PROVIDER TOTAL REMUNERATION & CONTRACTS: A CHANGING ENVIRONMENT

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Today's Agenda

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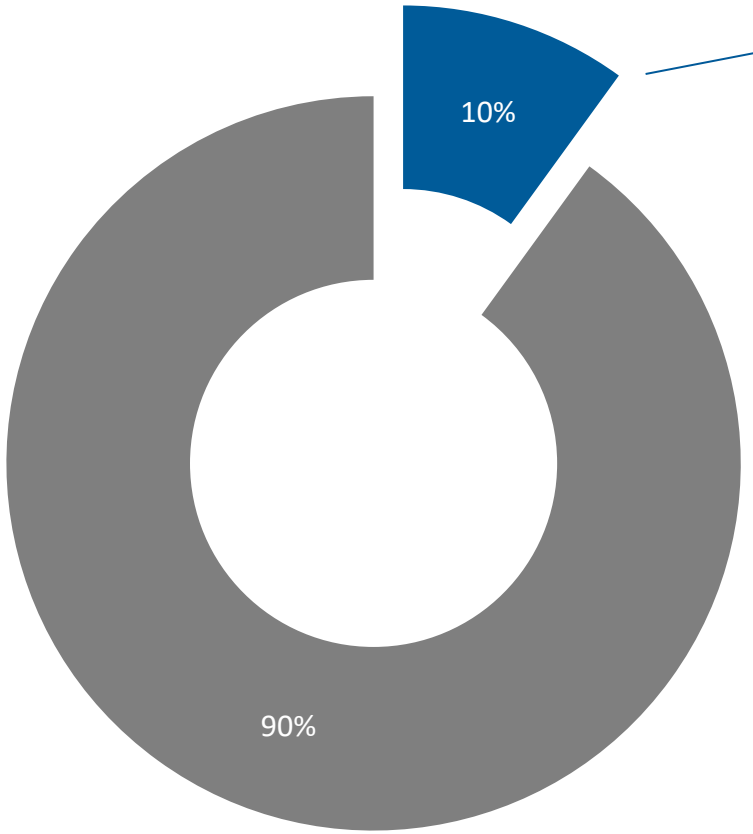
- Physician Compensation: Complex and Heavily Regulated
- 2021 CMS and COVID-19 Impacts
- Call to Action

PHYSICIAN COMPENSATION: COMPLEX AND HEAVILY REGULATED

Why Do Provider Contracts Matter?



Physician expenditures equal 5-10% of the average hospital's net patient service revenue ("NPSR") and are projected to grow at 5.4% annually[1]

Further, Salaries & Wages and Employee Benefits typically represent the #1 and #2 highest Operating Expenses, respectively[2]

1. National Health Expenditure Projections, 2018–27: Economic And Demographic Trends Drive Spending And Enrollment Growth." Health Affairs, February 20, 2019
2. Stroudwater

Stark Requirements – The Big 3

FAIR MARKET VALUE ("FMV")

COMMERCIALLY REASONABLE

VOLUME/VALUE

The Cost of Compensation Compliance

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Home > Anti Kickback > Wheeling Hospital Agrees to Pay $50 Million to Settle Stark Law, AKS Allegations

Wheeling Hospital Agrees to Pay $50 Million to Settle Stark Law, AKS Allegations

By Thomas Sullivan — Last Updated Nov 1, 2020

ANTI KICKBACK DOJ

Texas-Based Heart Hospital Agrees To $48 Million Settlement For Alleged Violations Of Anti-Kickback Statutes

by Peter Briccetti — January 7, 2021 in Corporate, False Claims-Qui Tam, News, SEC

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Reading Time: 3min read

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE — Thursday, August 2, 2018

Detroit Area Hospital System to Pay $84.5 Million to Settle False Claims Act Allegations Arising From Improper Payments to Referring Physicians

Fort Myers clinic to pay $1.6 million to settle kickback allegations

by Erin O'Brien — 11:29 AM EST, Tue February 02, 2021 AA

BECKER'S HOSPITAL REVIEW

Tennessee hospital to pay $4.1M to resolve false claims allegations

February 2020

The Cost of Compensation Compliance

- How do organizations end up in the hot seat?

Most commonly, a departing employee, especially a physician or CFO, acts as a “whistleblower”

A competitor or another hospital (particularly if that hospital was trying to recruit a physician and another hospital was successful) acts as a “whistleblower”

Patient complaints

Unusual billing patterns triggering an audit that expands to review compensation

Physician Compensation: Factors to Consider

- Hospital considerations when determining FMV for physician services include:

Specialty/subspecialty

Duties & responsibilities

Community need

(e.g., deficits, wait times, closed specialties, high disease incidence, outmigration, seasonality)

Community benefit

(e.g., new specialty or service)

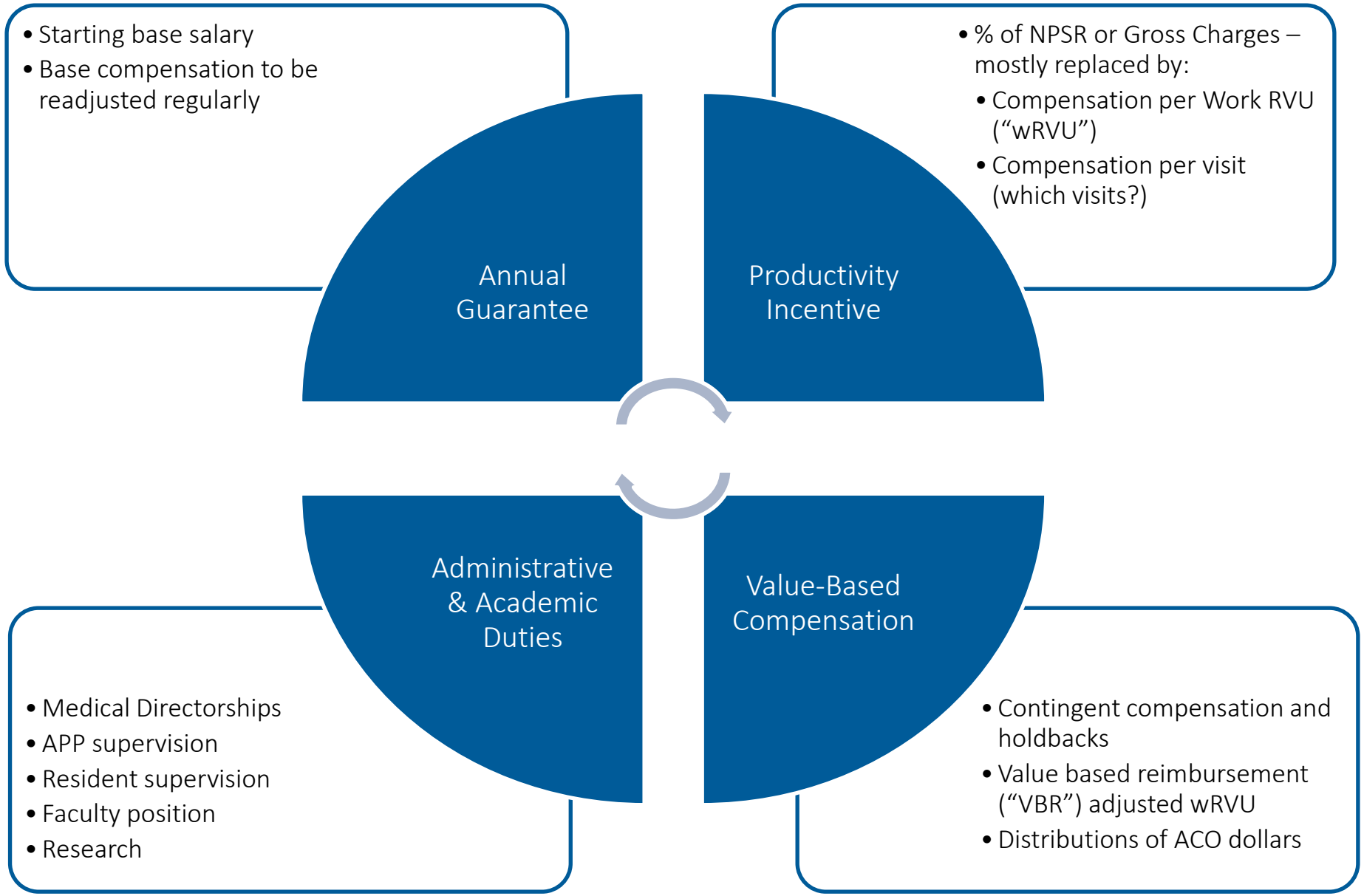
Time it takes to recruit

Training & experience

Compensation methodology & amount

(including cash and in-kind compensation)

Types of Compensation Models



More than Just "Compensation"

- Benefits have a cash or in-kind value, and are an increasingly important part of a provider's total compensation
- The table right distinguishes between what industry professionals typically categorize as "cash compensation" (or Medicare gross wages) vs. "benefits"
- Cost of employer-sponsored benefits is typically 10-20% of cash compensation for physicians, depending upon specialty
  - As a result, employee benefits are often the second highest Operating Expense next to Salaries & Wages

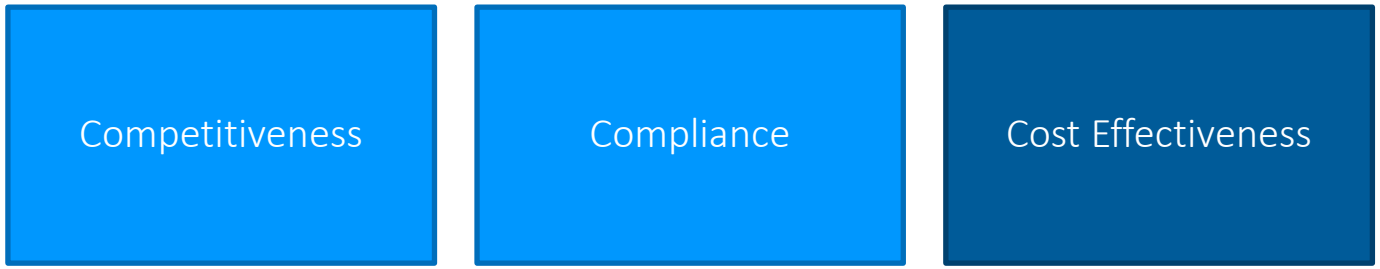
"Cash Compensation" What FMV opinions typically review	"Benefits" What FMV opinions should also consider
Base Salary	Health Insurance
Singing Bonus	Retirement Contributions
Extension Bonus	Continuing Education
Productivity Compensation	Dental Insurance
Quality Incentive Compensation	Disability Insurance
Medical Directorship	Employer-Paid Leave Premiums
Management of APPs	Life Insurance
Relocation Stipend	Licensure Fees
Housing Stipend	HSA and HRA Contributions
Tuition Repayment	Employer-Paid "Voluntary" Benefits
Other "Cash" Compensation	Other "In Kind" Compensation

CAUTION:

- FMV opinions often only consider "cash" compensation (or Medicare gross wages) and may overlook issues of stackable compensation and benefits (cash or in-kind)
- An organization's approach to compensation strategy and compliance must consider benefits

Assessing Total Remuneration

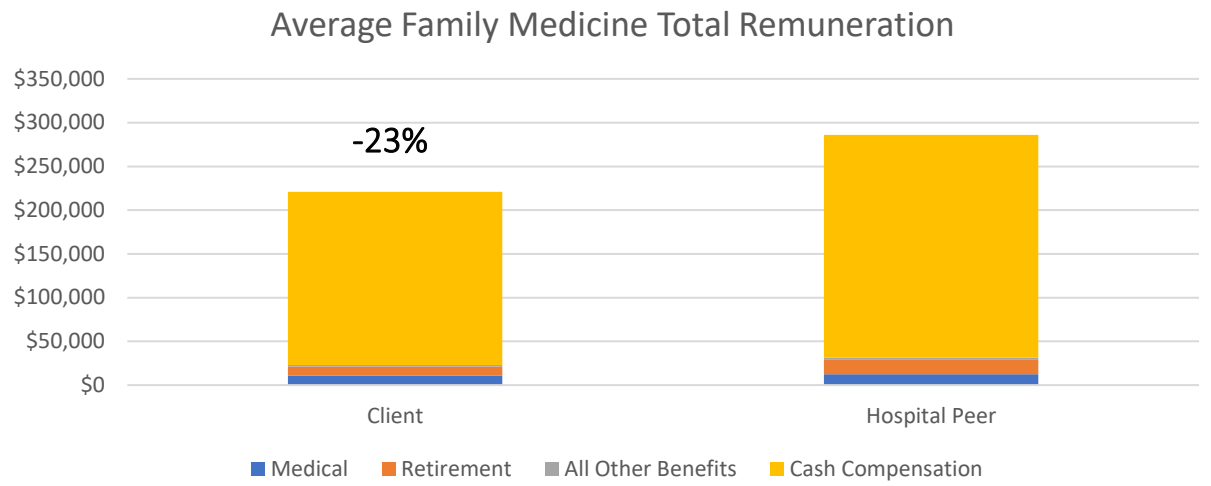
- Organizations should review their total remuneration offerings annually through the following lenses:

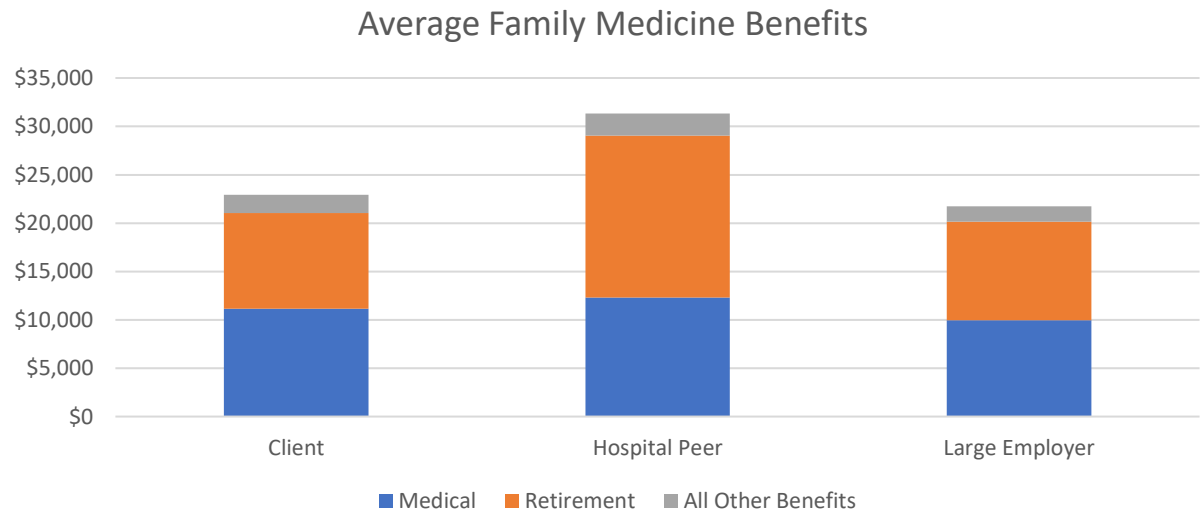


- A competitive lens is especially useful when considering the organizations total remuneration strategy as it relates to physician remuneration and recruitment
- Benchmarking against industry- and regional-specific peers/competitors answers the following questions:
  - What are my peers/competitors doing/offering?
  - Where does my organization's total remuneration fall relative to peers/competitors? Am I above or below the median?
    - If I am below the median, can I feasibly improve my offering to enhance my recruitment and retention objectives?
    - If I am above the median, when considering the total remuneration offered, is my provider remuneration within FMV and commercially reasonable?
- Organizations must be able to objectively quantify the employer-paid and employee value

Client Example: Evaluation of Total Remuneration

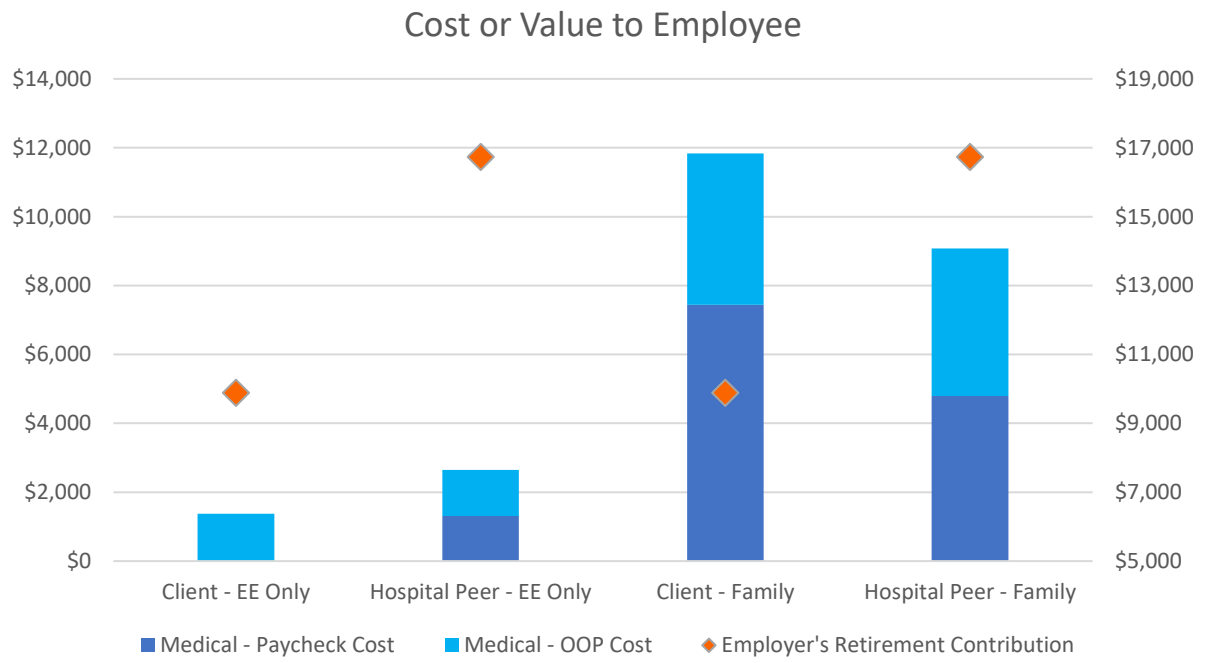
- This case study reflects de-identified data from a Stroudwater engagement with a hospital system that owns numerous physician practices
- The client engaged Stroudwater to develop their compensation strategy, among other elements of practice improvement, for their various physician practices
- We compared the client's average compensation and benefits for Family Medicine physicians relative to industry ("Hospital Peer") and regional, all industry benchmarks ("Large Employer")
- The client's total remuneration (compensation plus benefits) is 23% below the Hospital Peer median benchmark, driven by compensation (which is below the 25th percentile) and less generous benefits
  - The client's employer-sponsored cost for the benefits program is more in line with regional employers (in any industry) than Hospital Peers





Client Example: Evaluation of Total Remuneration, cont.

- The previous slide considered the employer's costs
  - Employees view benefit programs differently
  - Generally, they consider the paycheck cost of the program, as well as the value (plan design), in addition to the employer's retirement contribution
- The exhibit at right illustrates an average Family Medicine physician's total out-of-pocket plus paycheck costs for their health insurance program ("Medical"; often ranked as one of the most important benefits to employees) and the employer's retirement contribution, relative to peers
- In both cases (single or family coverage), the physician's benefit program would be more generous under the Hospital Peer benchmark
  - In a recruitment situation, where all else is equivalent or competitive amongst two potential employers, a physician may be inclined to choose the employer with the more competitive benefits package



Assumptions:

- Employee ("EE") Only means that the physician is covering himself/herself only under the health insurance plan
- Family means that the physician is covering his/her spouse and child(ren) under the health insurance plan
- Assumes minimal costs for all other benefits (e.g., dental) and is excluded from the analysis
- OOP costs are determined based on an analysis of Actuarial Values and total plan costs

2021 CMS AND COVID-19 IMPACTS

2021 CMS wRVU Changes

- On December 2nd, 2020, CMS published the final rule for the 2021 Physician Fee Schedule
- Changes are made annually to address revised CPT codes and corresponding wRVUs
- Most significantly, CMS overhauled the office and outpatient evaluation and management ("E&M") codes 99201-99205 (new patients) and 99211 – 99215 (established patients)
  - These have not been changed significantly since 2007
  - Changes were intended to address the ongoing documentation burden on physicians and the undervaluation of time and effort involved in these services
    - Revises the times and medical decision-making process for all the codes and requires performance of history and exam only as medically appropriate
    - Allows clinicians to choose the E&M visit level based on either medical decision making or time
- The 99201 code was eliminated, which historically has been used primarily for nurse visits

Overall Impact: CMS Utilization

- When examined from a utilization perspective, the average weighted impact is an increase of 35.8% of wRVUs for the most utilized new and established patient clinic codes

CMS-1734-F_Calculation of volume-weighted average of increase to Office Outpatient E/M visits - FR 2021

HCPCS Code	2020 Work RVU	2021 Work RVU	RVU Difference	Utilization (2019)	Weight	Weighted Avg
99202	0.93	0.93	0.00	2,670,872	0.011	0.000
99203	1.42	1.60	0.18	11,349,523	0.046	0.008
99204	2.43	2.60	0.17	10,602,766	0.043	0.007
99205	3.17	3.50	0.33	2,897,019	0.012	0.004
99211	0.18	0.18	0.00	2,660,415	0.011	0.000
99212	0.48	0.70	0.22	10,678,725	0.043	0.009
99213	0.97	1.30	0.33	91,601,723	0.369	0.122
99214	1.50	1.92	0.42	105,752,974	0.426	0.179
99215	2.11	2.80	0.69	10,321,248	0.042	0.029
Total				**248,535,265**	**1.000**	**0.358**

Impact Across Specialties

- Based on MGMA's DataDive Procedural Profile, the increases in total wRVUs vary based on specialty[1]

Specialty	% Change in Total wRVUs
Urgent Care	24.4%
Family Medicine (w/o OB)	19.3%
Hematology/Oncology	17.4%
Internal Medicine: General	17.4%
Pediatrics: General	13.5%
Cardiology: Noninvasive	8.4%
Orthopedic Surgery: General	6.3%
OB/GYN: General	3.9%
Gastroenterology	3.8%
Surgery: General	3.0%

1. Gallagher/Integrated Healthcare Strategies

2021 CMS Reimbursement Changes

- On December 2nd, 2020, CMS published the final rule for the 2021 Physician Fee Schedule
- Originally, changes were subject to budget neutrality adjustment to account for changes in RVUs – conversion factor was set at $32.41, a decrease of $3.83 from the CY 2020 PFS conversion factor of $36.09
  - After significant lobbying and feedback from physicians, under the Consolidated Appropriations Act, the conversion factor was set to $34.89 for 2021, which provided a 3.75% increase

CPT Code	Medicare Reimbursement (2020 FS)	Medicare Reimbursement (2021 FS)	% Change from 2020
99201	$27.07	n/a	n/a
99202	$51.61	$46.02	-11%
99203	$77.23	$78.43	2%
99204	$132.09	$128.34	-3%
99205	$172.51	$174.36	1%

Client Example: PSA Arrangement

- Below is an example of a Professional Services Arrangement ("PSA") between a hospital system and a highly productive six provider internal and family medicine primary care group
- With expected wRVU changes, the practice would have a 22.1% increase in wRVUs, costing the healthcare system almost $1.3M in increased compensation without any contract changes

	2020	2021 Projection	Proposed	Break Even	Amended Contract
wRVU	59,798	72,994	72,994	72,994	72,994
PSA Rate	$98.35	$98.35	$80.00	$88.89	$85.00
Total wRVU Payments	5,881,147	7,178,984	5,839,540	6,488,147	6,204,511
Expeted Revenue Increase (Hospital)		607,000	607,000	607,000	607,000
Impact to Hospital		(690,837)	648,607	0	283,636
		-11.7%	11.0%	0.0%	4.8%
Impact to Practice		1,297,837	(41,607)	607,000	323,364
		22.1%	-0.7%	10.3%	5.5%

"New" Stark Rules

- Most impactful for health systems and hospitals: Direct Referral Safe Harbor
  - Addresses organizations concerned with "leakage"
  - Allows organizations to make compensation contingent upon achieving a percentage of "in-network" referrals
  - However, compensation still must be within FMV
  - Permits organizations to reduce a provider's fixed salary in future years if not met
- Doesn't apply if:
  - Patient expresses a different preference
  - Patient's insurer determines a different provider, practitioner or supplier
  - Referral is not in the patient's best medical interests
- Facilitates the transition from a fee-for-service ("FFS") dominated payment system to one based on value
  - An important component of physician-alignment is compensation tied to organizational goals
- Organizations must continue to use caution in how the formula is established
  - Recommend creating a bonus pool where the pool is funding is based on the volume/value of referrals
  - Cannot interfere with patient choice

CMS has now EXPRESSLY said you cannot rely on SURVEY SAYS!

Impact of COVID-19 Compensation

- Stark blanket waivers permitted organizations to:
  - Provide compensation above or below FMV
    - Including office space or equipment rentals
  - Remove incidental payment and non-monetary compensation caps
  - Provide free services (e.g., childcare, clothing, meals, etc.)
  - Adopt arrangements prior to writing and signature
- While the regulatory burden has been lessened, many organizations faced significant financial losses and had to make difficult choices
  - Sampling of outcomes:
    - 72% of physicians experienced a reduction in income[1]
    - Reductions and suspensions to physician and other employee retirement and CME[2]
    - As of June 2020, 266 hospitals had furloughed employees[3]
  - Some organizations expanded access to low-cost support like mental health services; however, what will our providers remember?

1. 2020-Survey-of-Americas-Physicians_Exec-Summary.pdf (physiciansfoundation.org)
2. PRESS RELEASE | Annual results from SullivanCotter's Physician Compensation and Productivity Survey | SullivanCotter
3. 266 hospitals furloughing workers in response to COVID-19 (beckershospitalreview.com)

COVID-19's Impact on Physician Wellbeing & Burnout

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58%
of physicians often have feelings of burnout, up from 40% in 2018[1]

18%
of physicians have increased their use of drugs and alcohol as a result of COVID's impact on their employment situation[1]

37%
of physicians would like to retire in the next year[2]

30%
of administrators have lost one or more physicians[3]

1. The Physicians Foundation 2020 Physician Survey: Part 2 | The Physicians Foundation
2. 2020-Survey-of-Americas-Physicians_Exec-Summary.pdf (physiciansfoundation.org)
3. COVID-19 is exacerbating physician retention and burnout. Here are some tips to address it | FierceHealthcare

Physician Engagement & Alignment Is Waning

69%
of physicians are actively disengaged[1]

83%
of physicians reported their employer had no physician retention program as compared to 30% of administrators[1]

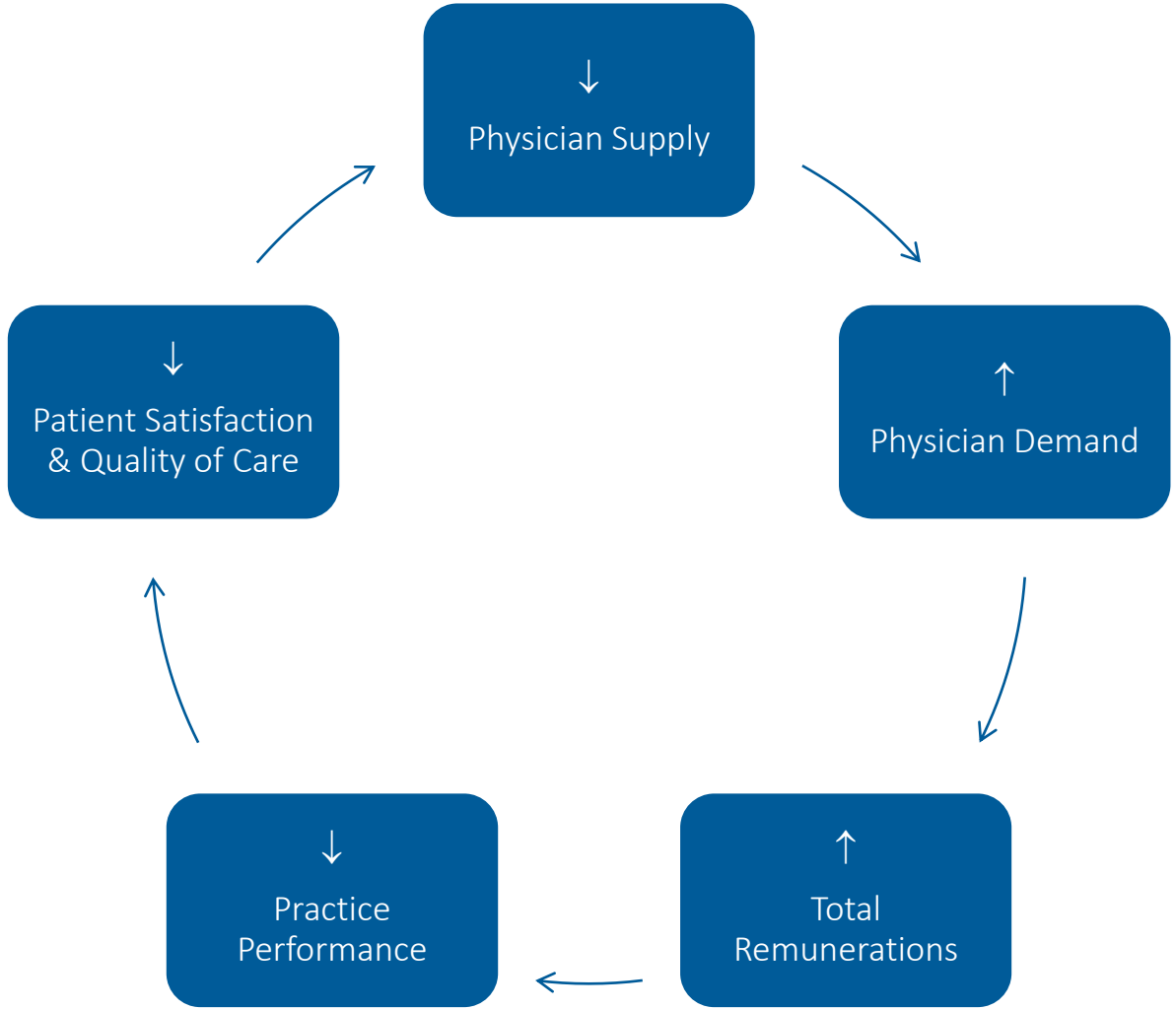
32% & 29%
of physicians indicate lack of respect and insufficient compensation/ reimbursement is a primary reason for burnout[2]

41% & 55%
of employed physicians do not understand the operational metrics to achieve VBR goals and do not understand the impact to compensation, respectively[3]

1. COVID-19 is exacerbating physician retention and burnout. Here are some tips to address it | FierceHealthcare
2. Medscape National Physician Burnout & Suicide Report 2020: The Generational Divide
3. Physician employment in the COVID-19 era | McKinsey

Impacts of Disengagement & Burnout

- If burnout and succession planning are not managed, we can expect the following short-term impacts:
  - Reduction in physician supply as physicians exit the workforce
  - Increase in physician demand as organizations compete for a smaller pool of candidates
  - More competitive recruitment environment
  - New (and increased) standard for total remuneration and compensation
  - Reduction to practice financial and operational performance (temporary or sustained)
  - Reduction in patient satisfaction and quality of care



CALL TO ACTION

How Might Organizations Respond?

Short-Term

- "Status quo"
  - Continue under the 2020 PFS for wRVU calculations
  - Continue under the 2020 PFS for a partial year (most commonly through June 2021)
- Make changes
  - Adopt 2021 PFS
  - Adjust productivity incentives and/or wRVU thresholds

Planning for the Future

- Examine CMS PFS and COVID-19 impacts under the context of a larger total remuneration and physician recruitment/development plan
- Key considerations:
  - Does your organization have a:
    - Total remuneration & compensation strategy?
    - Provider retention, recruitment & development plan?
  - What type of protective language is in your contracts?
  - What will you do when faced with future CMS changes?
  - How do you engage providers around compensation now?
  - Are you aligned with your providers?

The Transition to Value-Based Reimbursement

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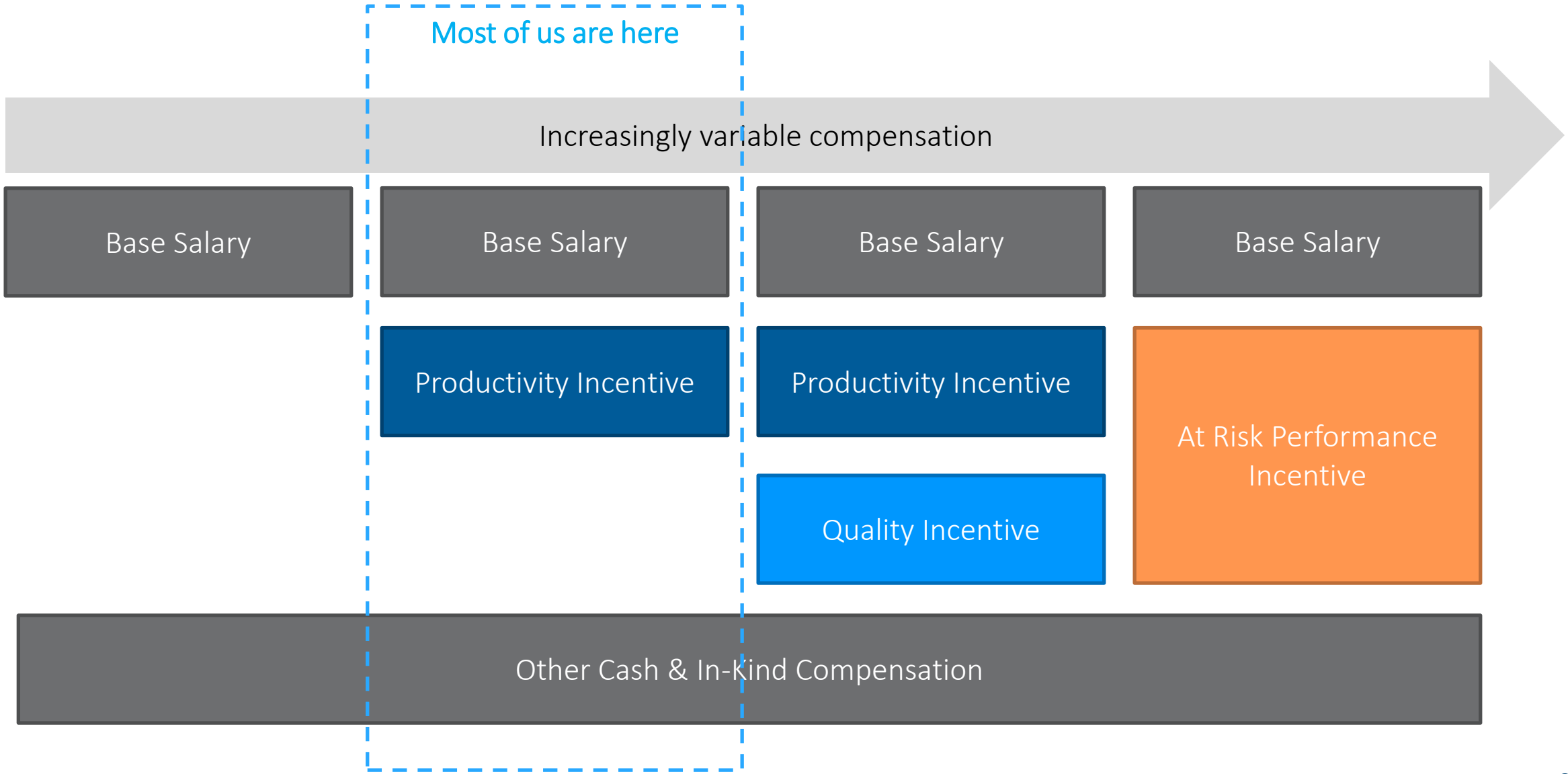
- Value-Based Reimbursement ("VBR") will have a direct impact on how we compensate physicians and APPs
- Where is your organization on its transition to value?
- Where is your organization in its compensation model?
- What do physicians in your area expect?

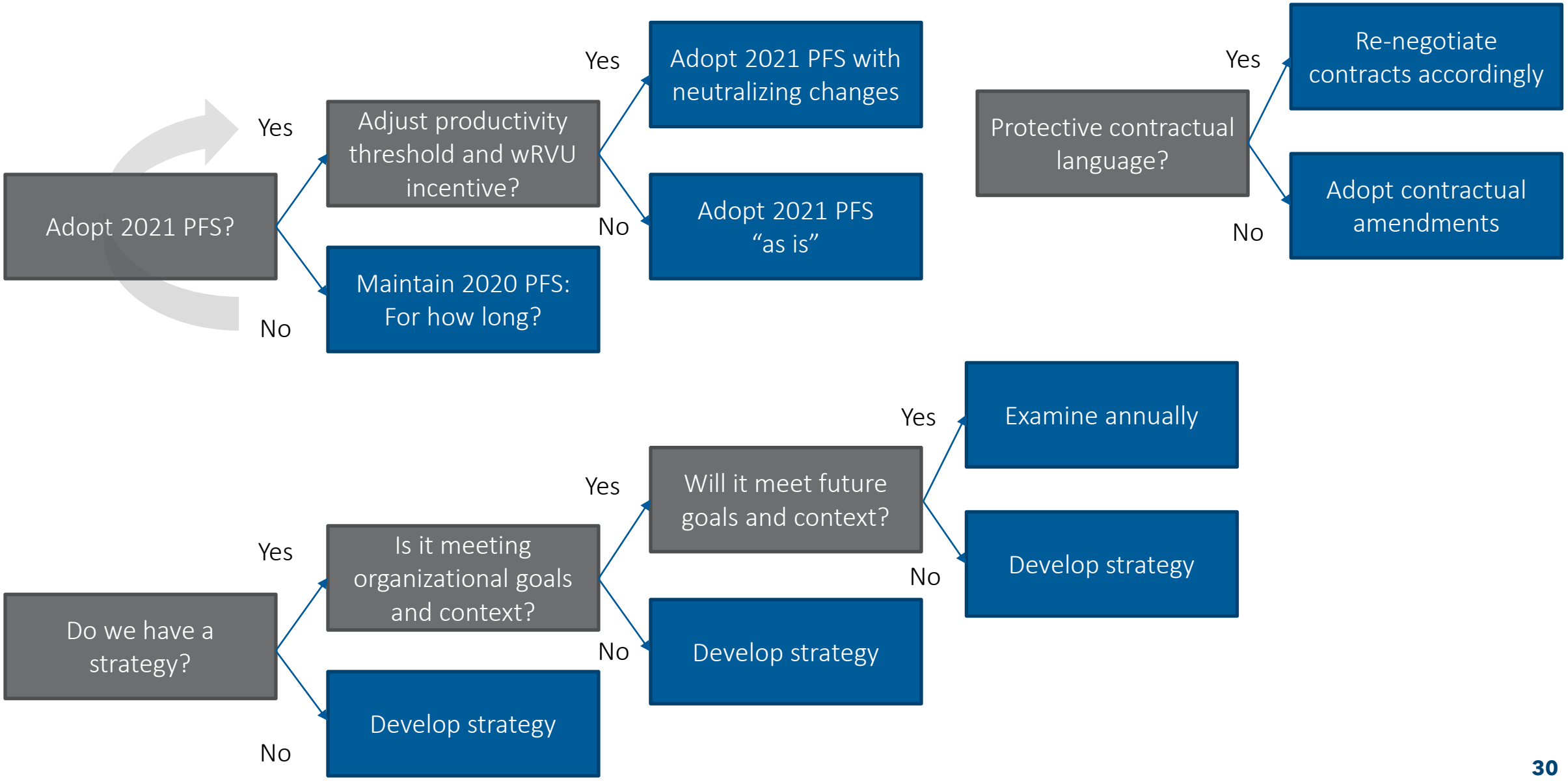
Transition of Compensation Scheme



Contract Compliance Is Good Hygiene

- Consistent documentation
- Guardrails for the outliers
- Identification of high-risk contracts
- Contract audit policy in place and practiced

Next Steps


Adopt 2021 PFS?
Yes
Adjust productivity threshold and wRVU incentive?
Yes
Adopt 2021 PFS with neutralizing changes
No
Adopt 2021 PFS "as is"
No
Maintain 2020 PFS: For how long?
Protective contractual language?
Yes
Re-negotiate contracts accordingly
No
Adopt contractual amendments
Do we have a strategy?
Yes
Is it meeting organizational goals and context?
Yes
Will it meet future goals and context?
Yes
Examine annually
No
Develop strategy
No
Develop strategy
No
Develop strategy

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