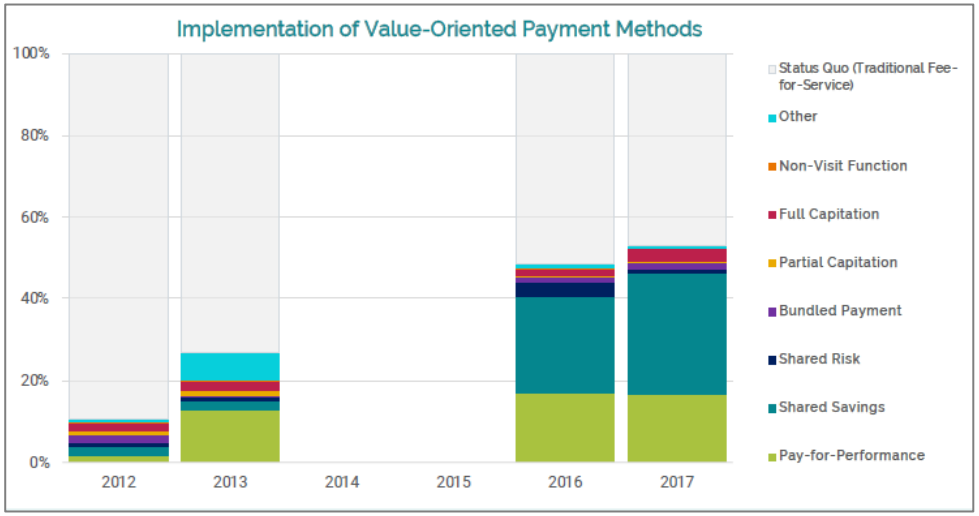
Robert-Wood Johnson Foundation

National Alliance of Healthcare Purchaser Coalitions

Catalyst for Payment Reform







Market Forces: Competing on Quality

- **Increased focus on quality in patient directed marketing materials**
- **Increased public access to quality data and rankings**
- Examples include:

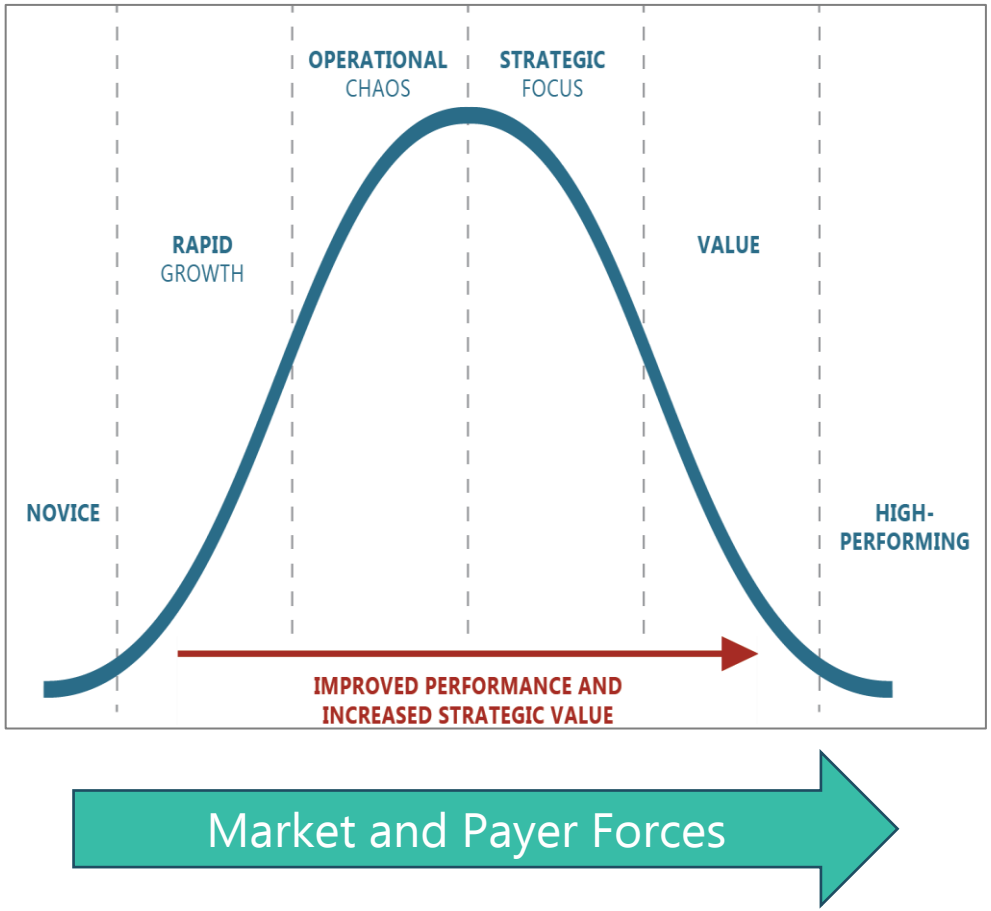
Program	Included Measures	Program	Included Measures
US News Best Hospitals	• Patient outcomes • Process measures • Patient experience • Volume • Structural resources	**Healthgrades Hospital Ratings & Awards**	• Mortality and complications • Patient safety ratings • Outstanding patient experience
CMS Care Compare (Hospital)	• Timely and effective care • Complications and deaths • Unplanned hospital visits • Psychiatric unit services • Payment & value of care	**The Leapfrog Group**	• Patient Safety • Healthcare Associated Infections • Quality of care – Peds, OB, Surgery, others
CMS Care Compare (Physician)	• MIPS, APM metric performance		

Internal Factors: Improving Value Capabilities

Employed physician networks follow a natural evolution.

- Starting as a fledgling physician group with little infrastructure, networks must grow into a strategic force for the health system.
- In their ultimate phase, high-performing groups produce reliable quality and cost outcomes and manage risk contracts.
- This evolution is accelerated by payer and market forces pushing the organization to develop value capabilities.

HSG Network Growth Phases



Internal Factors: Improving Value Capabilities

	Growth Mode	Operational Chaos	Strategic Focus	Value Phase
Description of Network Phase	As the system acquires more and more practices, it enters a phase of rapid growth and begins to aggregate in size.	The network experiences progressive "operational chaos" as the disparate practices operate under disparate processes and insufficient infrastructure.	Network operations become better aligned and focus shifts to developing shared vision and associated strategy.	Network becomes more integrated – developing common culture with focuses on quality initiatives and learning how to succeed in a value environment.
Compensation Building Blocks	• Centralize physician deal making to during recruitment and acquisition process. • Select compensation models that are easy to understand and administer	• Focus on right-sizing and creating alignment between compensation and productivity.	• Standardization • Introduction of non-productivity incentives	• Expansion of dollars allocated to non-productivity incentives • Evolution of quality metrics • Incentivizing team-based care

Organizations moving toward value must adapt internal operations, **including provider compensation methodologies.**

Internal Factors: Improving Value Capabilities

Percent of groups using value or quality-based incentives[1]

Specialty Type	%
Primary Care	**55%**
Medical Specialties	**50%**
Surgical Specialties	**51%**

Average amount of value or quality-based incentives as a percent of total compensation[1]

Specialty Type	%
Primary Care	**9%**
Medical Specialties	**9%**
Surgical Specialties	**9%**

1: Sullivan Cotter

Prevalence of Non-Productivity Incentives Percent of Groups Using

	Sullivan Cotter	AMGA
Patient Experience	82%	78%
Process, Quality, and Outcome Measures	79%	78%
Citizenship	49%	53%
Patient Access	45%	45%
Group/Department Financial Performance	23%	31%

Identifying Best Practices

Key Question:
What must be considered when building a compensation plan?

Key Considerations:

1. Selecting the right framework
2. Selecting parameters for each component
    a. Base salary
    b. Productivity incentives
        i. May not apply to all specialties
    c. Non-productivity incentives
    d. Other compensation

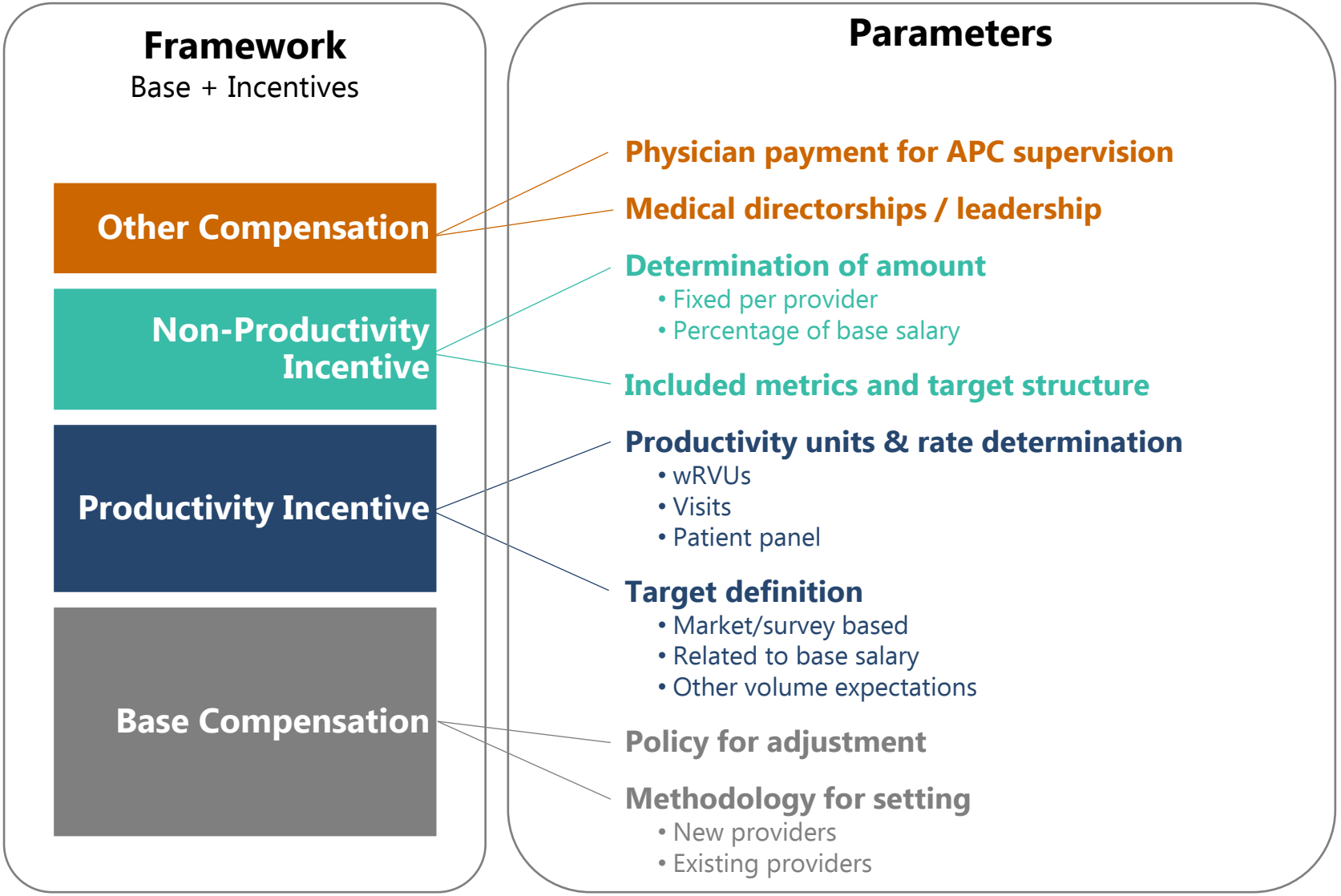
Compensation Models – General Frameworks

Model	Incentivizes	Potential Pitfalls
Straight Salary	• Minimum contractual requirements	• If provider is not internally driven, only meets (or marginally exceeds) minimum expectations of contract • May require centralized management of patient scheduling • May not encourage engagement in organizational initiatives
Revenue minus expenses	• Increase revenue (effort) • Minimize expenses	• Tends to be favorable for "bottom line" • Disincentives provider from spending time on any non-revenue generating activities • Requires proper expense tracking and allocation • May cause provider to micromanage practice • Providers could be penalized if payer mix is unfavorable or revenue cycle is inefficient • Disconnect with value-based care principles

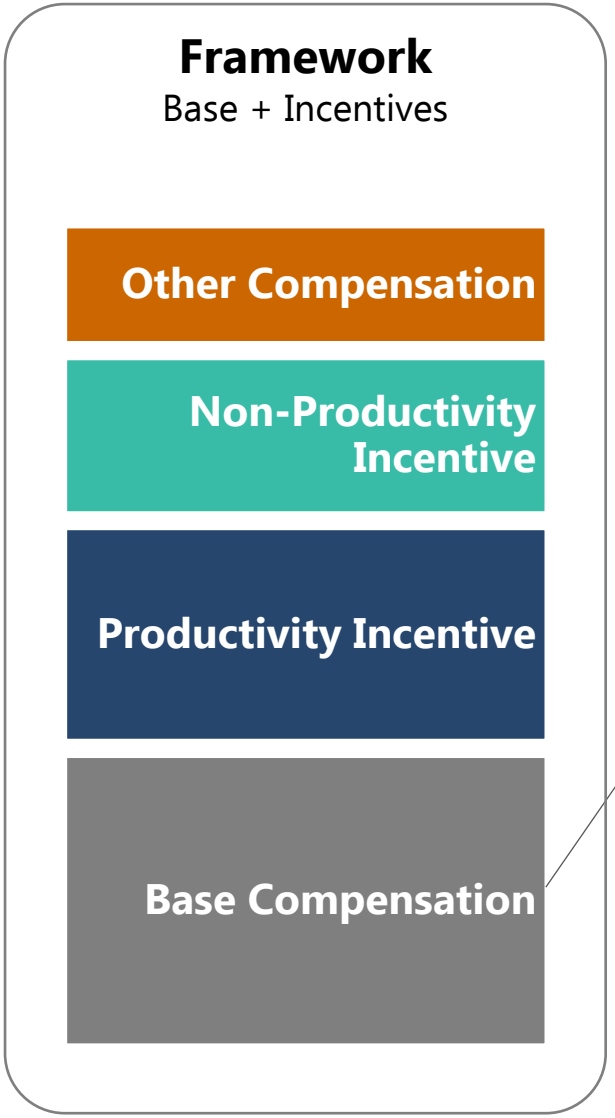
Straight productivity
 	
Compensation = $/wRVU
	• Increased effort/ productivity	• Tends to be favorable for "bottom line"
		• Focus on individual disincentivizes – anything that is not "mine"
		  ○ Spending time on any non-revenue generating activities
		  ○ Recruiting, onboarding, and supporting new colleagues
		  ○ "Investing" in expense control or practice operations improvement
		• May lead to over coding encounters or overly recommending or providing care
		  ○ Regular audits recommended

Salary + Incentives	• Increased effort/ productivity
	• Dependent on specific incentives and targets – and whether group vs individual basis
		• Highly flexible model … but
		  ○ May lead to overcomplication
		  ○ May behave like other models
		  ▪ Only individual productivity incentives is like Straight Productivity
		  ▪ Unrealistic targets behaves like Straight Salary
		  ▪ No downward adjustment risk behaves like Straight Salary
		• Requires right mix of base salary, productivity targets/rates, and non-productivity incentives

Compensation Framework Discussion



Compensation Framework Discussion



Base Compensation
Key Questions & Considerations

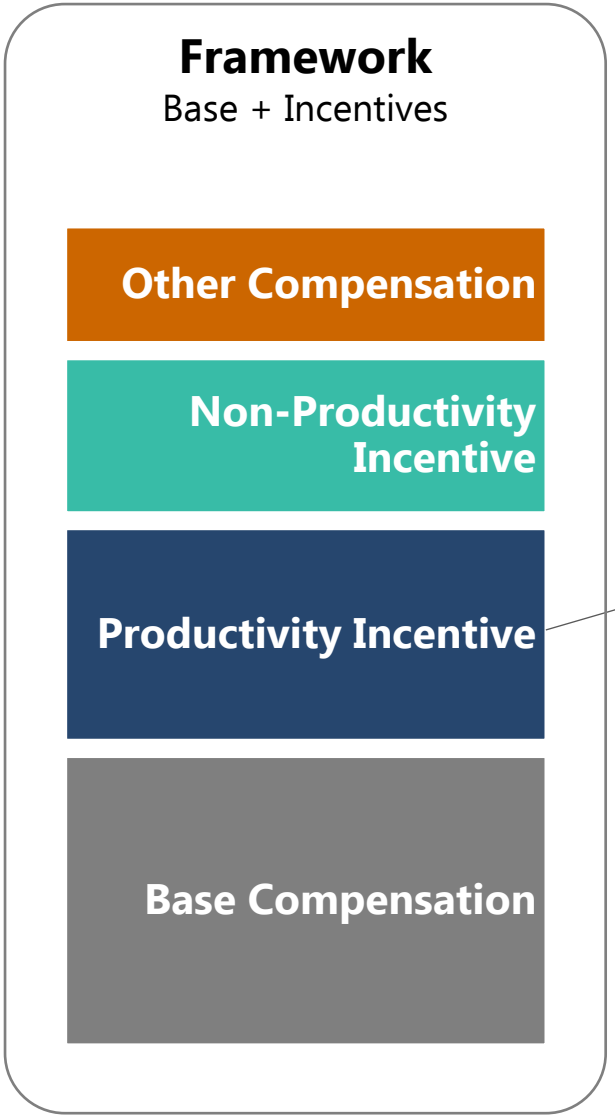
How is base salary determined?

- Departmental standard vs provider specific
- Adjustment for FTE status
- Alignment with realistic productivity expectations
- Must balance recruitment and financial sustainability needs

How is base salary adjusted?

- Annual vs quarterly
- Methodology
- Adjust limit to protect providers
- Organizational wherewithal to implement
- Exclusion for certain specialties and/or extenuating circumstances

Compensation Framework Discussion



Productivity Incentive
Key Questions & Considerations

Does it apply?
- Shift-based specialties that cannot influence volume of services

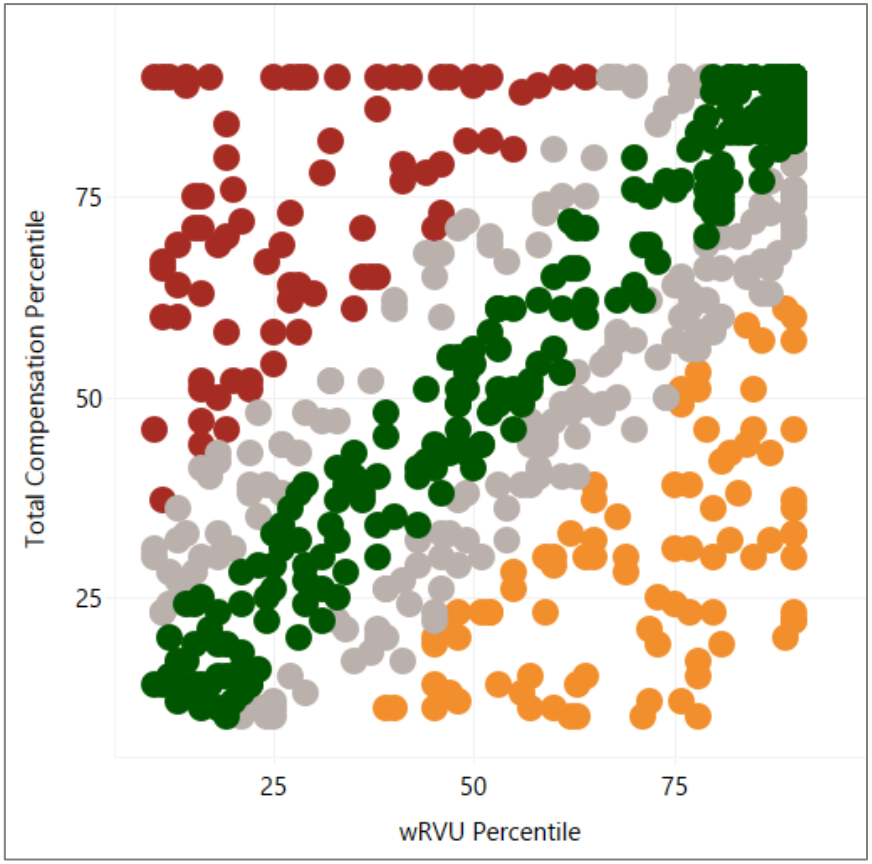
How often to pay?
- Annual vs quarterly
- Reconciliation (additional pay / paybacks)

How to determine target/threshold?
- Linked to base salary & reduction mechanism
- Linked to rate

How to select the right rate?
- . . Because it's all about the rate

Compensation Alignment- It's All About the Rates

HSG Client Sample Data: 800+ Physicians



Approach to Compensation vs Productivity Analysis

Details

Each dot represents one physician. Position along x axis corresponds to productivity percentile. Position along y axis corresponds to compensation percentile.

Compared to MGMA Provider Compensation and Productivity Survey: 2019 (National)

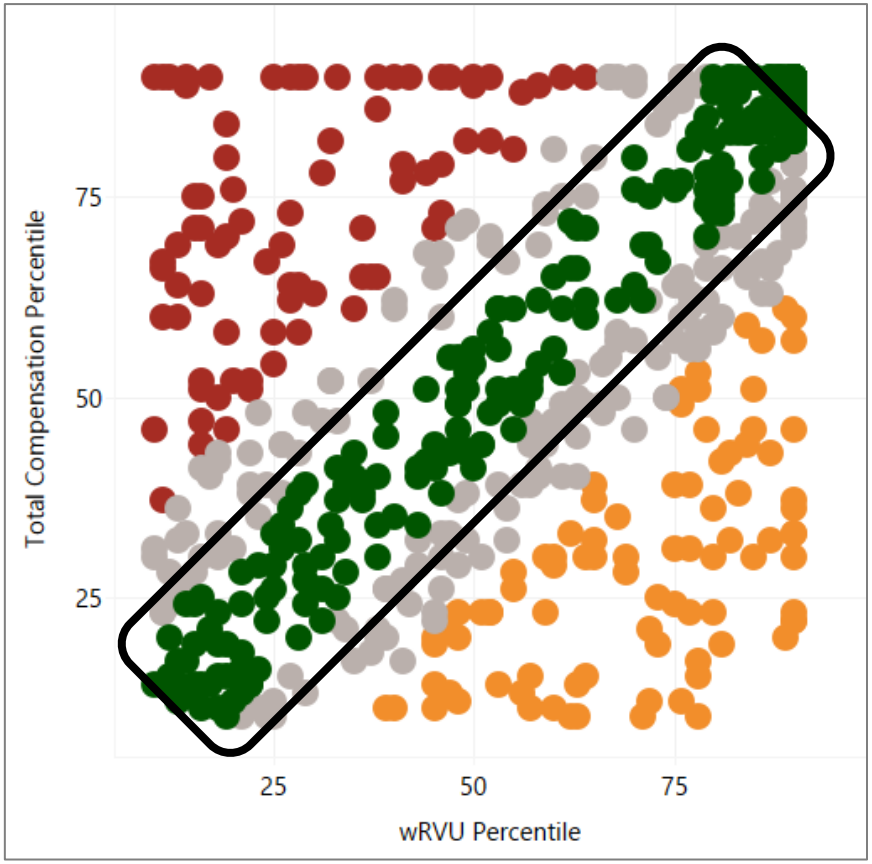
Upper Quadrant: Potential Compliance Risk

Center: Aligned Compensation & Productivity

Lower Quadrant: Potential Retention Risk

Compensation Alignment- It's All About the Rates

HSG Client Sample Data: 800+ Physicians

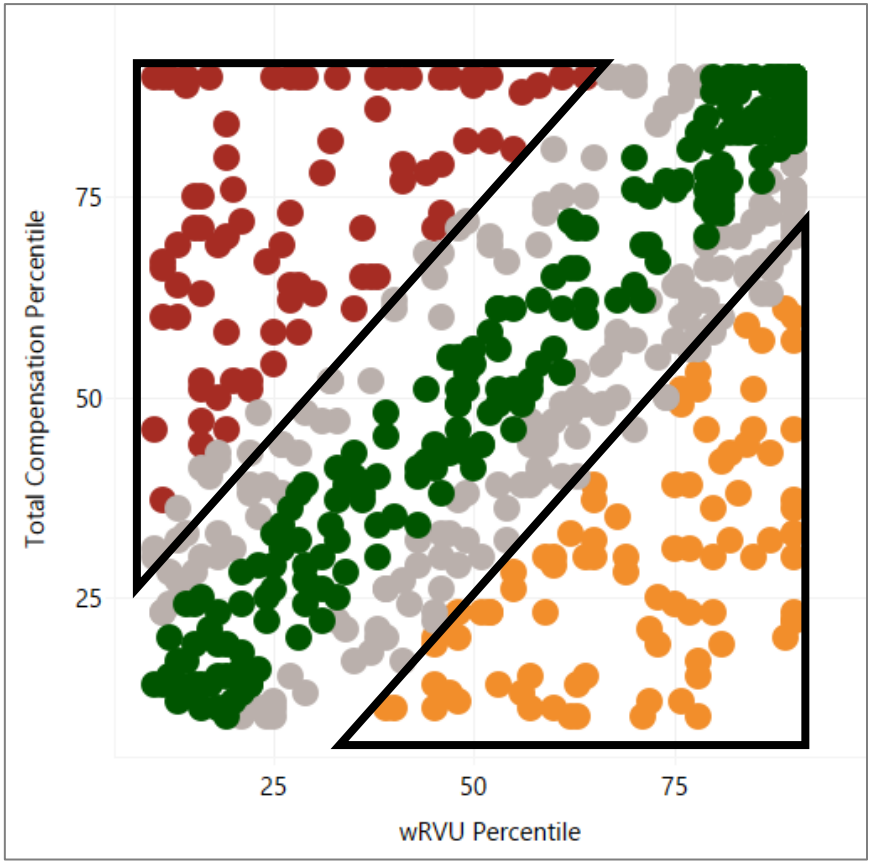


The goal when designing most compensation plans is to find a rate that maximizes number of close to this category

Center: Aligned Compensation & Productivity

Compensation Alignment- It's All About the Rates

HSG Client Sample Data: 800+ Physicians



Rates that are too high or too low will drive physicians into these zones

Upper Quadrant: Potential Compliance Risk

Lower Quadrant: Potential Retention Risk

Compensation Alignment- It's All About the Rates

So how do I select a rate?

Total Compensation per wRVU Survey Data – Surveys Weighted Average

Survey Year + Name	Survey Specialty	Count	Percentile				
			10	25	50	75	90
2019 Sulivan Cotter: National	Neurology	1,468		$55.86	$65.59	$81.02	
2020 AMGA: National	Neurology	1,620		$55.01	$65.65	$82.18	$111.35
2020 MGMA: National	Neurology	1,314	$45.76	$55.40	$65.84	$81.27	$111.98
Grand Total			$45.76	**$55.41**	$65.69	**$81.52**	**$111.63**

"We need competitive rates to attract highly productive providers"

Compensation Alignment- It's All About the Rates

So how do I select a rate?

Detailed Rate Range Calculation – Using 2020 MGMA: National

Percentile	Total Compensation		wRVUs	Implied Lag	Rate
25	$271,547		3,719	-25	**$87.67**
30	$280,779		3,937	-20	**$82.82**
35	$292,626		4,185	-15	**$77.91**
40	$303,910		4,434	-10	**$73.53**
50	$326,054		4,949	0	**$65.88**
60	$344,342		5,441	10	**$59.93**
65	$355,810		5,771	15	**$56.50**
70	$377,466		6,120	20	**$53.28**
75	$399,923		6,454	25	**$50.52**

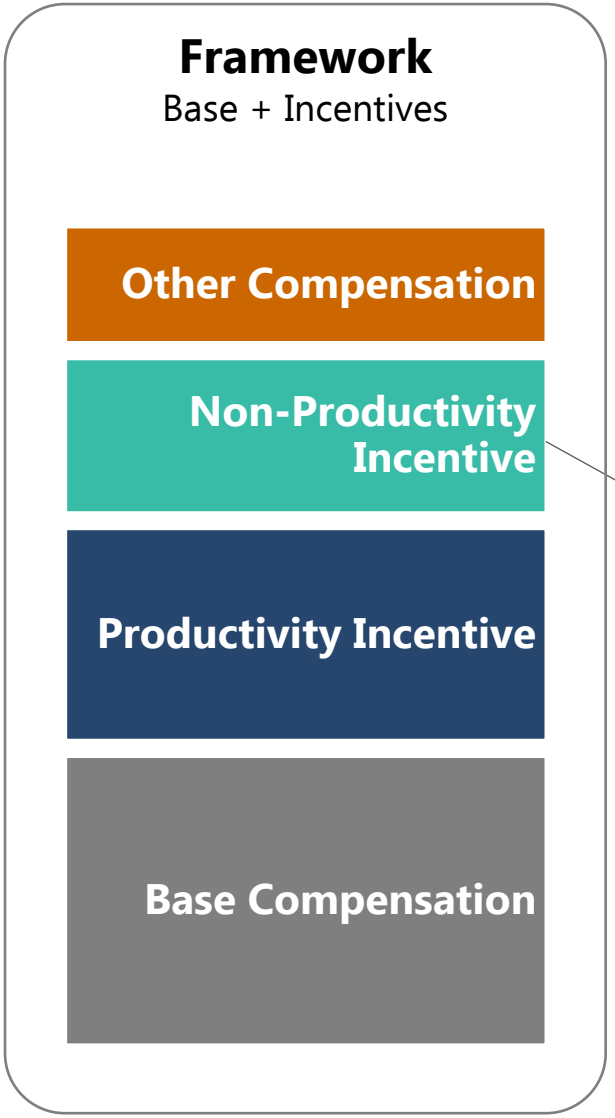
FMV compliance risk

Financial sustainability risk

Financially sustainable target zone

Potential recruitment / retention challenges

Compensation Framework Discussion



Non-Productivity Incentive

Key Questions & Considerations

How often to pay?

- Annual vs quarterly
- Data abilities

How will measures be determined?

- Provider input
- Regular updating within framework
- Number of measures
- By specialty

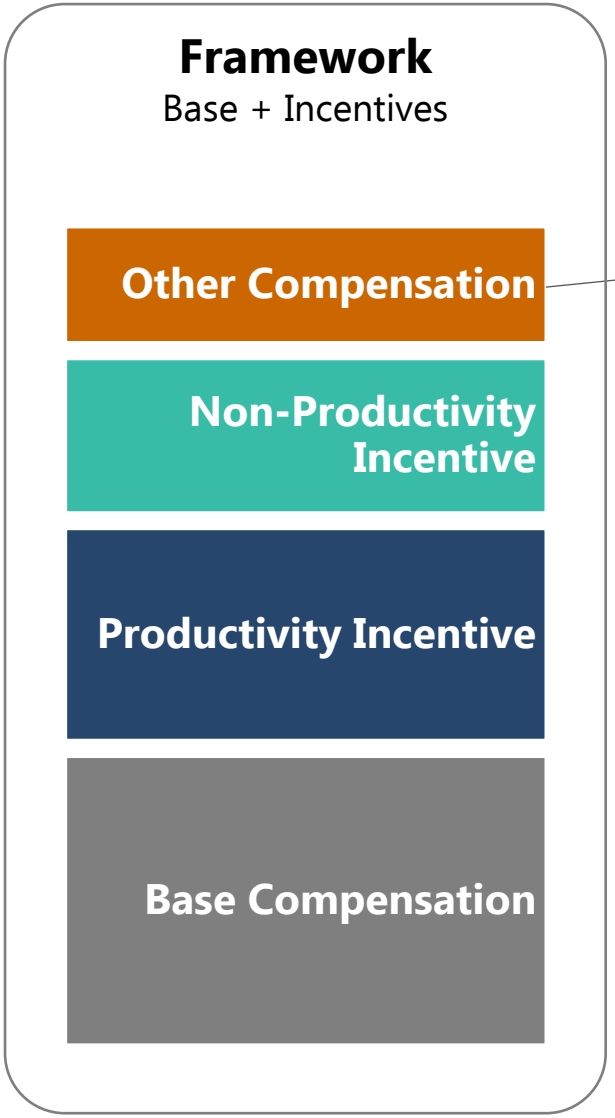
What is the target structure?

- Single, multiple, sliding scale

What is amount?

- Fixed amount per provider
- Percentage of base or total comp
- How much to target. . .

Compensation Framework Discussion



Other Compensation
Key Questions & Considerations

What additional duties do we need our providers to perform?

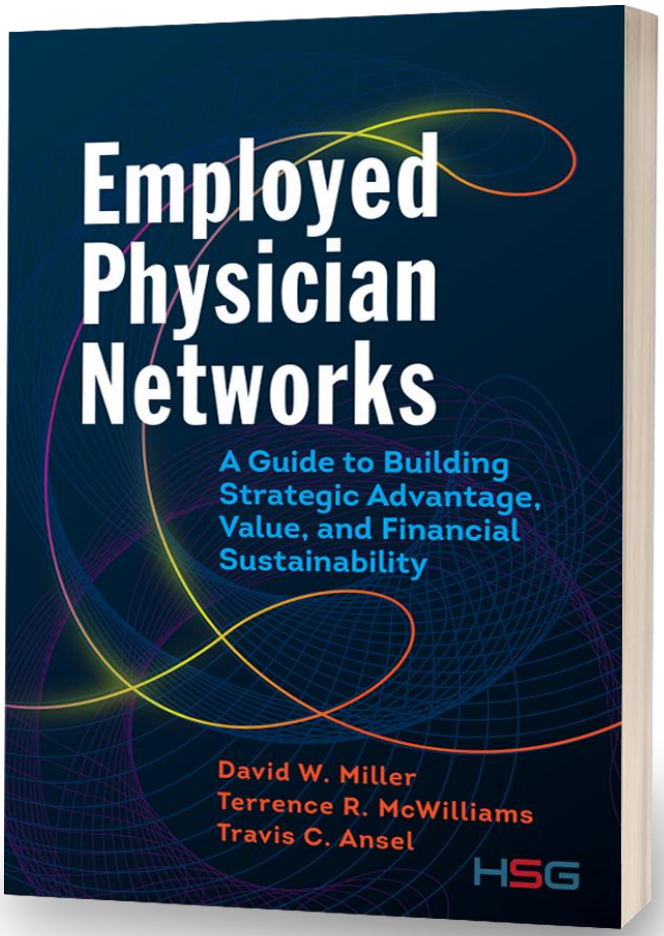
- Medical direction
- APP supervision
- Others

Variation in payment practices for APP mentoring and supervision:

- For Sullivan Cotter respondents, 48% offer additional compensation to physicians for supervising APPs.
- For IHS respondents, 72% offer additional compensation to physicians for supervising APPs.
- In the both surveys, a fixed stipend was the most common approach. Although the IHS respondents were more likely than the Sullivan Cotter respondents to include incentives tied to the APPs productivity (55%).


HSG | Questions

HSG Employed Network Growth Phases



Employed Physician Networks: A Guide to Building Strategic Advantage, Value, & Financial Sustainability represents HSG's perspective on how employed physician networks evolve over time; specifically focused on networks whose size has outstripped their capability to manage.

Core Concept:

As an Employed Physician Network evolves towards maturity in terms of its growth and size, **the network must have a systematic plan** that is focused on evolving its management team's capabilities, infrastructure, governance, provider engagement and leadership to address the network's current and future needs.

HSG works with health systems to assess current performance and build **Performance Improvement Plans** to guide future performance.

Employed Physician Networks is published through the American College of Healthcare Executives (ACHE) and Health Administration Press (HAP). Available now.

Conflict of Interest

I have no real or perceived conflicts of interest that relate to this presentation.