Building a Sustainable Compensation Strategy

Best Practices for Employed Compensation

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Speakers do not have any financial conflicts to report at this time.

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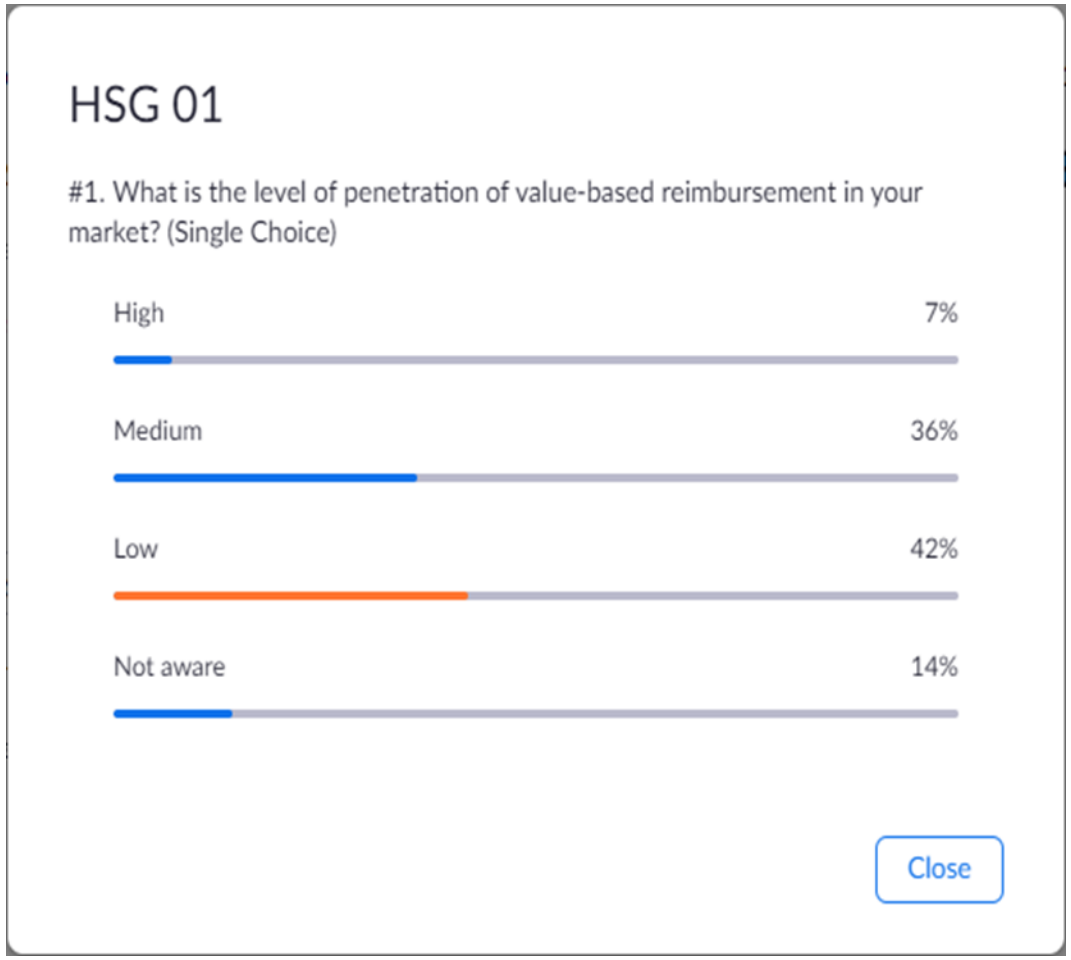
Learning Objectives

1. Discover the forces driving many hospitals to re-evaluate their provider compensation strategies in 2021
2. Manage a compensation strategy that evolves with and supports your organization's progress toward value and high-performance

Poll
What is the level of penetration of value-based reimbursement in your market?

- High
- Medium
- Low
- Not aware



Forces Driving Reevaluation

What factors are pushing organizations to reevaluate provider compensation?

1. Payer Factors
   - CMS is shifting dollars towards office visits and away from procedures as a result of changes introduced in the 2021 Medicare Physician Fee Schedule (MPFS)
   - CMS continues to increase the proportion of dollars linked to quality and value
   - Commercial payers are following suit
2. Market and competitive factors
   - Increased focus on quality in patient directed marketing materials
   - Increased public access to quality data and rankings
3. Internal factors in response to prior two

CMS is Shifting Dollars Towards Office Visits

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

- **Conversion Factor decreased by 3% to $34.89**
- **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	Medicare 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

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CMS is Adding Quality Dollars

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)

* Replaced Prior CMS PQRS & Value-Based Modifier Programs

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

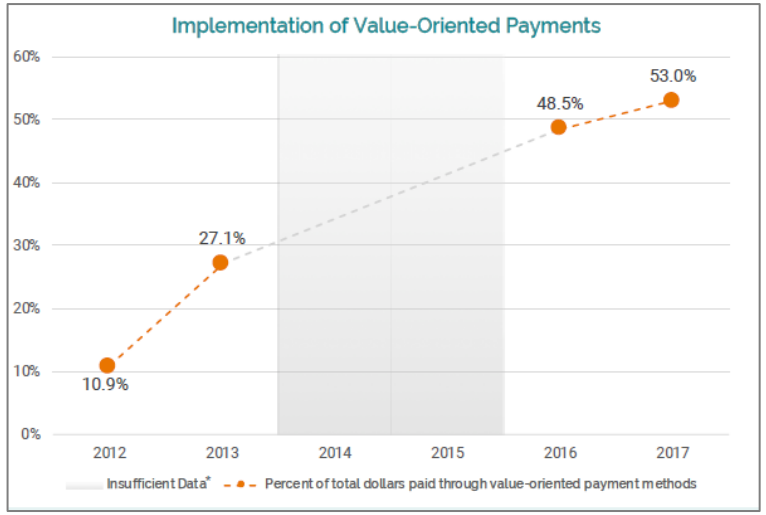
Commercial Payers Shifting Dollars Towards Value

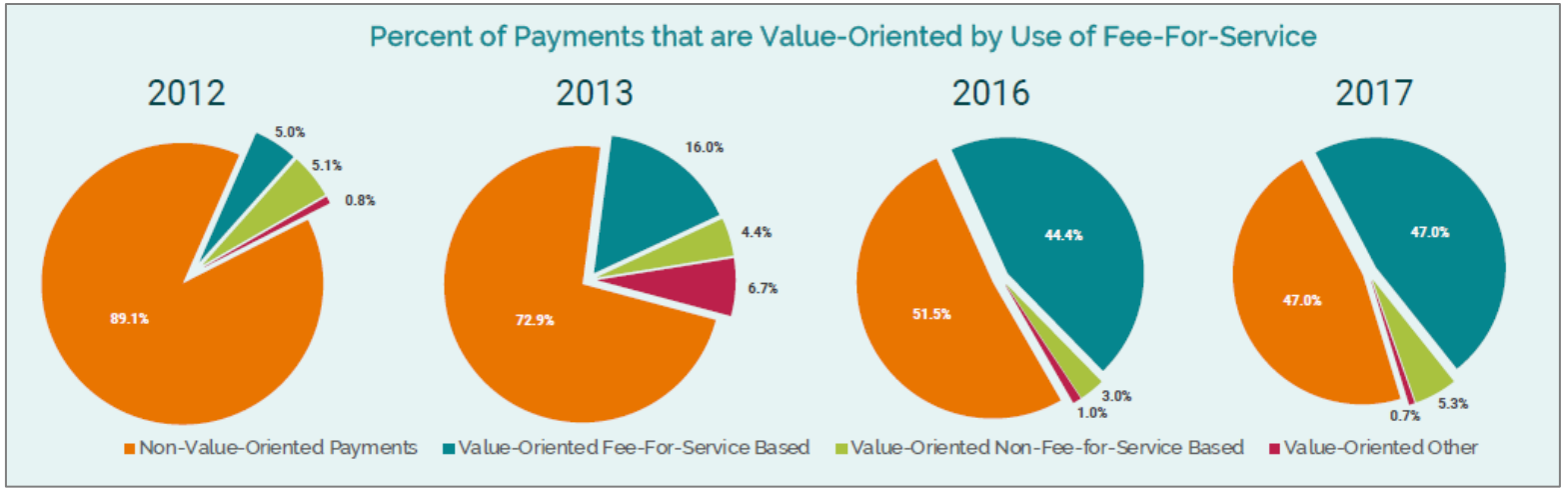
National Scorecard on Commercial Payment Reform

Robert-Wood Johnson Foundation

National Alliance of Healthcare Purchaser Coalitions

Catalyst for Payment Reform



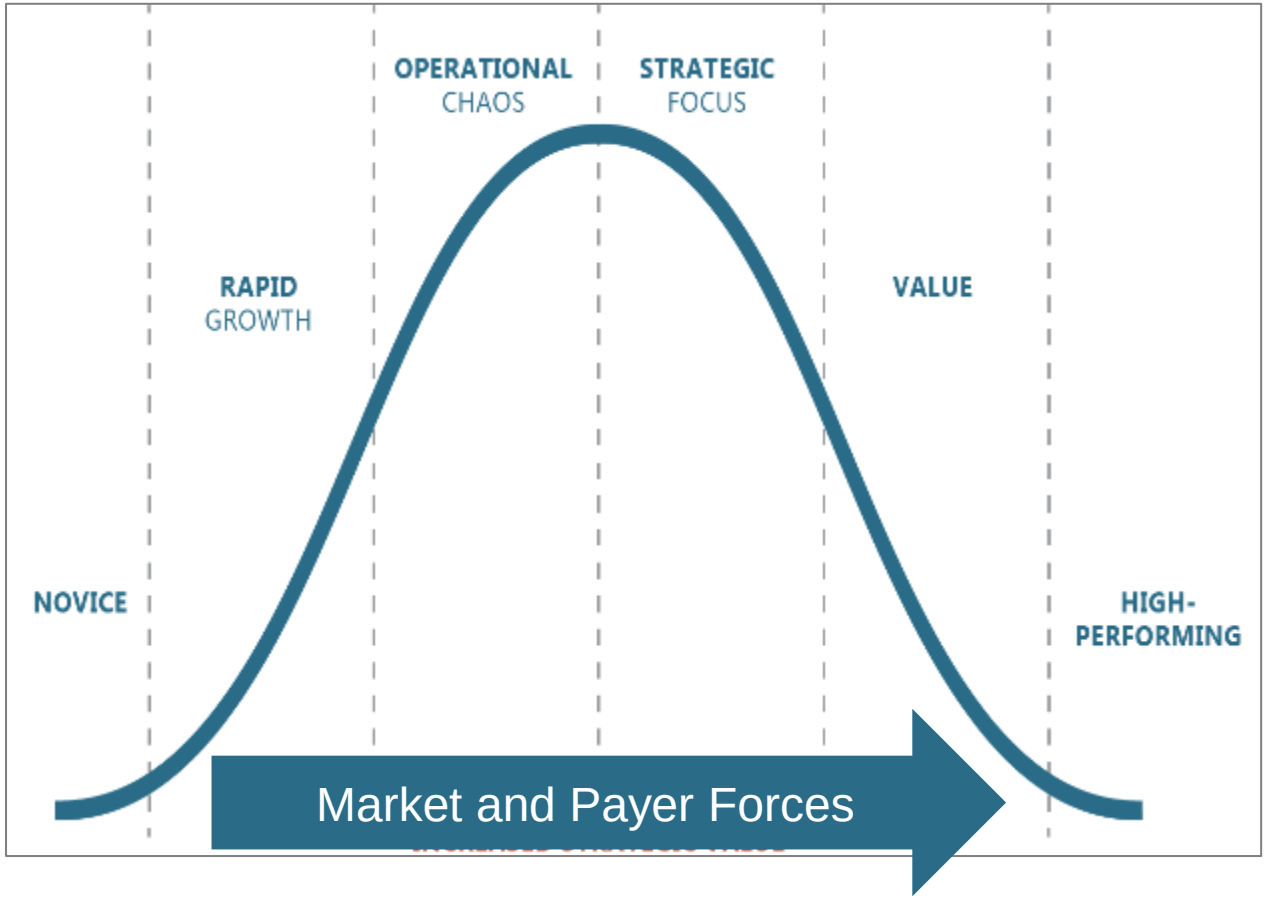


Patient Awareness of Quality is Increasing

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		

Employed 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.

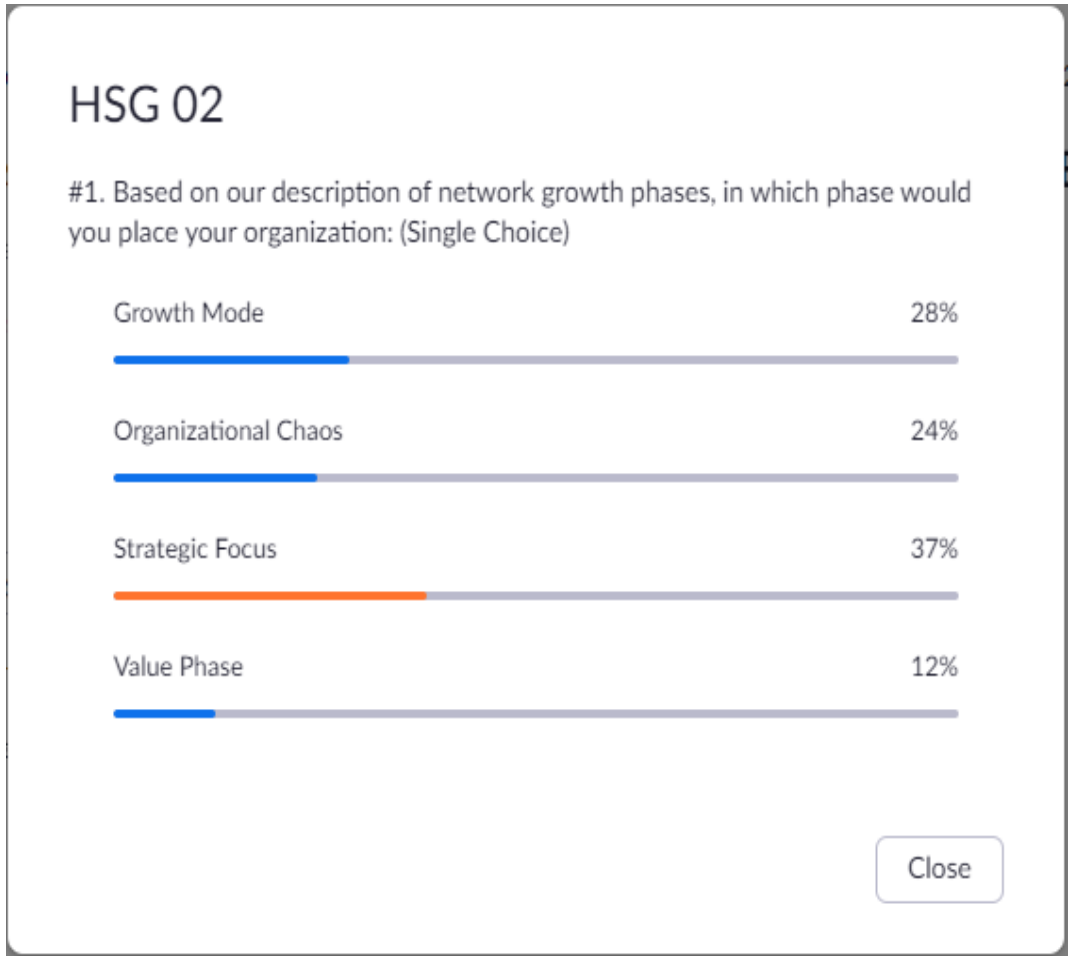


Organizations moving toward value must adapt internal operations, **including provider compensation methodologies.**

	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.

Poll:
Based on our description of network growth phases, in which phase would you place your organization:

-Growth Mode
-Organizational Chaos
-Strategic Focus
-Value Phase



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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

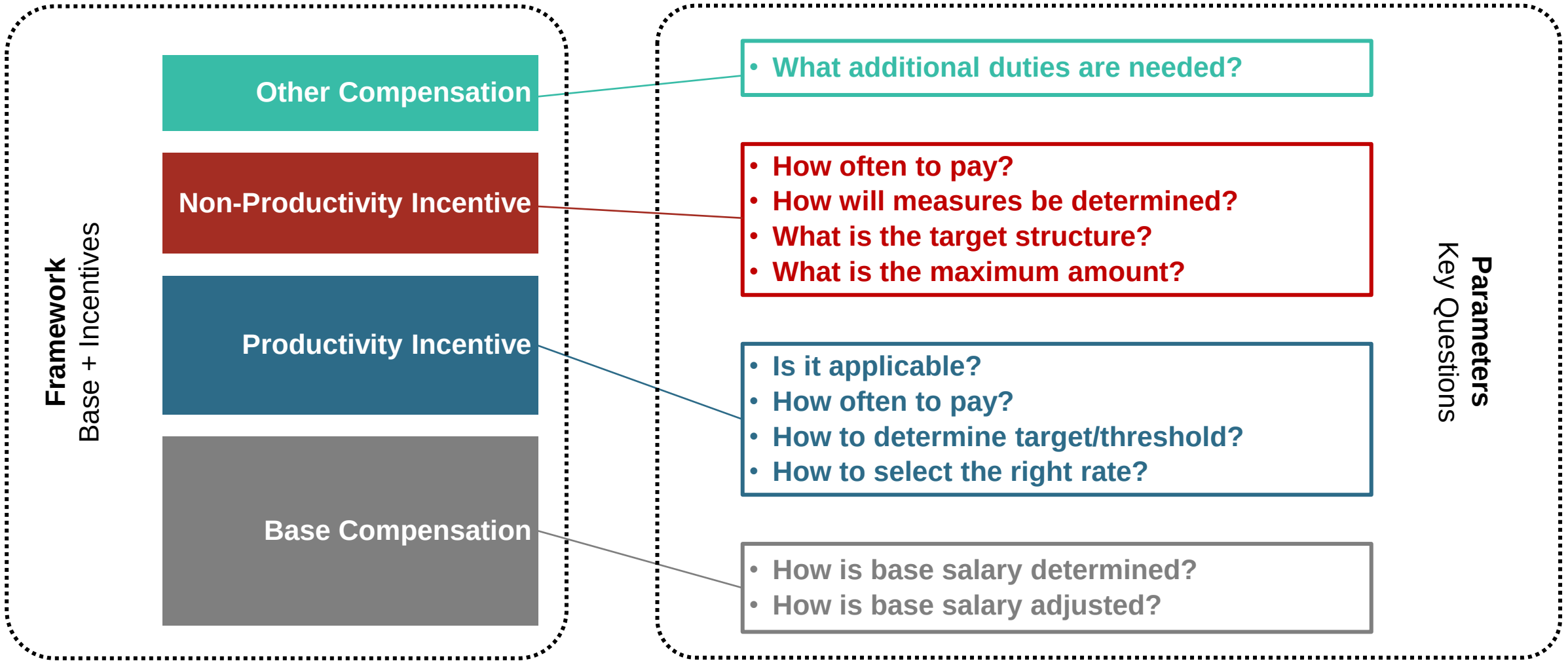
Managing Compensation Strategy

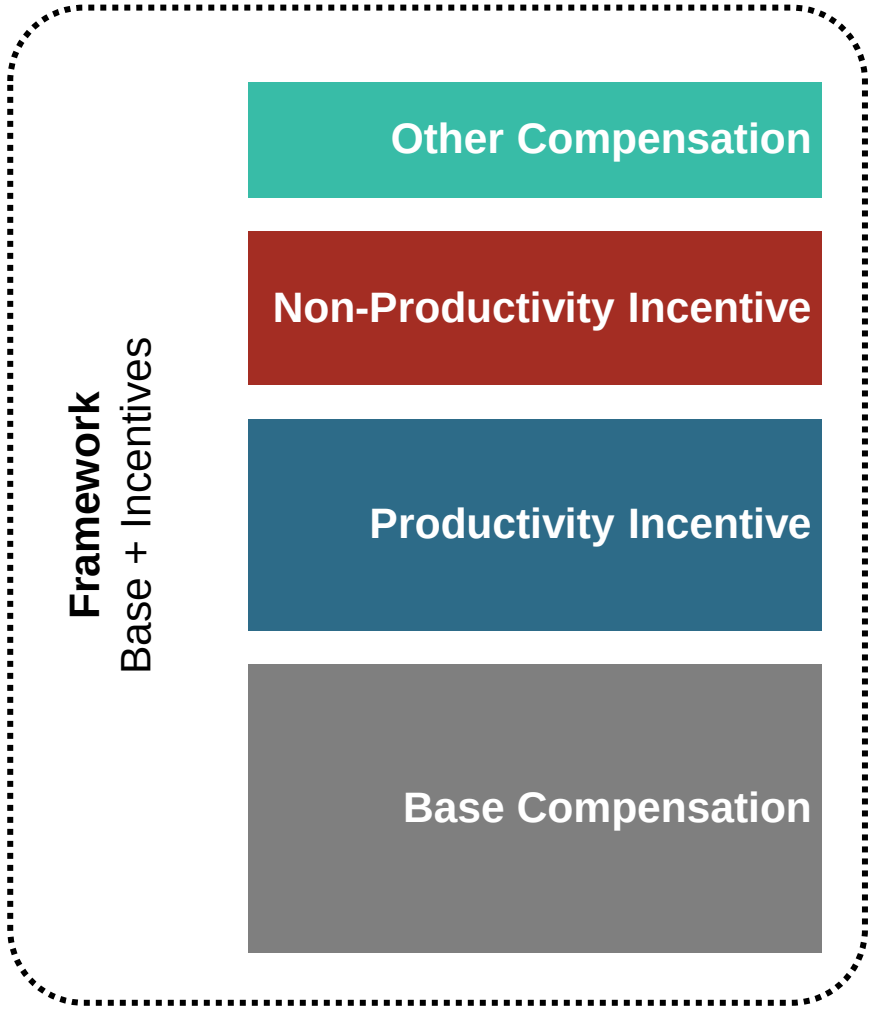
What must be considered when building a compensation plan?

1. Selecting the right framework
2. Selecting parameters for each component
   - Base Salary
   - Productivity incentives (if applicable)
   - Non-productivity incentives
   - Other compensation

Compensation Framework Examples

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
Straight productivity	• Increased effort/ productivity	• Tends to be favorable for “bottom line” • Disincentives provider from spending time on any non-revenue generating activities • Disincentives provider from facilitating recruitment or supporting new recruits • May lead to overcoming or overuse of care (regular audits may be recommended) • Provider unlikely to be interested in expense control or practice operations improvement
Base + Incentives	• Increased effort/ productivity • Dependent on specific incentives and targets	• Flexibility in model may lead to overcomplication • Requires right mix of base salary, productivity targets/rates, and non-productivity incentives (if included) – will not provide proper incentives if targets are unrealistic • Organization must be willing to adjust base salaries to ensure continued alignment with productivity levels





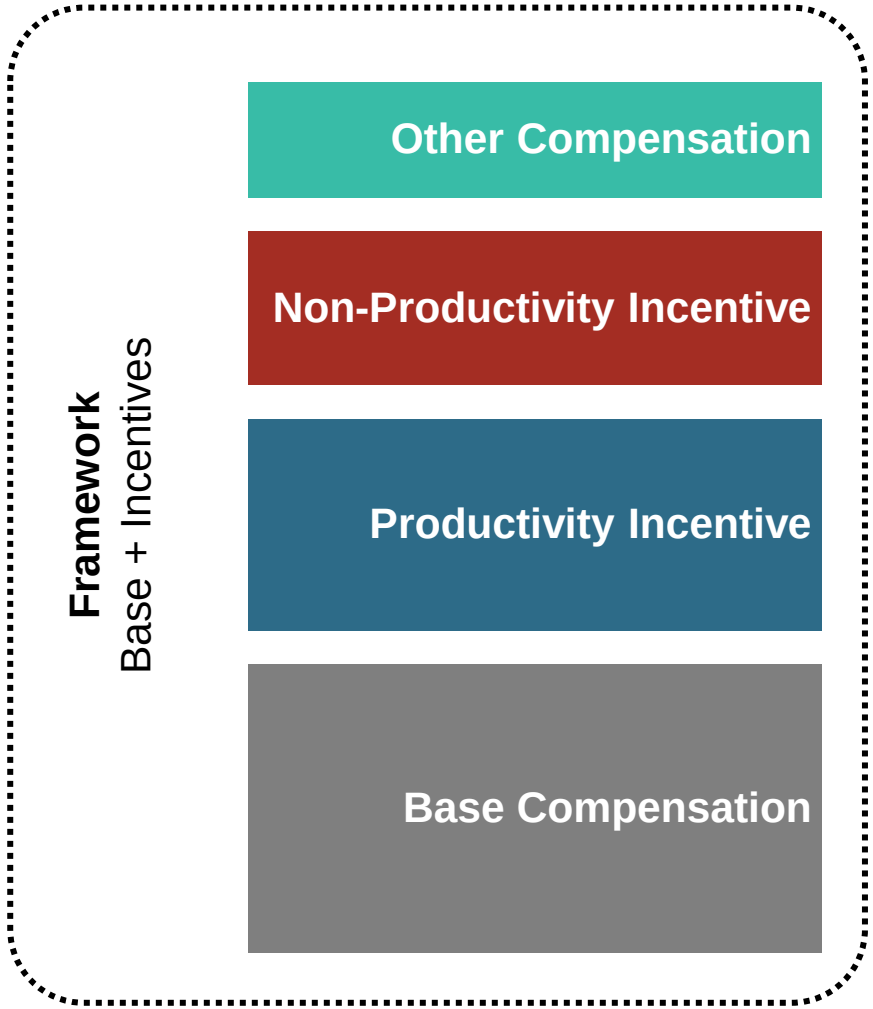
Base Compensation
Key Questions & Considerations

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



Productivity Incentive

Key Questions & Considerations

Does it apply?

- Shift-based specialties that cannot influence volume of services

How often to pay?

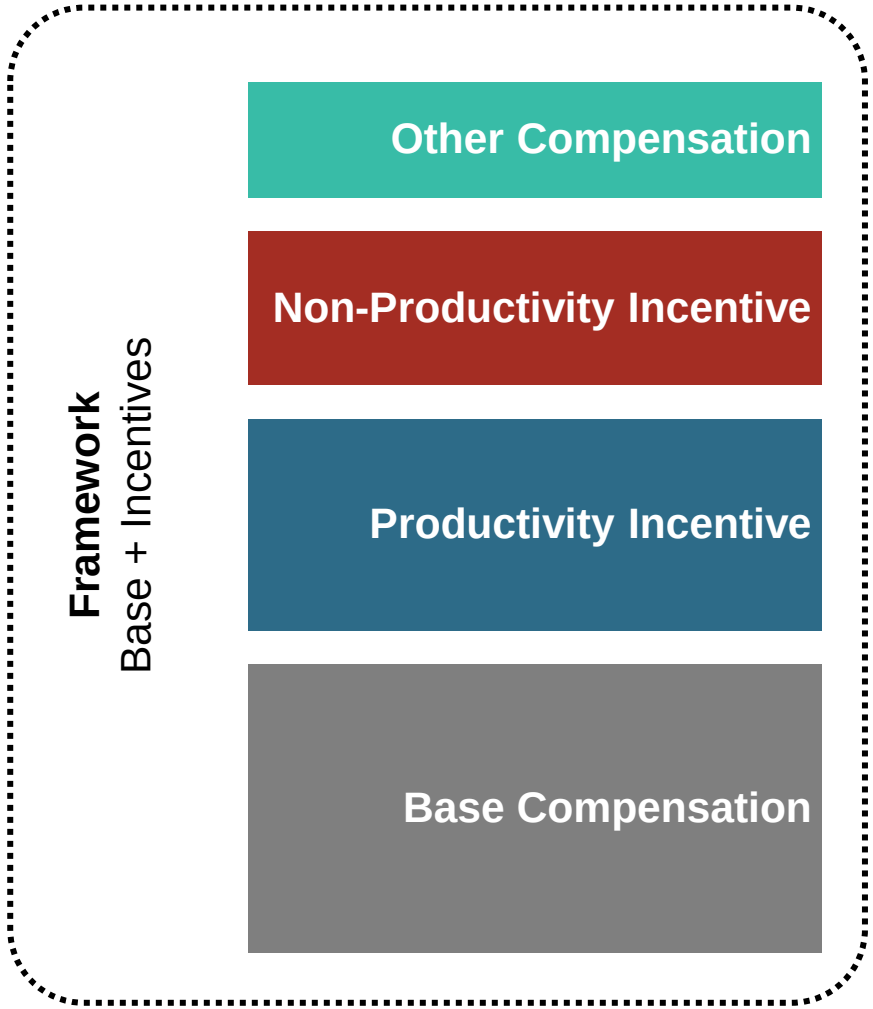
- Annual vs quarterly
- Reconciliation (additional pay / paybacks)

How to determine target/threshold?

- Linked to base salary & reduction mechanism
- Linked to rate

How to select the right rate?

- Historic precedent
- Careful use of survey data
- Financial sustainability



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?

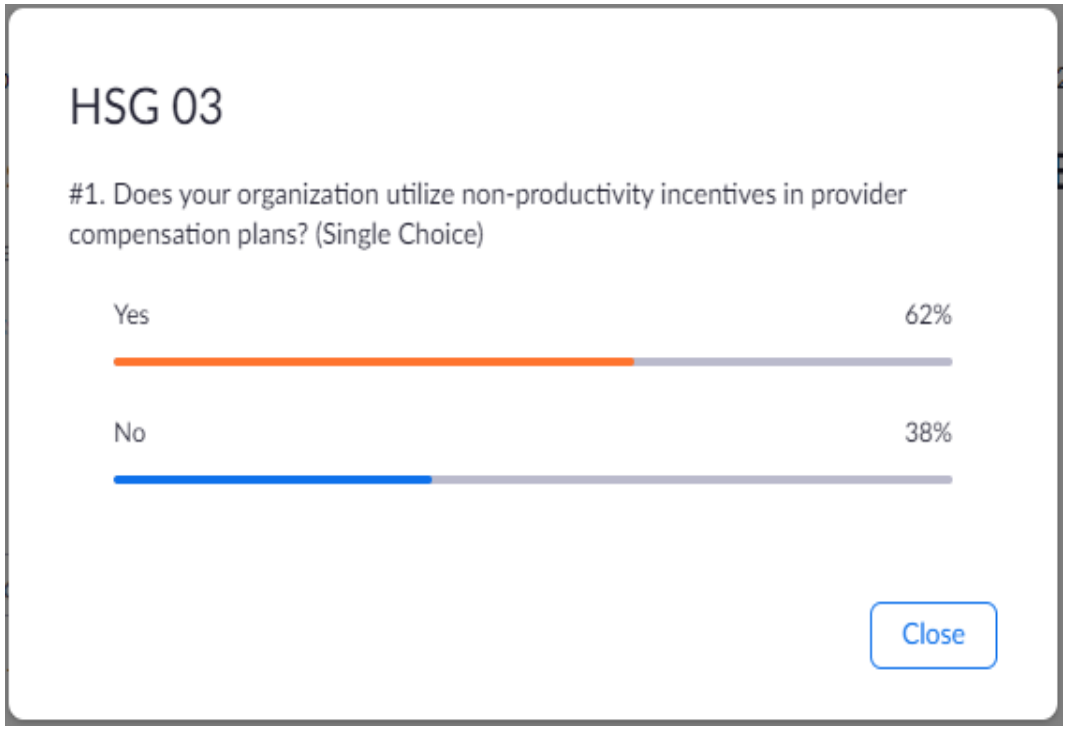
- Single, multiple, sliding scale

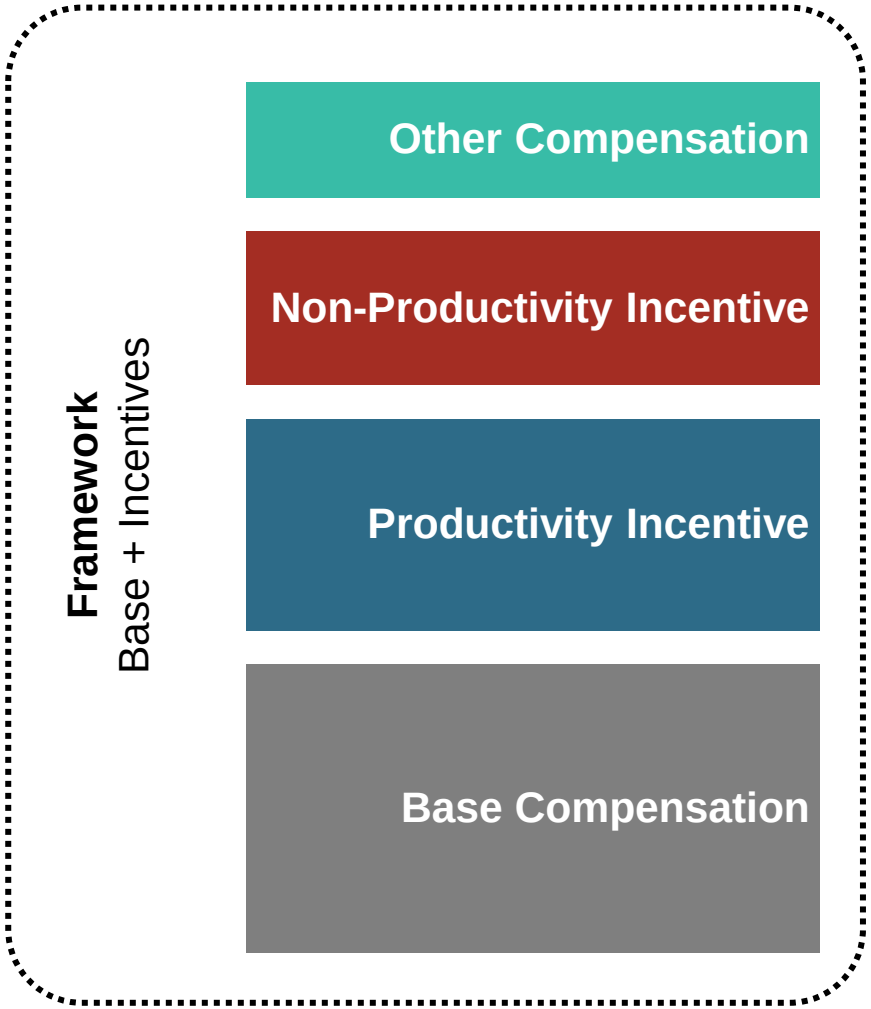
What is amount?

- Fixed amount per provider
- Percentage of base or total comp

Poll:
Does your organization utilize non-productivity incentives in provider compensation plans?

-No
-Yes





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

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

1: Sullivan Cotter

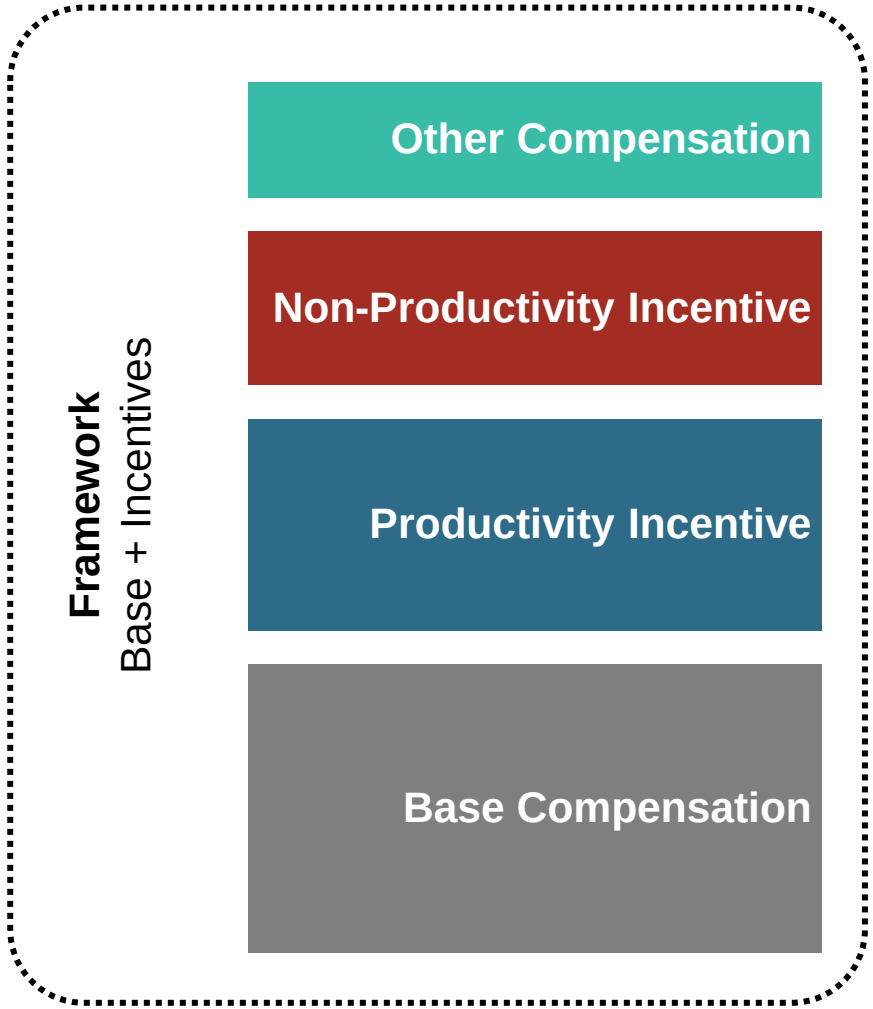
Average amount of value or quality-based incentives as a percent of total compensation[1]

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%



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 APP productivity (55%).

In Summary

- Increasing focus on value-based care delivery and reimbursement models and the changes created by the 2021 Medicare Physician Fee Schedule combine to make this the ideal time to consider wholesale changes in provider compensation models
- Consider re-evaluating your provider compensation framework to comprehensively redesign its structure to align with organizational goals and objectives predicated by future healthcare trends

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Thank you

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