Coker GROUP

Business Advisors for the Healthcare Industry

Physician Compensation: Innovative Models in a Dynamic Healthcare Environment

South Carolina Chapter HFMA

May 31, 2019

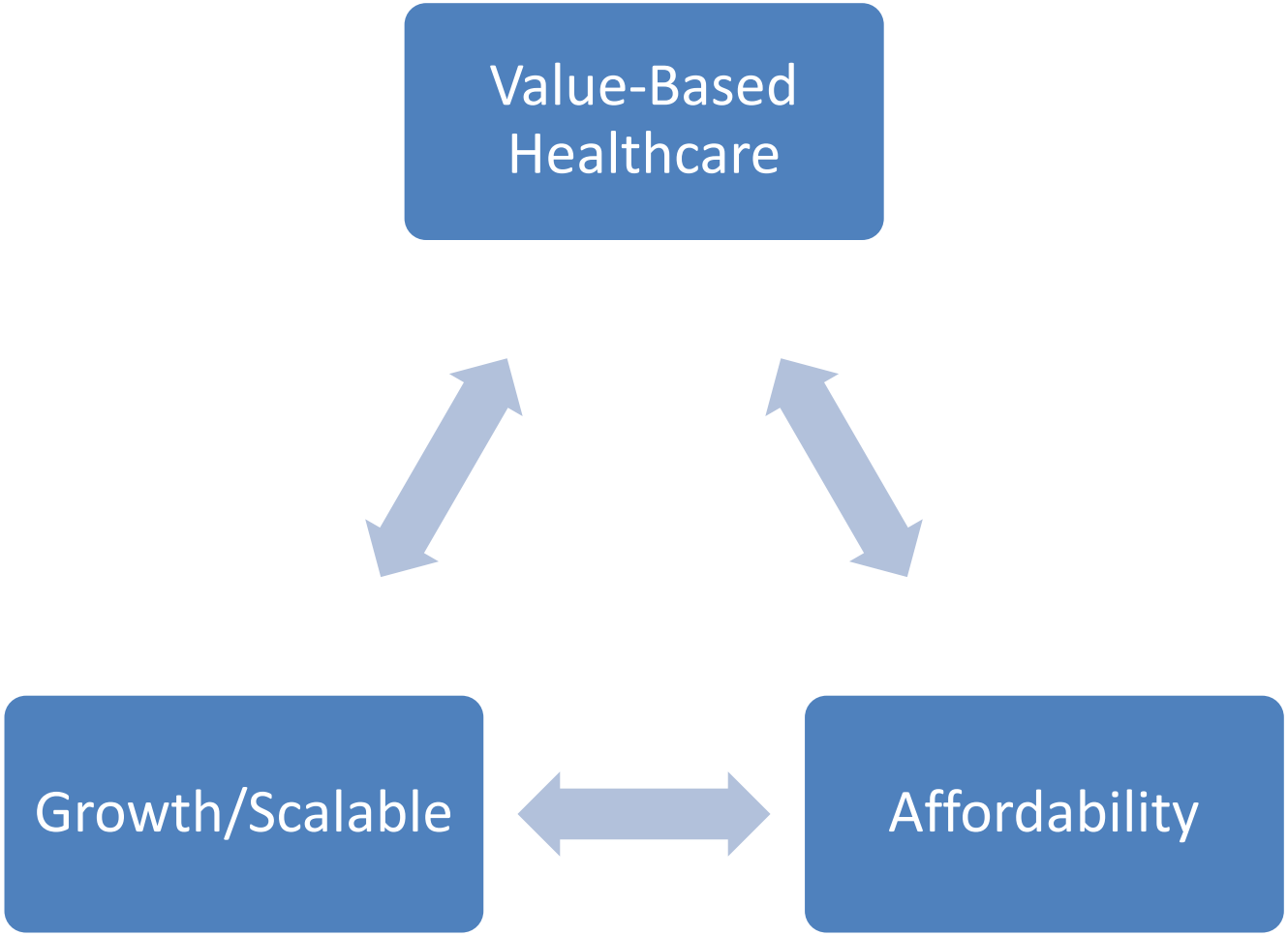
Justin Chamblee

Senior Vice President, Coker Group

Learning Objectives

- Understand the dynamics currently affecting physician compensation
- In-depth analysis of the new model structures that are being contemplated
- Consideration of the key challenges associated with innovation

Key Considerations/Pressures



VALUE-BASED REIMBURSEMENT

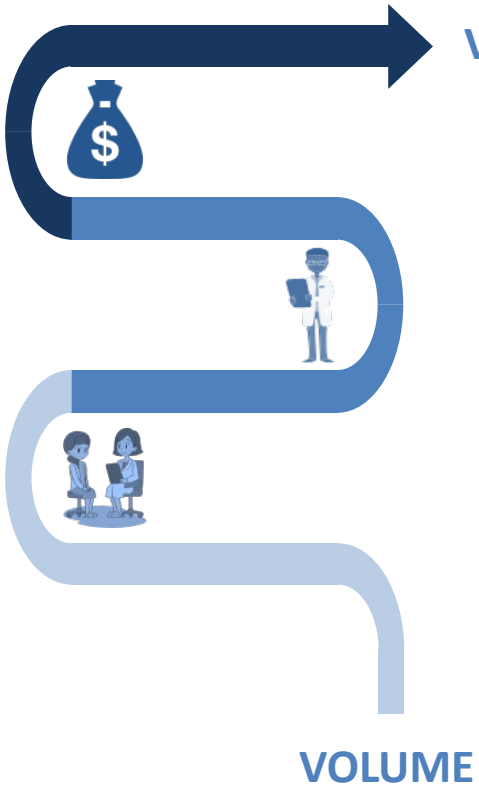
Industry Paradigm Shifts

Payers

- Risk shifting from payers to providers (both upside and downside risk based upon outcomes)
- Increasing number of value-based programs (i.e., bundled payments, pay-for-performance, shared savings plans, etc.)

Patients

- Consumer-driven, high deductible health plans with increasing price transparency



Providers

- Re-tooling operations to infuse more focus on care management, cost reduction, data utilization and prevention/overall wellness
- Harnessing innovation and entrepreneurialism (particularly for independent providers) to develop clinically integrated networks (CINs) that are private practice or ASC based

Changing Payment Models

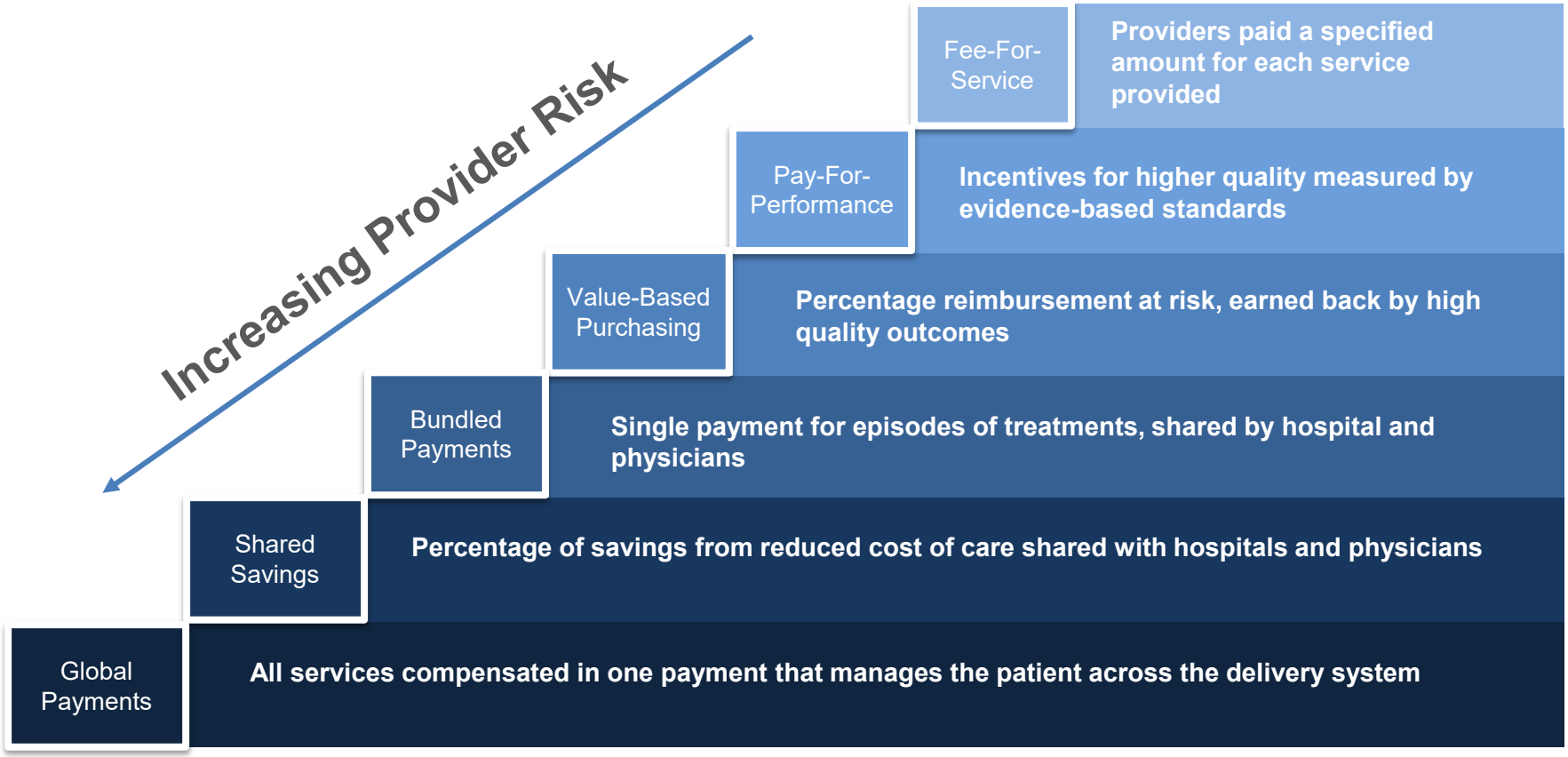
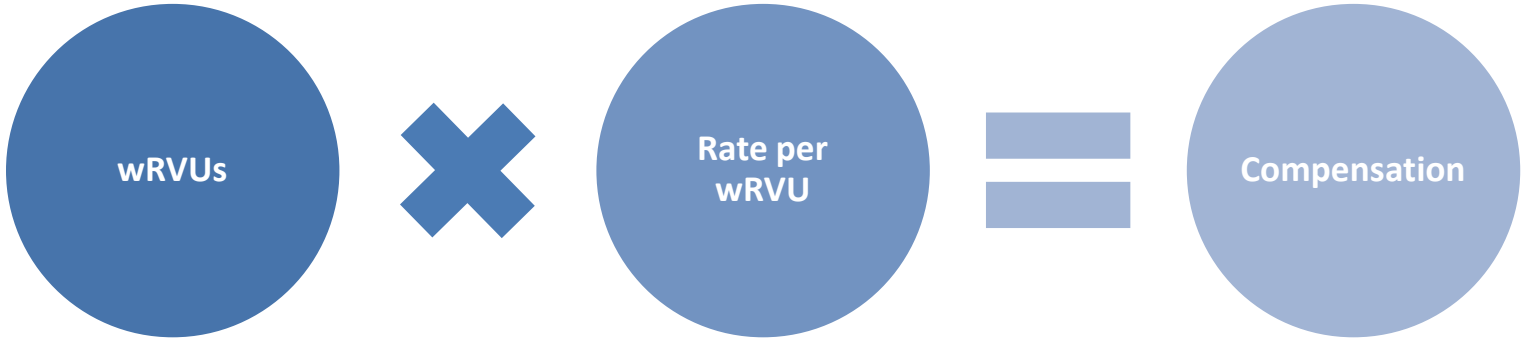
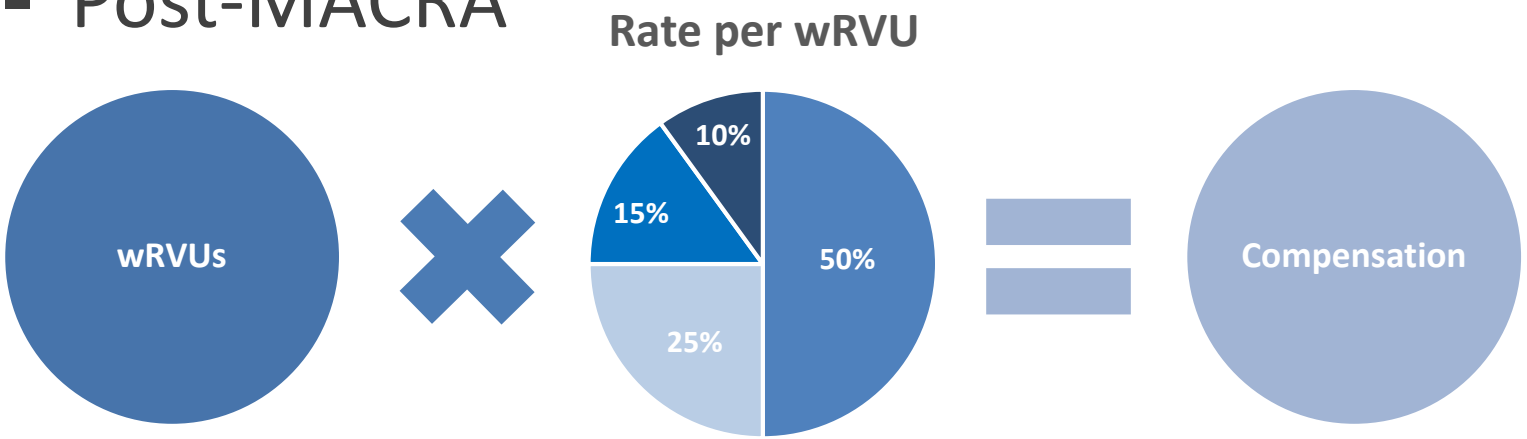


Illustration of Changing Models

- Pre-MACRA



- Post-MACRA



2017 QPP Outcomes (Paid in 2019)

More than 1 million clinicians participated in the Quality Payment Program ("QPP") in 2017

Small and rural practice participants earned lower scores

- Rural – mean score 63.08
- Small practices – mean score 43.36

The majority of MIPS participants (93%) received a positive payment adjustment (maximum 1.88%)

2% of clinicians had a neutral (or no change) adjustment

5% of clinicians received a negative payment adjustment (maximum -4%)

Treatment of Value-Based Funds

Do not pass-through external incentives

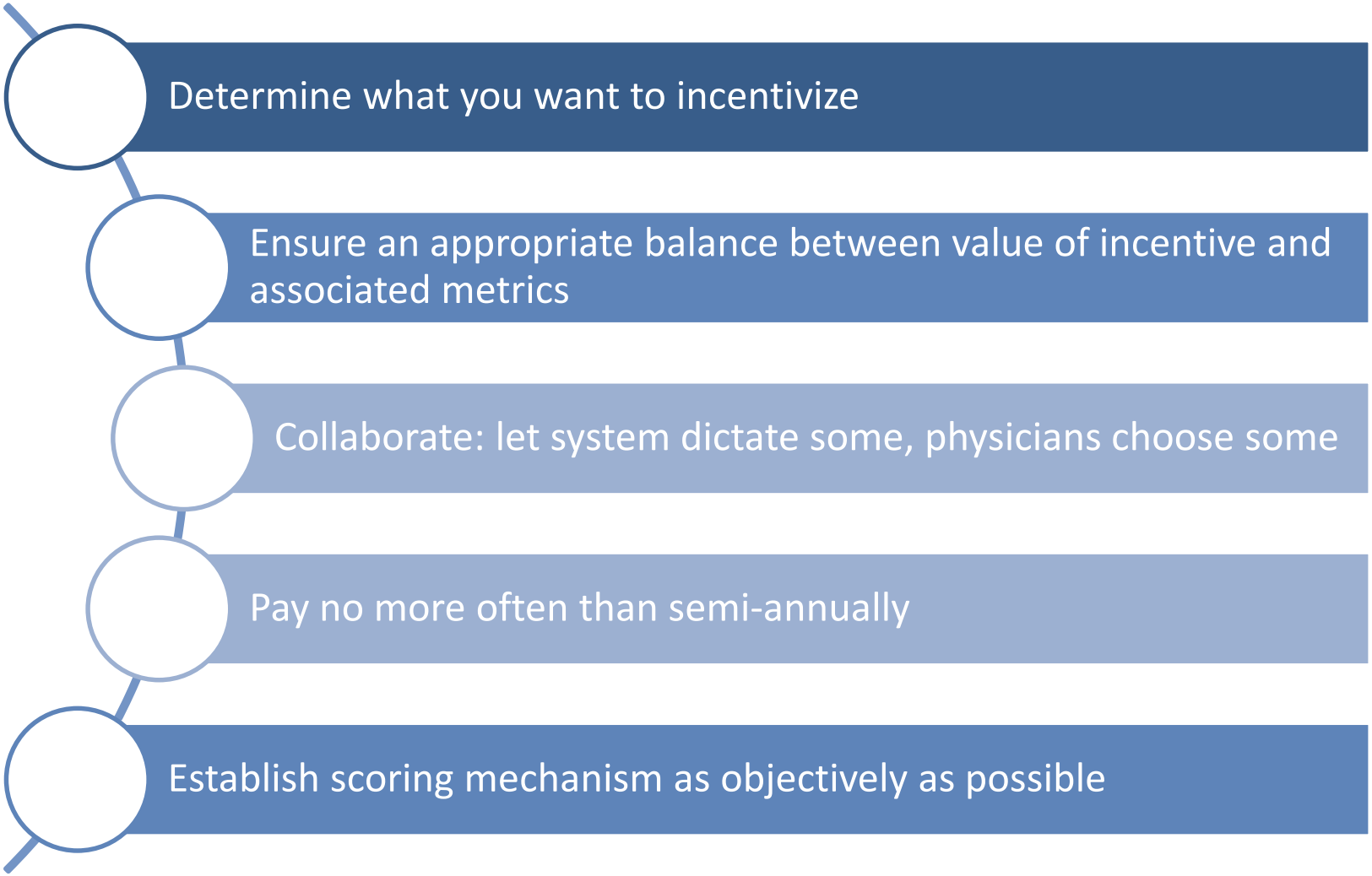
Align drivers of value-based revenue with incentive structure

Pace change in compensation structure with changes in reimbursement environment

Value-Based Incentives

- **Value**
  - Focus on factors physicians can influence
  - Makes measuring meaningful
  - Balance value of incentive and metrics
- **Structure**
  - Part of total compensation arrangement, not “add-on”
  - Scorecard approach
- **Primary Care vs. Specialty Care**
  - Primary Care incentives focus on increased patient access and population health management
  - Specialty Care incentives focus more on specific procedures and specialized care that relate to the specific specialty

Value-Based Incentives



Value-Based Incentives

Individual Incentive

- Scorecard based approach
- Not an all or nothing incentive
- The quality committee should decide each year which metrics are most relevant
- Paid out annually based on achievement of individual goals
- Suggested categories
  - Quality
  - Patient Satisfaction
  - Expense Control
  - Citizenship/Peer Review
  - Access

Group Incentive

- Organization-wide goals or measures
- Goals that require a team effort to achieve
- Reward providers for exceptional group performance
- Opportunity of 5% of the target rate for all specialties
- Paid out annually based on achievement of group goals
- Suggested categories:
  - Organizational stretch goals
  - Quality
  - Financial performance

Value-Based Incentives

Data Capture	• Ability to capture data for required reporting
True External Drivers	• Strategic need for a given specialty
Lack of Cohesive Compensation Philosophy	• Different models for different practices may not drive collective mindset
Perceived "Decrease" in Compensation	• Value contracts have to replace previous revenue streams
Provider Buy-In	• Coordination needed between specialties
Interpretation of Market Data	• Numerous survey sources and benchmarks

Outpace the Market

Disproportionately incentivize behavior that's not aligned with revenue streams

Panel Incentives

- **Rationale**
  - Incentivizes access
  - Recognizes non-wRVU generating activities
  - Begins to develop capitated mindset
- **New Models**
  - Including panel as a component of overall pay
- **Challenges**
  - Measuring
  - Alignment between panel data (internal vs. payer)
  - Toes in two different models

Panel Incentives

Derivation of Base Pay

- Some models let panel size drive the majority of base pay.
- For example, compensation could be derived using a PMPM amount of $10.00. Thus, a 1,800- panel size would equate to total compensation of $216,000.
- Of this amount, potentially $9.00 (approximately 90%) could be guaranteed, with the remaining $1.00 at-risk based on performance metrics.

Small Add-On Component

- Some models have panel size representing 5-10 percent of total cash compensation.
- This component is either established as a separate component of pay or allocated as part of the overall value of pay.

Allocation of Performance Incentive Opportunity

- Instead of a direct payout to the physician, this sets the performance opportunity that the physician can earn, with the actual payout based on the physicians performance.
- For example, if a physician's performance incentive is $12,000, and that physician scored a 75 percent on his scorecard, the physician would be paid $9,000.

AFFORDABILITY

Market Data Increases

- Over a five-year period, we demonstrate the effect of paying the median rate per wRVU before and after the addition of a quality incentive, panel size compensation and advanced practice provider supervision:

Family Medicine (without OB)	2014	2015	2016	2017	2018
wRVUs	5,000	5,000	5,000	5,000	5,000
Rate per wRVU (Median)	$45.34	$46.50	$47.68	$49.37	$50.07
Clinical Compensation	**$226,700**	**$232,500**	**$238,400**	**$246,850**	**$250,367**
Quality Incentive	$15,000	$15,000	$15,000	$15,000	$15,000
Panel Compensation	$10,000	$10,000	$10,000	$10,000	$10,000
Midlevel Oversight	$10,000	$10,000	$10,000	$10,000	$10,000
Total Compensation	**$261,700**	**$267,500**	**$273,400**	**$281,850**	**$285,367**
Rate per wRVU (Median)	$45.34	$46.50	$47.68	$49.37	$50.07
Total Effective Rate per wRVU	**$52.34**	**$53.50**	**$54.68**	**$56.37**	**$57.07**

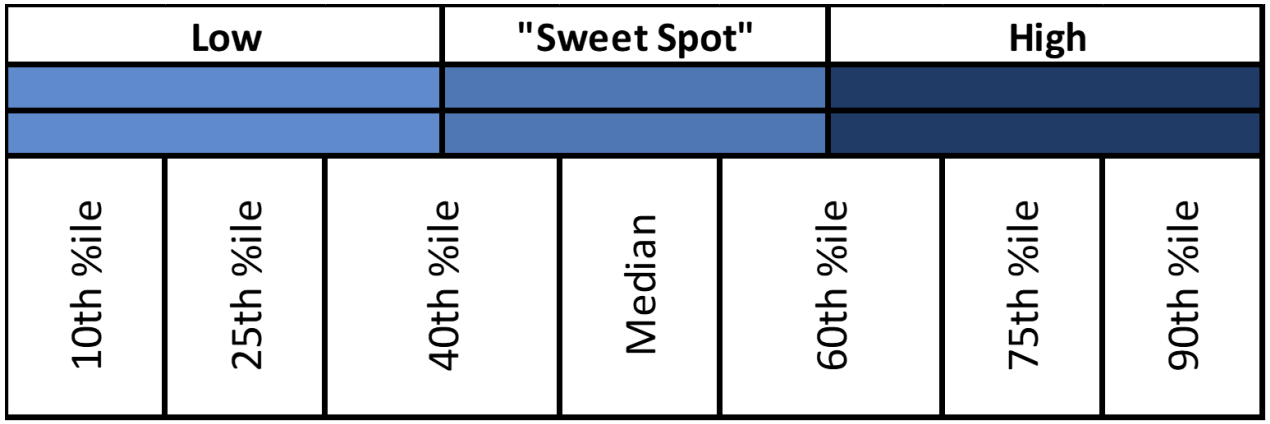
- There has been an inherent increase in clinical compensation from consistently paying at the median
- The addition of incentive pay increases the total compensation by $35,000

Compensation Model Design

- Overall Economics – Funding
  - How should the Target Rate per wRVU be set?
    - Survey Data (MGMA, AMGA, SCA)
    - Collections per wRVU x Market TCC to Collections Ratio

Market Data		Collections per wRVU	
Pros	Cons	Pros	Cons
Represents the national market	May not be financially sustainable	Represents actual financial scenario	May not represent marketing recruiting rates
Same rate (as a %ile) set for all specialties	Assumes all specialties should be at the same rate (as a %ile)	Rates will reflect specialty specific financial performance	Difficult to set specialty rates if provider performance varies greatly
Updates every year	Updates may not reflect local market changes	Data is current and reflects current market	Local market changes have big impact

Overall Economics - Funding



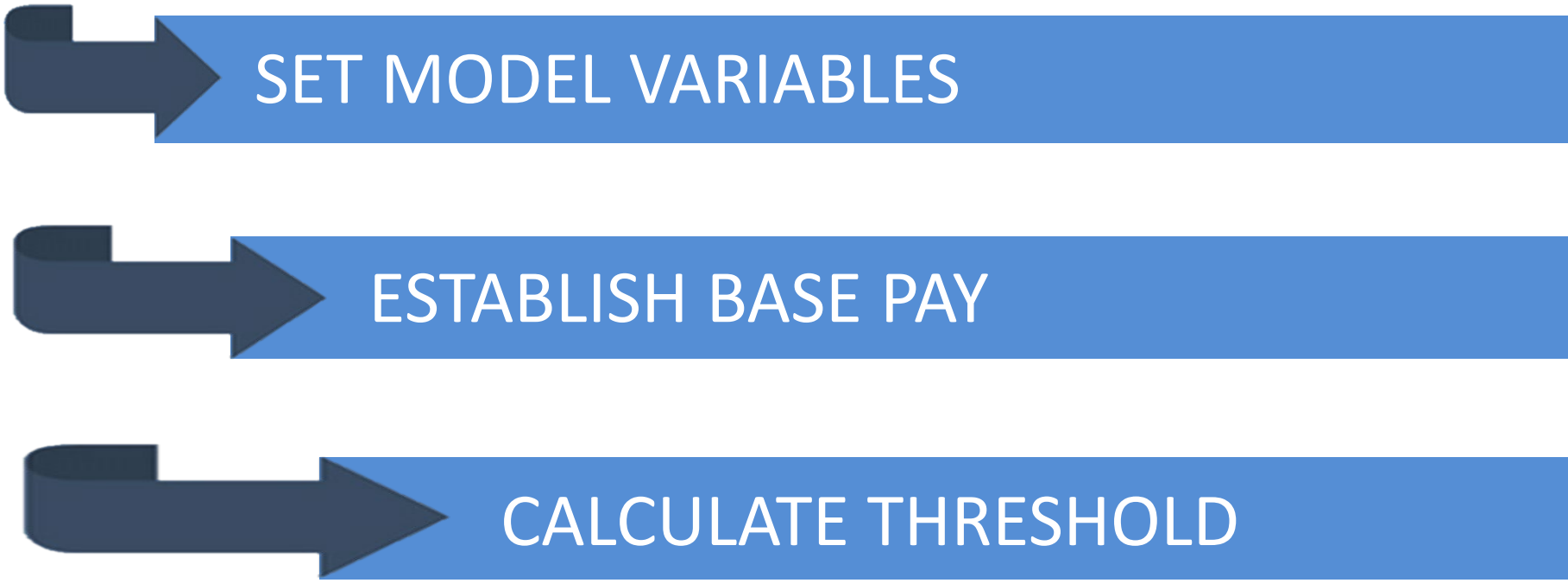
- **Low:** Productivity will likely outpace compensation
- **Sweet Spot:** Productivity and compensation are somewhat aligned
- **High:** May not be representative of typical economics, presents potential compliance issues, compensation may outpace productivity

Overall Economics – Funding

- Using the median TCC per wRVU tends to result in an alignment in compensation and productivity

wRVUs	Market%ile	TCC/wRVU	Market%ile	TCC	Market%ile
5,805	25th %ile	$57.60	40th %ile	$334,368	17th %ile
7,629	Median	$57.60	40th %ile	$439,450	40th %ile
9,609	75th %ile	$57.60	40th %ile	$553,498	69th %ile
5,805	**25th %ile**	$61.52	**Median**	$357,143	**21st %ile**
7,629	**Median**	$61.52	**Median**	$469,382	**48th %ile**
9,609	**75th %ile**	$61.52	**Median**	$591,198	**77th %ile**
5,805	25th %ile	$67.00	60th %ile	$388,935	27th %ile
7,629	Median	$67.00	60th %ile	$511,165	59th %ile
9,609	75th %ile	$67.00	60th %ile	$643,825	83rd %ile

Order of Operations



Top-Down Approach to Pay

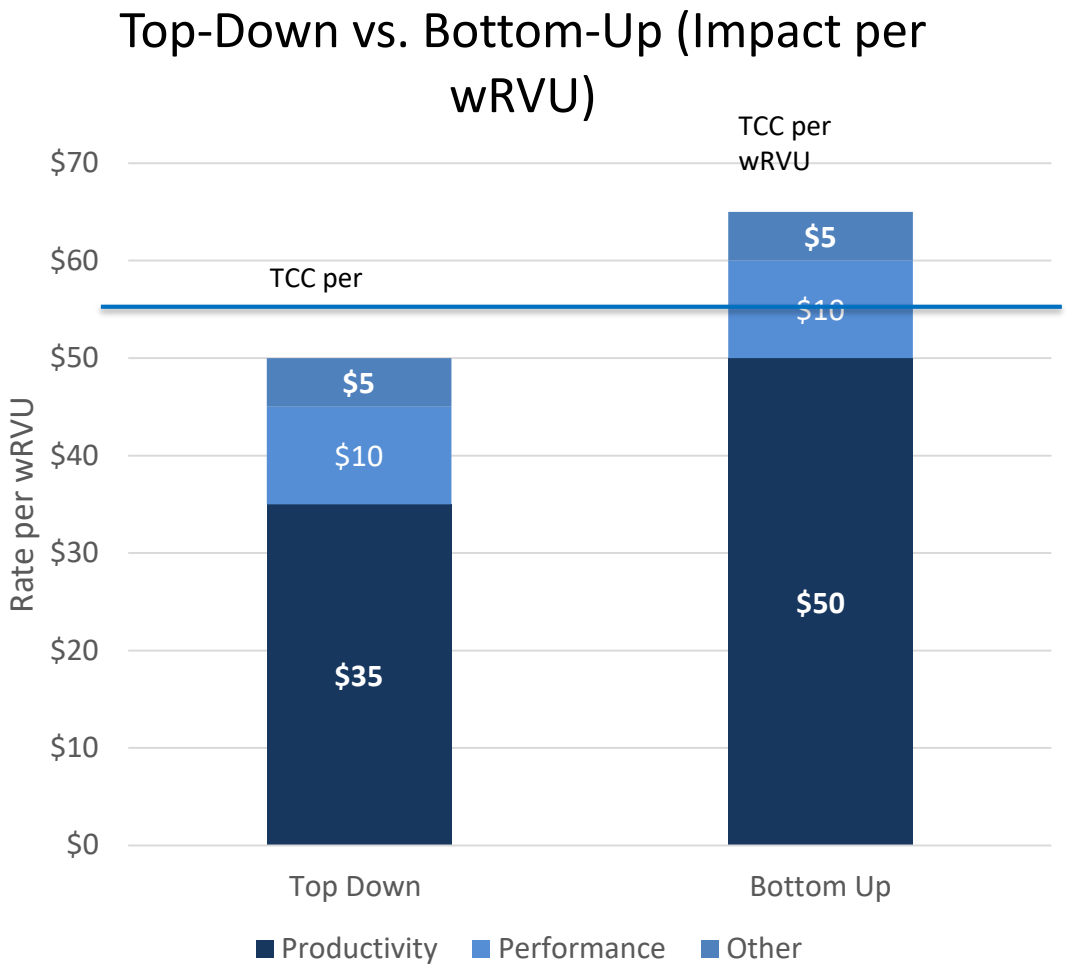
Targeted Comp/wRVU Ratio (Target %ile of Market Data)

wRVU Productivity (75 – 85%)	Individual Group Performance Incentive (10- 20%)	Other Components of Pay (5%)

- Value (targeted comp/wRVU is set and then allocated amongst the three components of the compensation model
- Full value is achieved through maximum performance in all areas
- Model creates flexibility to adjust value among components over time as changes in reimbursement occur

Allocation of Value

TARGET RATE PER WRVU



Base Compensation

- **Goal with Base Compensation**
  - Provide ongoing level of compensation from pay period to pay period
  - Ensure consistency in pay without sacrificing the incentive structure
- **Recommended Approach**
  - Structured as a draw on total cash compensation (i.e., not guaranteed compensation)
  - Expand the draw to potentially consider other components of pay beyond just productivity
    - As other components of pay grow in value, basing the draw only on productivity pay will cause the draw to decrease
  - Guarantees should be reserved for new physicians
  - If guarantees are needed, due to market locale, consider a hybrid guarantee
    - Base compensation only stays the same if the productivity is within XX% of supporting base pay
    - Base pay cannot be adjusted more than XX% per year

Hybrid Guarantee

10% Productivity Corridor Illustration

	A	B	C
Base wRVU Threshold	5,000	5,000	5,000
Actual wRVUs	4,000	5,250	7,000
Percent Difference	-20%	5%	40%
Base Compensation	$200,000	$200,000	$200,000
Adjustment to Base Compensation	-10%	0%	10%
Adjusted Base Comp	$180,000	$200,000	$220,000

Example

Physician A generates 4,000 wRVUs

- Productivity is more than 10% below the base threshold
- Base compensation is reduced 10%

Physician B generates 5,000 wRVUs

- Productivity is within the 10% productivity corridor
- Base compensation remains the same

Physician C generates 7,000 wRVUs

- Productivity is more than 10% above the base threshold
- Base compensation is only increased 10%

SCALABILITY

Factors Driving Physicians to Employment

More physicians are shifting from private practice in favor of health system employment due to increased levels of required investment, security in uncertain times, and personal decisions.

Adoption of expensive and complex EHRs

- Capital investments
- Learning something new
- Changing practice patterns

Work/life balance

- Extra administrative duties
- Security
- Generational shift in mindset

Increased regulations and payer mandates

- MACRA
- Commercial risk-models
- State-based initiatives

Complexity of data collection and reporting

- Data capture
- Data performance
- Data submission strategy

Shift from FFS to FFV

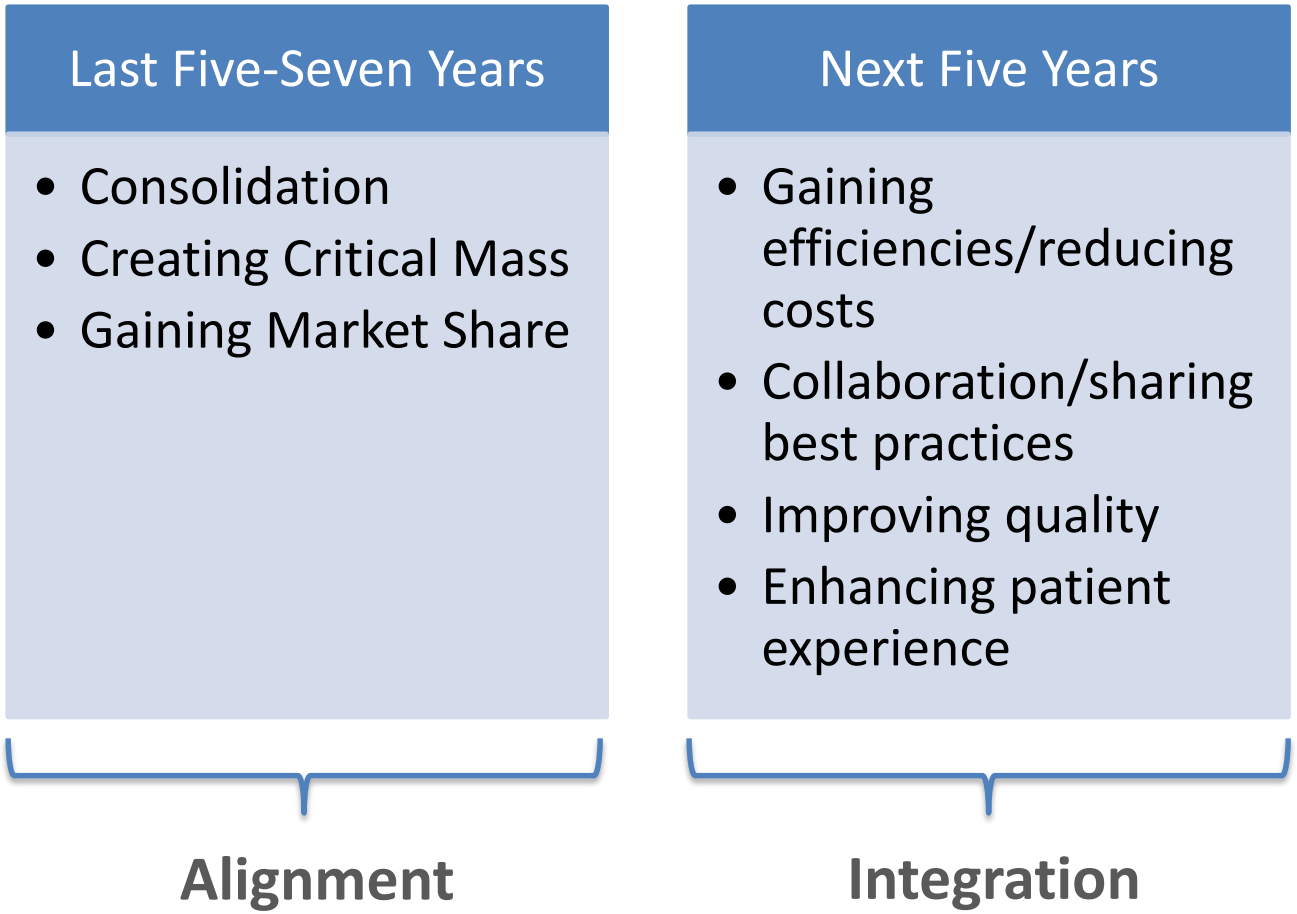
- More clinical integration and alignment
- Data reporting
- Patient cost management

Risk shifted onto providers

- Carrots and sticks
- Attribution
- Unstable markets

Alignment vs. Integration

- Moving forward, integration will be the key to achieving success in this new value-based healthcare environment



Compensation Governance

Compensation Committee

- Who "governs" compensation issues and structures?
  - Hospital board, C-Suite, Legal, Medical Group Board

Compensation Policy

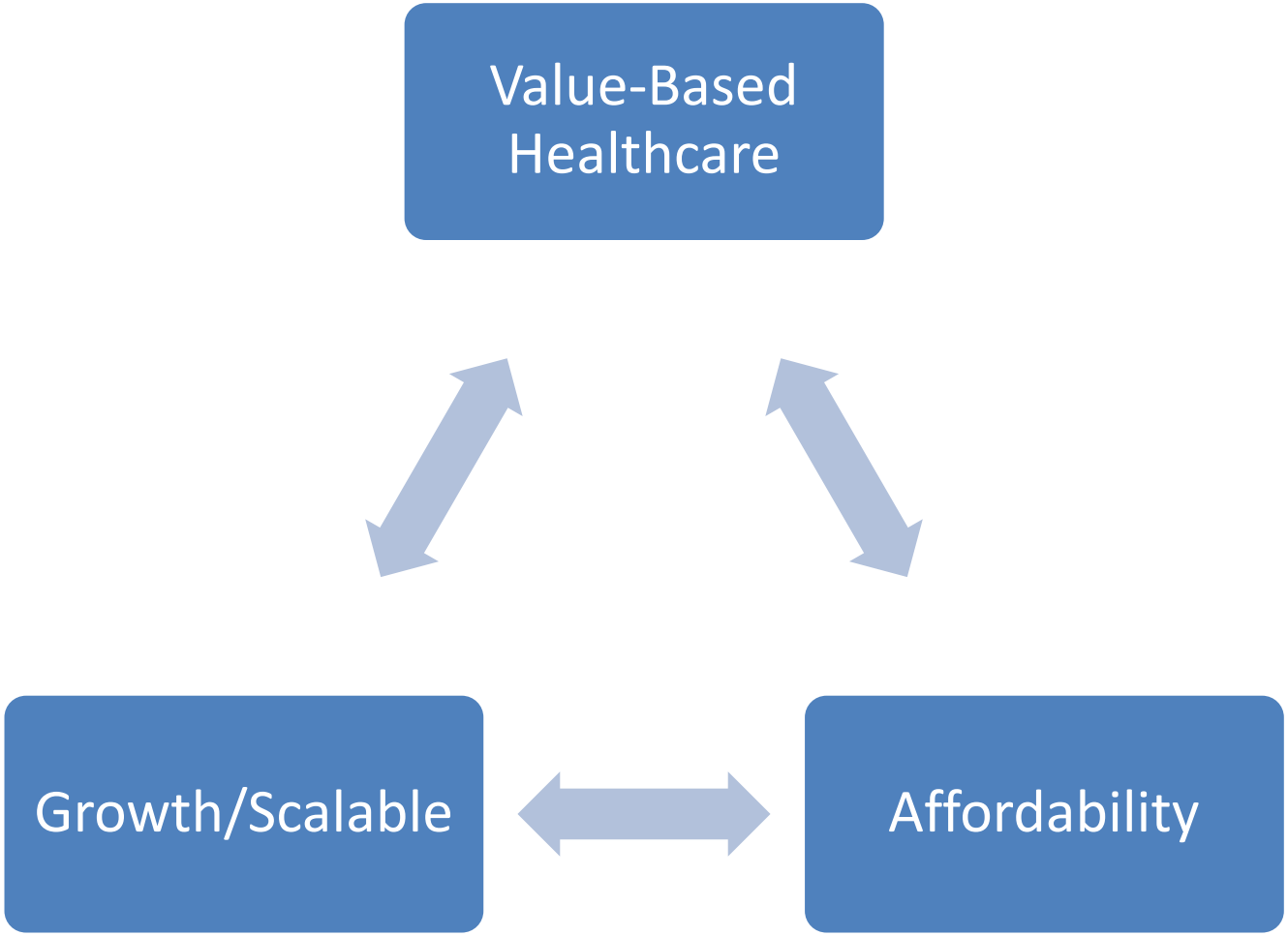
- Focuses attention of all stakeholders on key tenets of compensation structure
- Provides a “lens” through which to ensure compensation structure adheres to mission/vision/values of organization
- Example:
  - Adaptable
  - Equitable
  - Compliant
  - Reasonable
  - Effective
- Outlines policies and procedures with respect to FMV and CR testing
  - What triggers internal review?
  - What is sent out for external review?
  - How do we adjudicate issues to the extent they exist?
  - How often should we perform FMV reviews for all employed physicians?

Compensation Policy

- **Compensation Model Document**
  - Requires a centralized model structure for a sizeable group of physicians
    - *If each agreement is different, this is likely not possible.*
  - Ensures terms are consistent across all physicians/specialties
  - Documents key tenets of compensation structure *outside* of employment agreement
    - *Employment agreement references this document.*
  - Allows for simplicity in model updates
    - *Updating a single document versus multiple physician employment agreements.*
  - Illustrates key components of structure
  - Documents key terms

SUMMARY/REVIEW

Summary/Review



Contact Information

Justin Chamblee, CPA
Senior Vice President
Coker Group Holdings, LLC
T: 678-783-5599
jchamblee@cokergroup.com
linkedin.com/in/justinchamblee
@Justin_Chamblee