HealthTech Management Services
Webinar Series

Designing an Equitable Physician Compensation Plan

Mike Lieb, FACHE
Regional Vice President / Director, Practice Mgt
Mike Lieb, FACHE
Regional Vice President / Director, Practice Management
Mike Lieb serves as a consultant to hospital and physician owned medical practices nationwide. He brings more than 20 years of healthcare experience to his role providing operational and organizational guidance to healthcare organizations.

He has served as CEO in health systems of all types; large community hospitals, public hospital districts, critical access hospitals, and has held senior leadership positions in large academic group practices.

Mike earned a Master’s Degree in Healthcare Administration from Trinity University in San Antonio, and holds a Bachelor’s Degree in Marine Biology from Rice University in Houston. He is a Fellow in the American College of Healthcare Executives, and is a member of the Medical Group Management Association.
HealthTech History

1971
• Company was formed as Brim Healthcare by Gene Brim and his associate, James Williams. The first managed hospital was The Eugene Hospital & Clinic in Eugene, Oregon. Brim Healthcare was one of the first hospital management companies in the US.

1984
• Brim partners with The Hillhaven Corporation, a subsidiary of NME. Within 2 years Brim had 13,119 employees on the books in owned, managed, and leased hospitals.

1995
• Brim Inc. had 59 hospital management contracts, 14 managed retirement facilities, and owned 8 senior living facilities.

1998
• Partnership with Province Healthcare moved the company headquarters from Portland, OR to Brentwood, TN. Dave Woodland soon became CEO.

2009
• HealthTech Solutions Group was established in Plano, TX to develop innovative products and solutions using technology to reduce the costs for community hospitals. Brim Holdings is sold to IASIS Healthcare. Hospital Management and Technology are separated and established as HealthTech and Gaffey Healthcare.

2015
• HealthTech Management Services is relaunched as HealthTech S3 with a focus on strategic hospital management, consulting, technology, and managed services.
HealthTech Management Team

**Derek Morkel, CEO**
More than 20 years of experience in both health care and technology industries. Previously served as Senior Vice President at MedCath Corporation, Operations CFO at IASIS Healthcare, CEO US Operations for Craneware, Hospital CFO at Province Healthcare and Division Director Finance HCA.

**Neil Todhunter, President**
Brings over 37 years of healthcare experience, of which 30+ years were in the capacity of President and CEO of hospitals ranging from 200 to 300 beds, with services including acute care, behavioral health, home care, skilled care and physician practice management.

**Michael Jennesse, CFO**
Certified Public Accountant with over 25 years of experience in health care management and has a deep understanding of business intelligence technology to drive operating improvements. Previously, he served as a Division CFO at IASIS Healthcare, HCA & Hospital CFO at Universal Health.

**Sara Stanton, VP Marketing**
Responsible for marketing and business growth for both new and existing clients. She is a business development leader with over 15 years of experience in healthcare strategy, consulting, data analytics, and patient communications. Sara has worked with large provider organizations, community hospitals, regional health systems, national ASCs and specialty providers, and the largest IDN's in the nation.

**Greg Voss, Regional VP**
Voss has more than 30 years of healthcare administration experience including the past 20 years with HealthTech Management Services (formerly Brim Healthcare), serving as Executive Vice President and CEO at St. Anthony’s Memorial Hospital in Effingham, Illinois.

**Ron Winger, Regional VP**
Winger has more than 35 years healthcare administration experience, serving as president and CEO of four different not-for-profit and for-profit hospitals and health systems, including most recently as president and CEO at the Heart Hospital of New Mexico, a 55-inpatient bed facility in Albuquerque, New Mexico.

**Brian Moyer, EVP / CIO**
Moyer served as President and CEO of NOVAS Technology Group. In the 1990's, Moyer was founder and President of MW Technologies, where he developed and sold the TAMS (Total Asset Management System) product suite into hospitals across the Midwest. He is heavily involved in the health IT community, serving as President of the HIMSS Tennessee Chapter.

**Peter Goodspeed, VP Executive Placement**
Peter Goodspeed is an accomplished healthcare executive recruiter having more than twenty-five years of executive search experience. With his wealth of knowledge, Goodspeed is a proven recruiter when your hospital is searching for a knowledgeable and experienced healthcare professional whether for an interim or permanent engagement.
HealthTech Executive Consultants

Diane Bradley, PhD, RN, NEA-BC, CPHQ, FACHE, FACHCA
Regional Chief Clinical Officer

Carolyn St. Charles, RN, MBA
Regional Chief Clinical Officer

Faith Jones, MSN, RN, NEA-BC
Director of Care Coordination and Lean Consulting

Susan Murphy
Executive Director Supply Chain Resources
Supply Chain Specialist

Joy Smith
Senior Patient Financial Consultant
Revenue Cycle Specialists

Michael Lieb
Regional Vice President / Director Practice Management
Physician Practice Specialist

Julie Haynes
Strategic Planning Consultant
Strategy and Marketing Specialist

Cheri Benander, MSN, RN, CHC, NHCE-C
Director of Compliance Consulting Services

Kevin Stringer
Assistant Vice President
Finance/Hospital Operations Specialist
HealthTech Clients

• HealthTech Management Services (HTMS) – currently provides consulting, turnaround, supply chain management, hospital management, and professional and physician recruitment services to:

  – More than 50 hospitals and health systems nationwide
  – Community Hospitals, Critical Access hospitals, district hospitals, non-profit hospitals
  – Most operate physician clinics
  – Net Revenue between $20M and $200M
  – Business Partner Illinois Critical Access Hospital Network (ICAHN)
  – Preferred vendor with California Critical Access Hospital Network and Texas Organization of Rural and Community Hospitals
HealthTech Client Successes

• With approximately 50 hospital clients across the nation, HTMS is proud to work with people dedicated to service excellence in the healthcare field. Below is just a partial listing of the many awards and recognitions received by our clients.

- 100 Great Community Hospitals
  - Adirondack Health, New York
  - Grant Regional Health Center, Wisconsin
  - Hammond Henry Hospital, Illinois
  - Tomah Memorial Hospital, Wisconsin

- Becker’s Most Wired Hospitals 2015
  - Hammond Henry Hospital, Illinois
  - Sunnyside Community Hospital, Washington

- 50 Rural Hospital CEOs to Know
  - Chandler Ralph, Adirondack Health, New York
  - Nicole Clapp, Grant Regional Health Center, Wisconsin
  - John Gallagher, Sunnyside Community Hospital, Washington
  - Phillip Stuart, Tomah Memorial Hospital, Wisconsin
Future Webinars and Collaboratives

CCM: Capturing Additional Reimbursement from CMS

September 18, 2014

Topic: Part 1: Outpatient CCM through Primary Care Providers
Speaker: Faith Jones
CrossTX
Registration Link: https://global.gotomeeting.com/join/445025485

Operations and Finance: Lean Health Care

October 14, 2014

Topic: Part 1: Lean Program Implementation in Health Care
Speaker: Faith Jones
Registration Link: https://global.gotomeeting.com/join/588008285
Instructions for Today’s Webinar

If you are accessing the audio portion of the webinar by telephone, you must enter the pin provided when you logged in if you would like to ask a question.

If you are accessing the audio portion of the webinar by computer audio controls must be enabled if you would like to ask a question.

You may type any questions or comments you have during the webinar in the question box on your computer.

Please take the time to complete the survey at the conclusion of the webinar.

You may contact Sara Stanton, Vice President for Business Development, after the webinar with questions or comments at Sara.Stanton@HT-Ilc.com
• 615-970-0453 Cell
• 615-309-6053, ext. 7411 Office
Overview

• Trends
• General Principles
• FMV
• Production vs. Salary
• Incentives
• Directorships and More
• Benchmarking Resources
Trends

• Hospitals are rapidly expanding physician employment

More physicians are employed by hospitals in 2013 than 2012. And the solo practitioner continues to disappear.

Between 2012 and 2013, solo practitioners decreased from 21 to 15 percent. During the same period, hospital-employed physicians increased from 20 to 26 percent, while physicians working as non-ownership employees increased from 12 to 15 percent.

Thirty-nine percent of physicians younger than 45 years of age have never worked in private practice.

When asked why they chose hospital employment over private practice, 42 percent reported they did not want to deal with the administrative hassles of owning a practice. Other reasons cited included wanting to “be a doctor not a businessperson” (32 percent), better opportunities in a hospital (28 percent) and not having the money to invest in a medical practice (27 percent).
Trends

• Physicians are reporting broad dissatisfaction with the profession

• According to a 2013 Jackson Healthcare Study 59% of active physicians would not recommend the medical profession to a young person

• 42% of current physician respondents to the JH study reported significant dissatisfaction with the field.
The top three reasons given by those who have left private practice:

1. Overhead costs too high (45 percent)
2. Focus on practice of medicine without administrative hassles (34 percent)
3. Reimbursement cuts (32 percent)
Trends

Satisfied physicians were more likely to be:

- Hospital employees or employees of a physician-owned practice with no ownership stake
- Supported by nurse practitioners or physician assistants
- Practicing concierge medicine
- Working 11 hours per day or less

Dissatisfied physicians were more likely to be:

- Female, younger than 45
- Practicing in internal medicine, primary care, family medicine, emergency medicine, hospitalist/critical care, musculoskeletal specialties or radiology.
- Practice owners, locum tenens physicians or employees of a practice owned by a hospital/health system
- Working 12 or more hours per day
- Not utilizing advanced practitioner support

Jackson Healthcare Research - 2013
General Principles

So, given the movement toward physician employment, to create a stable and durable environment for both the physicians and hospitals, we need to establish a relatively hassle-free and equitable model for long-term alignment between both parties...
General Principles

• Employment contracts *must* be:
  – Easy to understand
  – Attainable
  – Reproducible
  – Consistent
  – Win-Win
  – Evergreen
General Principles

• Easy to understand
  – The terms of any agreement must be readily understood by all parties
  – Use clear language
  – Be transparent and share data with the physicians
  – Provide examples if necessary (particularly important in compensation calculations) – especially if there are withholds or recoupments
General Principles

• Attainable
  – Compensation incentives, in particular, must be attainable. They are meaningless as tools (or as motivators) if there is no realistic way to reach the targets.
  – Goals aren’t goals if they are impossible to reach – they are just wishes...
  – But, they do need to address the desired outcomes (production, citizenship, quality, etc.)
**General Principles**

- Reproducible
  - Metrics for quantifying performance have to be easily calculable and *trusted*.
  - Standard data sources should be used, and not extrapolated from multiple feeds.
  - Contracts should specify the data source and time periods for reporting (include samples if necessary).
  - Agree in writing on the metrics up front.
  - Be fair with staffing and support.
General Principles

• Consistent
  – Make sure that the methodologies for compensation or incentive calculation will continue to be available for the duration of the contract period
    • this is not usually an issue with financial metrics (wRVU’s, collections, etc.). It can be an issue with “softer” metrics (satisfaction, quality, turnaround times, etc.).
  – Use the same formats for all employed physicians
    • Terms can differ, but keep it standardized.
General Principles

• Win-Win
  – Structure the agreements so that, ideally, there is an uncapped (or at least very high) upside for the provider. If he or she “nails it,” then the physician can be suitably rewarded.
  – Remember, if your physicians hit a home run, you will too!
  – Provider contracting is not a zero-sum game.
General Principles

• Evergreen
  – Include auto-renewal clauses so that you minimize the risk of OIG non-compliance.
  – Include comparisons to accepted standards (e.g., median MGMA comp/production for the region, or Merritt-Hawkins benchmarks).
  – Don’t fall into the trap of having to renegotiate every two years or so.
 FMV

• Keep to Fair Market Value standards for specialty and region
  – If purchasing a practice; have an outside, independent, third-party valuator verify the practice value
  – If hiring the physician; compare proposed compensation to widely accepted benchmarking tools (MGMA, Merritt Hawkins, Sullivan Cotter, and others)
Production vs. Salary?

• Two competing approaches:
  – We are in a transition period between volume-based healthcare and value-based healthcare
  – Reimbursement in most healthcare systems is still volume based, but shifting (albeit slowly) toward value-based compensation
    • Paying more now for production
    • Will pay more for quality and performance vs. production later
Production vs. Salary?

• In a volume based system, a production based compensation model still makes the most sense.
  – Encourages efficient practice
  – Improves patient access
  – Builds good operational flow

• However, a scalable model will allow for the transition over time to a value based approach
Production vs. Salary?

• Physician production can be calculated using several methods:
  – Relative Value Units (worked – not total!)
    • Best measure of actual effort
  – Gross Charges
    • Encourages procedures not prevention or value
    • Also makes it tough to adjust pricing without comp effects
  – Net Collections
    • Dependent on CBO
  – Patient encounters
    • Paying the same for BP checks as for level 4 visits
Production vs. Salary?

- **Production 80+%**
  - Quality 10%

- **Production 70%**
  - Quality 20%

- **Base Salary 50%**
  - Quality 30%

*Move from Production to Value over several years by adjusting percentages – Balance with other factors*
Production vs. Salary?

Production Weighted

- Production: 80%
- Quality: 10%
- Practice Mgt: 5%
- Citizenship: 5%

Value Weighted

- Production: 50%
- Quality: 30%
- Practice Mgt: 10%
- Citizenship: 5%

Move from Production to Value over several years by adjusting percentages
Incentives

**Sample Measures**

**Quality:**
- PQRS Measures
- SCIP & Core Measures
- HEDIS / NCQA
- Screening Exam Usage
- Patient Satisfaction

**Citizenship:**
- Community Outreach
- MD Recruitment
- Protocol Development

**Practice Management:**
- EMR Usage
- Timely Dictation
- Denial Management
- Days in A/R

**Many Options!**

80% **Productivity**

10% **Quality**

5% **Practice Mgt**

5% **Citizenship**
Incentives

Production

– “Stair-step” these up as production increases
  • Increase comp per wRVU when certain targets are met.
– Example: Rocky Mountain Area FP (non-OB)
  – Median wRVU’s - 4,460, Median $/wRVU - $39.52
  – Baseline 80% of median or 3,568 @ $39.52 = $141,000
  – Set base salary at $140-$145K with expected target level of 
    median(4,460). Pay salary base + $39.52 for each wRVU 
    above 3,568.
  – Pay $42 per wRVU for each between 4,460 and 5,000
  – Pay $45 per wRVU for each above 5,000
  – Deduct $39.52 for each wRVU below 3,500
Incentives

Production example

• Base Compensation - $145,000 (~80% of median)
• Base Production Floor – 3,562 wRVU’s (~80% of median)
• Actual wRVU’s earned during year (5,250)

<table>
<thead>
<tr>
<th>wRVU's Earned</th>
<th>Rate/wRVU</th>
<th>Compensation</th>
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</thead>
<tbody>
<tr>
<td>Base Compensation</td>
<td></td>
<td>$145,000</td>
</tr>
<tr>
<td>wRVU's between Base (3,562) and Median (4,460)</td>
<td>892</td>
<td>39.52</td>
</tr>
<tr>
<td>wRVU's between Median and 5,000</td>
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<td>42</td>
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<tr>
<td>wRVU's &gt; 5,000</td>
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<td>45</td>
</tr>
<tr>
<td>Total Production Incentive</td>
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<td>$69,182</td>
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</table>

Total Production Compensation $214,182
Incentives

• Quality
  – Just pick two or three that fit the needs of your institution or practice.
    • Too many metrics result in loss of focus and little gain
  – Dollar amounts do not need to be large
    • A few thousand dollars per quality measure is sufficient
    • Pick these jointly with your combined group if possible, and make sure all participants agree on the measures and metrics selected (confirm in writing)
  – Update or replace these as improvements are met
Incentives

• Citizenship
  – This is more nebulous, because it gets to behaviors – so you must agree in advance on metrics
    • Does the physician complete his/her records in a timely fashion?
    • Will he/she support the staff/stay late/cover for one another?
    • Community speaking/marketing efforts?
    • How does the practice perform (high supply/staff costs)?
  – Group allocation of incentive pot
Incentives

“Be careful what you incent,
Because...
that is what you will get.”

- Unknown
Directorships & More

• Medical Directorships are good ways to raise the compensation levels of physicians
  – Must fill a legitimate need
  – Separate agreement from employment contract
  – Clearly specify duties and responsibilities
  – Specify timekeeping requirements – no time sheet, no pay… period.
  – Make sure your directorship rates meet FMV requirements (Use MGMA or Merritt Hawkins)
Directorships & More

• Call Coverage Agreements
  – Before any promise of incremental call pay, make sure you know what your Medical Staff Bylaws require as a condition of Med Staff Membership.
    • Many (if not most) hospitals require some ED coverage as a condition of membership
    • Most Bylaws are unclear with regard to office practice requirements – they were typically written for hospital based services.
  – You do not want to set an expensive precedent!
Directorships & More

• Oversight compensation
  – Many sites will compensate physicians for oversight of mid-level providers
    • Must meet FMV
    • Must report time-keeping
    • Your agreement should specify the requirements for availability and “questionability” to the mid-levels
    • Specify whether (and to what degree) there is any requirement to cover for their absences/when they need physical presence/assistance
Directorships & More

• Sign On Bonuses
  – You can do these as a recruitment tool for new (to the area) physicians
  – Not recommended (and often not legal) for physicians already in local practice
  – Compare to regional benchmarks

• Relocation Expenses
  – Same caveats as above
  – If used, then set a cap on expenses
Benchmarking Resources

• HealthTech Management Services
  www.htmsinc.com
  – Contracting Modeling
  – Governance Models
  – Clinic/Practice Assessments

• Medical Group Management Assn. (MGMA)
  www.mgma.com

• Merritt Hawkins
  www.merritthawkins.com
Benchmarking Resources

• One Final Thought!

Always have your own healthcare attorney review any proposed contract before offering it to your physicians!!!
Thank You!

Designing an Equitable Physician Compensation Plan

September 2, 2015

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