Current Trends and Topics in Provider Compensation Compliance

HEALTH CARE COMPLIANCE ASSOCIATION

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Speakers

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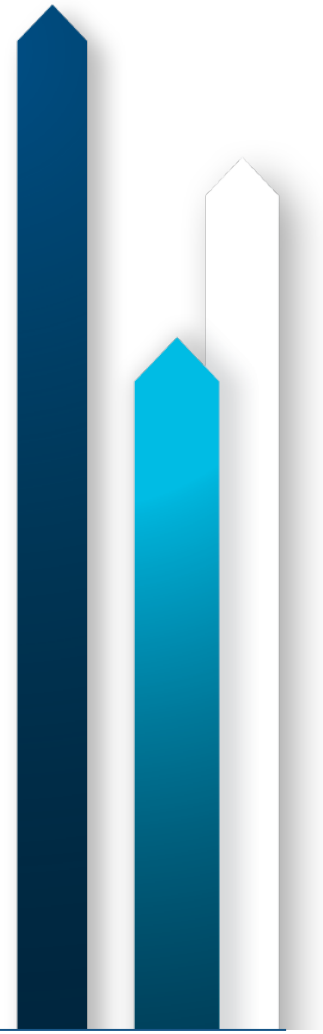
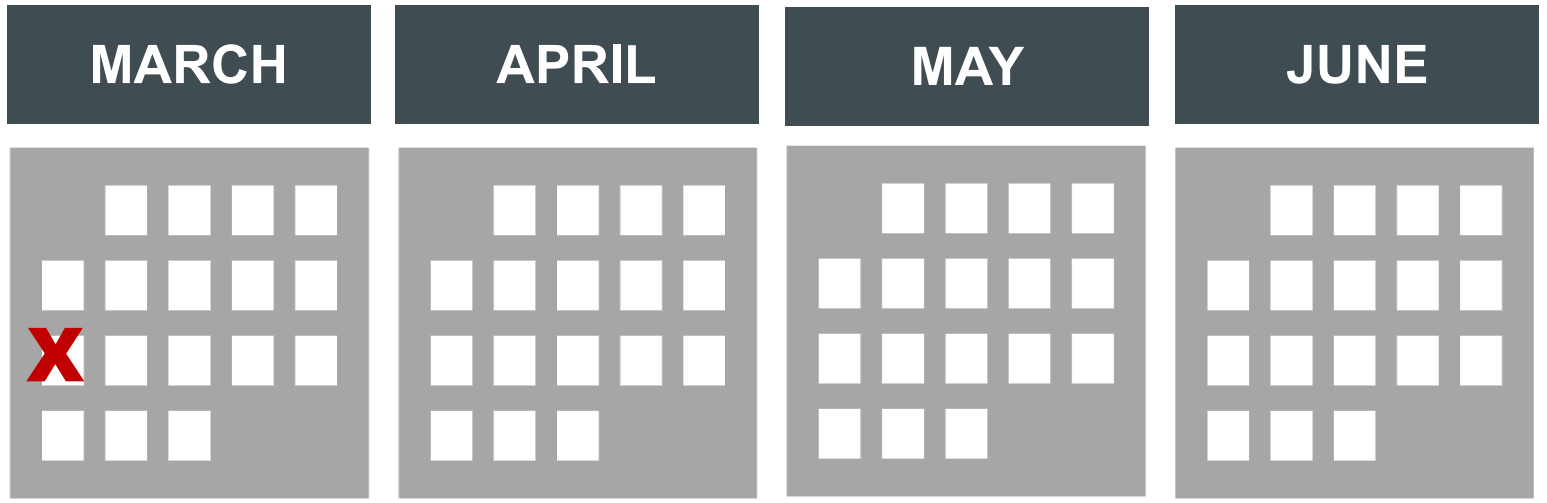
Agenda

- COVID-19 Impact On Benchmark Data
- Telemedicine Compensation
- 2022 Medicare Physician Fee Schedule
- Future Compensation Models
- Key Enforcement Activities Involving Provider Compensation
- APP Supervision Compensation



COVID-19 Impact on Benchmark Data

Timeline

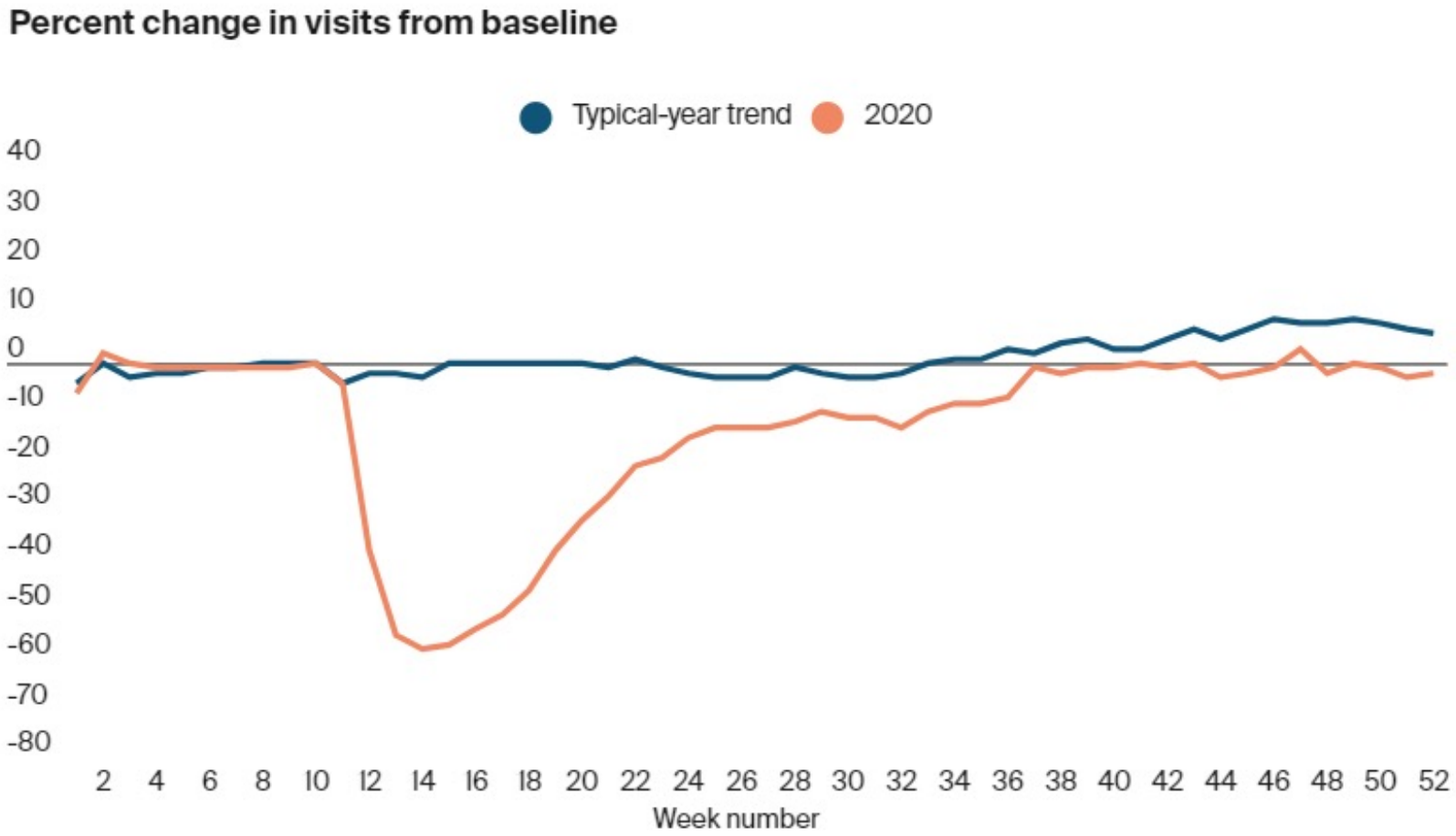


Mid-March
U.S. begins to shut down

Mid-March through May
Moratorium on elective procedures

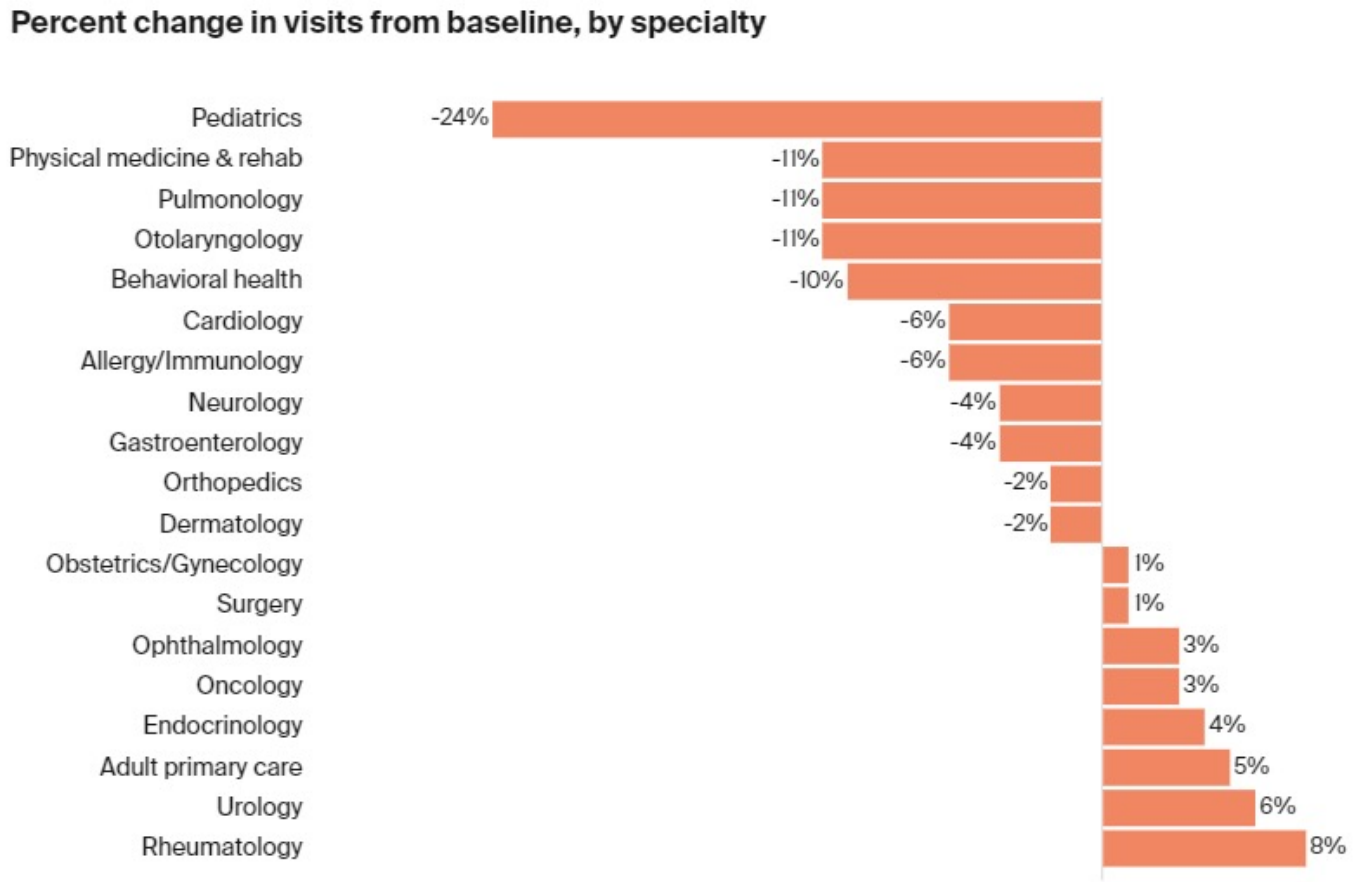
June
Operations begin to open up

Patient Volume During COVID-19[1]



1) https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge.

Patient Volume During COVID-19 (*cont.*)[1]



Data from the last three full weeks of 2020 compared to pre COVID-19 numbers (Baseline: March 1 – 7).

1) https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge.

COVID-19 Impact on Benchmark Data

- Benchmark Data Based on Prior Years
- 2020 vs 2021
- COVID Impact
  - Physician Compensation
  - wRVUs/Encounters

COVID-19 Impact on Benchmark Data

- COVID Impact (continued)
  - Compensation per wRVU
  - Collections
  - Trending

COVID-19 Impact on Benchmark Data

Table 1 - Physician Median Compensation Trend

Median Physician National Total Compensation Survey Data					
Description	**2017[1]**	**2020[1]**	**2021[1]**	**CAGR 2020**	**CAGR 2021**
Family Medicine	$237,356	$260,552	$262,238	3.16%	2.52%
Internal Medicine	$250,676	$272,498	$268,156	2.82%	1.70%
Pediatrics	$232,137	$243,366	$244,903	1.59%	1.35%
Urgent Care	$255,859	$274,333	$273,936	2.35%	1.72%
General Surgery	$402,101	$433,669	$416,329	2.55%	0.87%
Orthopedic Surgery	$576,037	$617,585	$616,948	2.35%	1.73%
Average				**2.47%**	**1.65%**

[1] Based on the average of median benchmark data reported by the MGMA DataDive *Provider Compensation Survey*, AMGA *Medical Group Compensation and Productivity Survey*, and SullivanCotter *Physician Compensation and Productivity Survey*.

COVID-19 Impact on Benchmark Data

Table 2 - Physician Median wRVU Trend

Median Physician National Total Compensation Survey Data					
Description	**2017[1]**	**2020[1]**	**2021[1]**	**CAGR 2020**	**CAGR 2021**
Family Medicine	4,909	4,959	4,451	0.34%	-2.42%
Internal Medicine	4,771	4,845	4,338	0.51%	-2.35%
Pediatrics	5,193	5,149	4,442	-0.28%	-3.83%
Urgent Care	4,782	4,839	3,945	0.40%	-4.70%
General Surgery	6,597	6,726	6,012	0.65%	-2.29%
Orthopedic Surgery	8,050	8,481	7,531	1.75%	-1.65%
Average				**0.56%**	**-2.87%**

[1] Based on the average of median benchmark data reported by the MGMA DataDive *Provider Compensation Survey*, AMGA *Medical Group Compensation and Productivity Survey*, and SullivanCotter *Physician Compensation and Productivity Survey*.

COVID-19 Impact on Benchmark Data

Table 3 - Physician Median Compensation per wRVU Trend

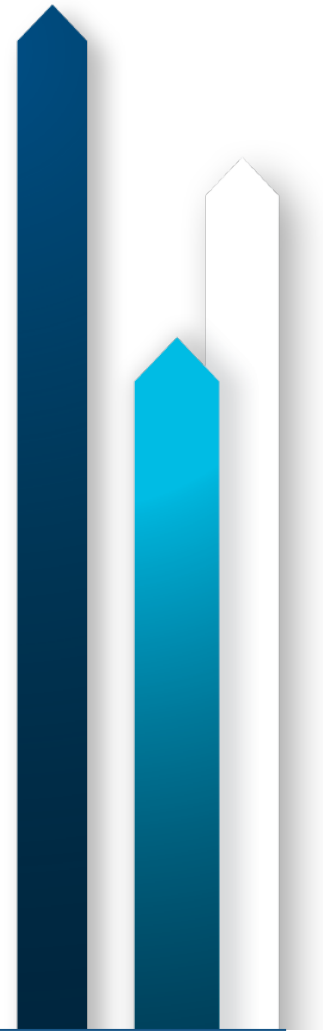
Median Physician National Total Compensation Survey Data					
Description	**2017[1]**	**2020[1]**	**2021[1]**	**CAGR 2020**	**CAGR 2021**
Family Medicine	$49.37	$52.21	$59.55	1.88%	4.80%
Internal Medicine	$53.41	$56.01	$62.71	1.60%	4.09%
Pediatrics	$46.23	$48.89	$56.26	1.88%	5.03%
Urgent Care	$54.28	$58.34	$70.09	2.43%	6.60%
General Surgery	$62.78	$66.33	$72.94	1.85%	3.82%
Orthopedic Surgery	$73.67	$75.64	$83.11	0.88%	3.06%
Average				**1.75%**	**4.57%**

[1] Based on the average of median benchmark data reported by the MGMA DataDive *Provider Compensation Survey*, AMGA *Medical Group Compensation and Productivity Survey*, and SullivanCotter *Physician Compensation and Productivity Survey*.

Telemedicine Compensation

Telemedicine Compensation – Background

- Pandemic spurred exponential growth
- Can be used in all settings – general clinical (i.e., the provider is 100% tele-based), call coverage, and in "downtime" (i.e., telemedicine coverage during hospitalist coverage hour)
- Growth called into question how the related compensation should be valued – is the service rendered different than in person services?

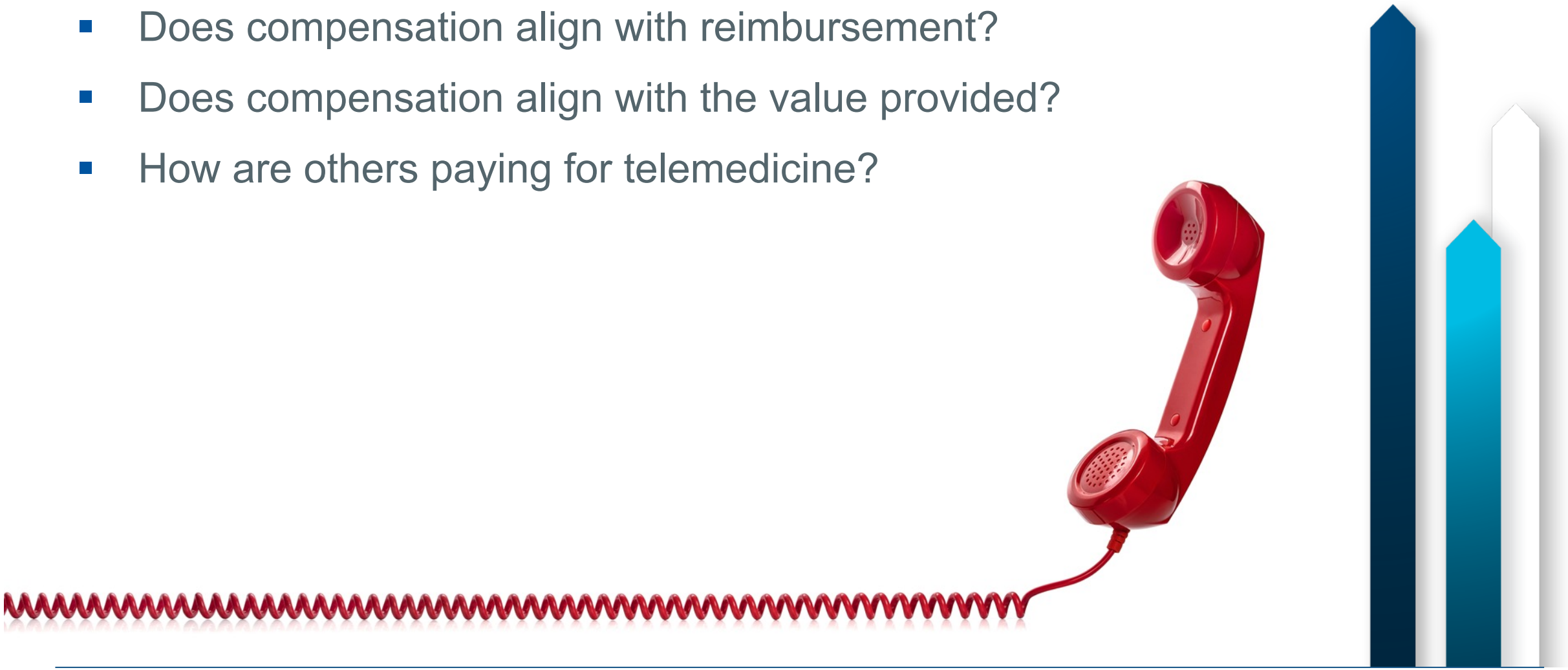


Valuation Considerations for Telemedicine Compensation – Employed Provider

- What telemedicine services are you offering?
- Does the organization offer telemedicine services to only patients or to other healthcare organizations as well?
- Are telehealth visits an expectation of receiving an annual salary?
- Are you staffing a dedicated telehealth program?

Valuation Considerations for Telemedicine Compensation – Employed Provider

- Does compensation align with reimbursement?
- Does compensation align with the value provided?
- How are others paying for telemedicine?



Valuation Considerations for Telemedicine Compensation – Independent Provider

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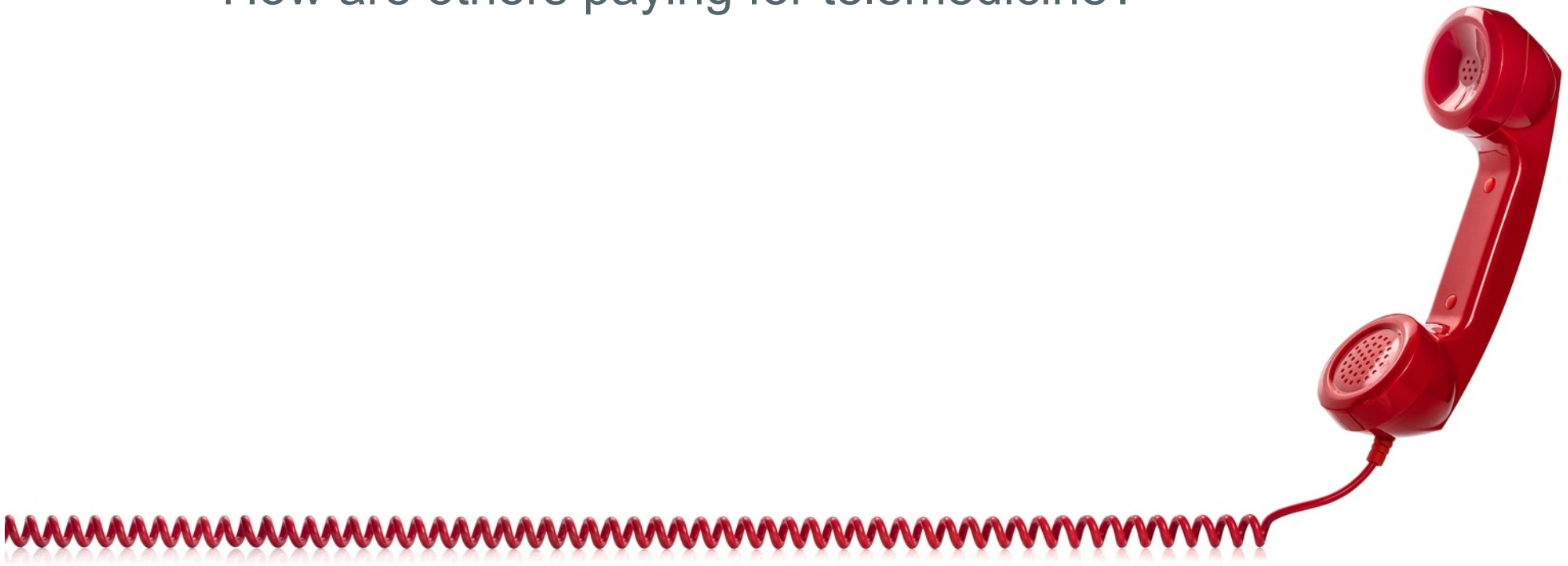
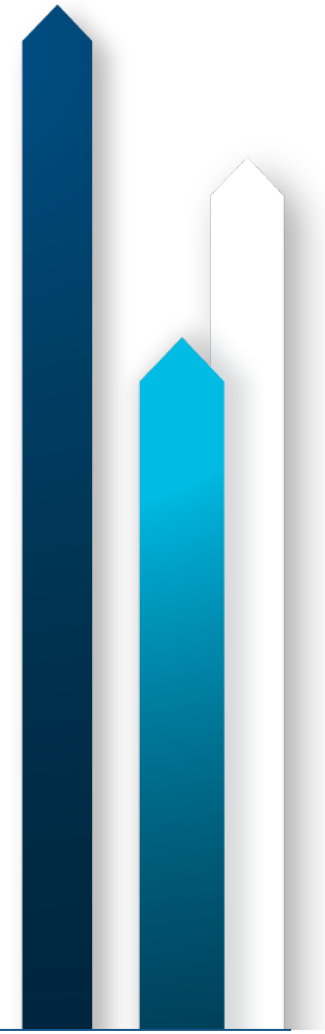


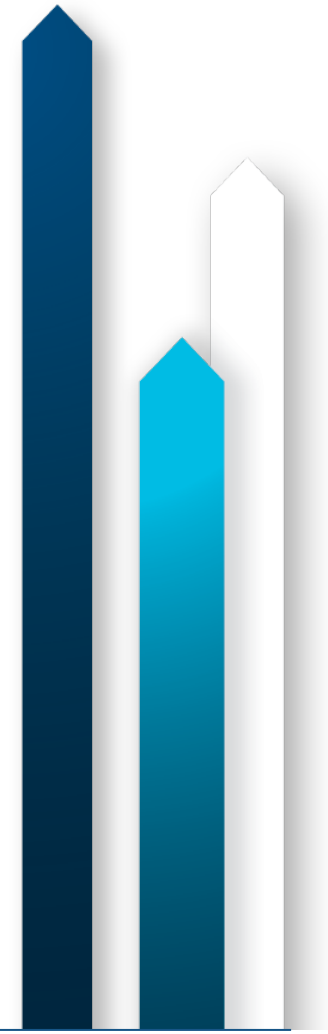
Telemedicine Compensation - Other

- How much do you charge a consumer?
- How much do I charge another health system?
- How do I value hospital-based services (ICU, Radiology, Stroke Coverage)



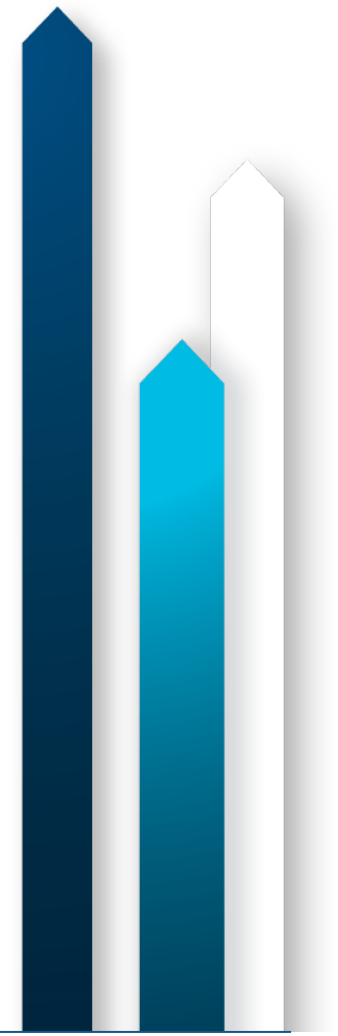
Telemedicine Compensation – Compliance Best Practices

- Document the provider's responsibilities around telemedicine – when, where, who, how, why
- Document the time commitment (burden and intensity of telemedicine service) and expertise required
- Is any "double-dip" accounted for correctly?
- Document the commercial reasonableness of the arrangement. Does the telemedicine service accomplish a legitimate and realistic business purpose that furthers the healthcare entity's strategic and financial goals?



Telemedicine Compensation – Compliance Best Practices

- Identify clearly what any payment is for (compensation, equipment, management fee, etc.)
- Understand and document any State requirements
- Understand licensing and credentialing of telemedicine providers
- Review telemedicine arrangements at least annually

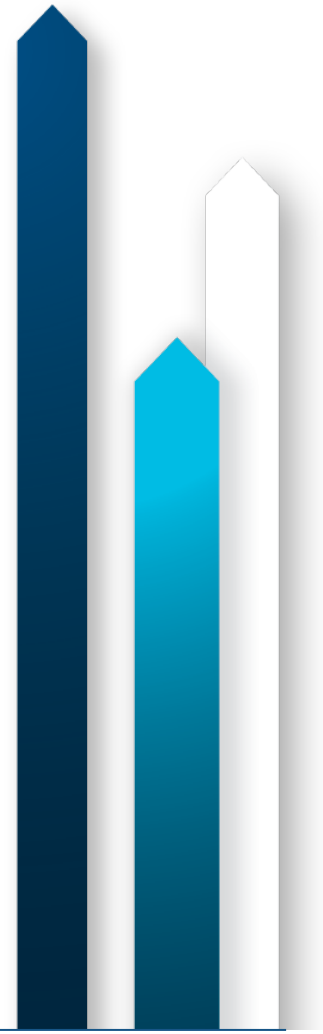


2022 Medicare Physician Fee Schedule

2022 Medicare Physician Fee Schedule Final Rule

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) published the 2022 Medicare Physician Fee Schedule Final Rule

- Conversion factor
- New telehealth services
- E/M changes (split/shared billing, critical care, teaching physicians)
- Billing for PA services
- Increased reimbursement for care management services
- Quality Payment Program updates



Conversion Factor

- A bit of history –
  - 2019 to 2020: $.05 increase ($36.04 to $36.09)
  - 2020 to 2021 (Final Rule): $3.68 reduction ($36.09 to $32.31) = 10.2% reduction
  - 2020 to 2021 (CAA revision): $1.20 reduction ($36.09 to $34.89) = 3.33% reduction
- CY2022 – $34.61
  - Statutory update of zero percent
  - Adjustment necessary to account for changes in RVUs and expenditures resulting from finalized policies
- Practice expense adjustments
  - Standard rate-setting refinements
  - Market-based supply and equipment pricing update
  - Clinical labor pricing update

Medicare Physician Fee Schedule

Moving from 2020, to 2021, to 2022

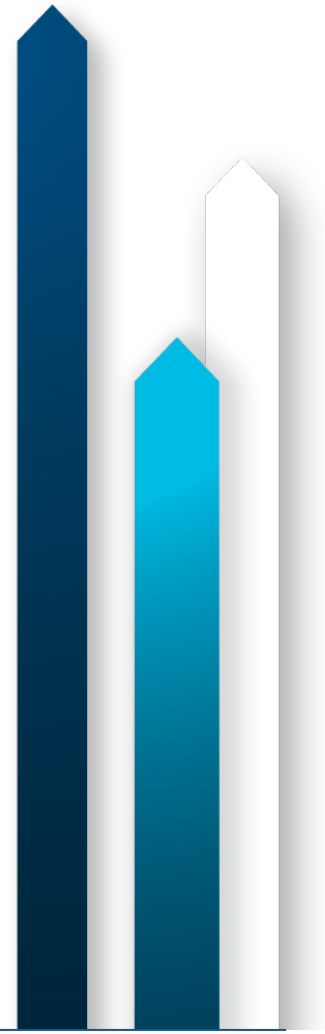
- wRVU increases and reimbursement disconnects
- Compensation model issues

Specialty	Weighted Average Proposed Rule Impact	
	"Per Unit" Medicare Reimbursement	"Per Unit" Work RVU
Orthopedic Surgery	-10.34%	-1.60%
Interventional Radiology	-9.79%	0.00%
Ophthalmology	-7.89%	0.40%
Diagnostic Radiology	-7.71%	0.00%
General Surgery	-6.21%	3.61%
Gastroenterology	-6.20%	3.95%
Cardiology	-1.39%	8.96%
OB/GYN	-0.16%	9.73%
Internal Medicine	0.54%	11.70%
Urology	0.81%	8.81%
Neurology	2.67%	14.44%
Psychiatry	3.35%	14.57%
Family Practice	7.06%	20.55%

Future Compensation Models

Looking Into The Future: Physician Compensation

- COVID-19 has reminded us that no industry is untouchable. We need to consider the future and how to structure physician compensation models to withstand the next disruption.
- Historically, physician contracts make up roughly 5% to 10% of average hospital net patient revenue. In addition, the projected annual growth of physician contracts is 5.4%.[1]
- The use of value/quality-based payment incentives continues to increase, 64% in 2020.[2]



1) https://www.beckershospitalreviewcom/hospital-physician-relationships/the-future-of-physician-compensation-in-a-changing-regulatory-landscape-4-things-to-know.htm.l

2) Merritt Hawkins 2020 Review of Physician and Advanced Practitioner Recruiting Incentives and the Impact of COVID-19.

Looking Into The Future: Physician Compensation (*cont.*)

- **Physician compensation from the hospital/healthcare system perspective:**
  - Fear of a future pandemic will likely impact the structure of future physician compensation arrangements.
  - Hospital leadership should evaluate physician agreements and consider the liability of guaranteed physician compensation for certain specialties.
  - Negotiate with physicians to include contract clauses that will allow financial flexibility for future pandemics/national disasters.

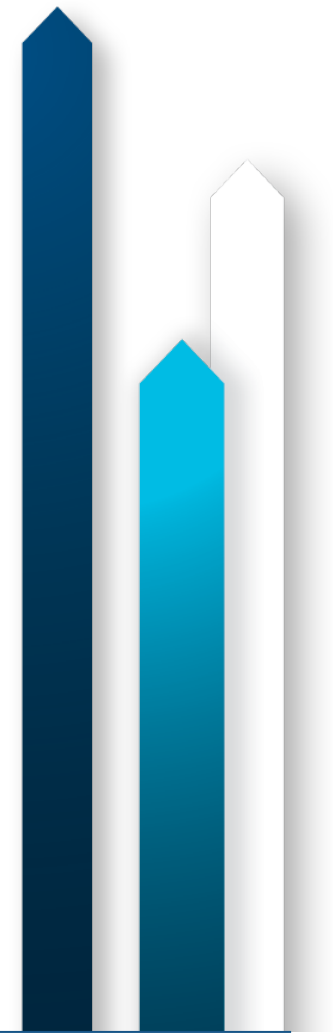
Looking Into The Future: Physician Compensation (*cont.*)

- **Physician compensation from the physician perspective:**
  - Negotiate guaranteed base compensation (if not already included in the current agreement).
  - Limit the amount of “at-risk” compensation associated with the level of production (wRVUs) if you are risk adverse.
  - If engaged in a fee for service type compensation model, negotiate to add clauses in the agreement which will protect you from a future shutdown (e.g., reasonable guaranteed base compensation).

Quality/Value-Based Compensation Models

Quality/Value Based Compensation Models (*cont.*)

- Keeping physicians who are burned out and who may have received a pay cut during COVID-19 can be a challenge.
- Changing from a productivity-based compensation model to a value-based compensation model can increase physician satisfaction and reduce burnout.
- Identify results that are desired and work with the physician to develop metrics to measure the results.
- Quality metrics must be tangible, take effort to achieve, and can be tracked.



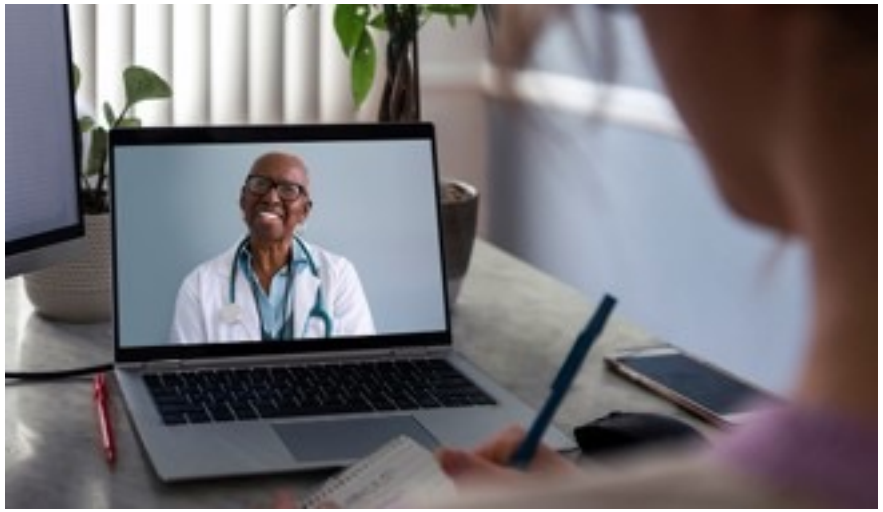
Updates on Key Enforcement Items

Remuneration Inconsistent with Fair Market Value, Free Services and Space

- April 30, 2021: OIG settlement arising from self-disclosure
- Hospitals agreed to pay $20.9 Million for violating the Civil Monetary Penalties Law
  - Payment above FMV
  - Remuneration in the form of free services and office space
- From April 1 – September 30, 2021, OIG self-disclosure cases accounted for $41.2 M in HHS receivables

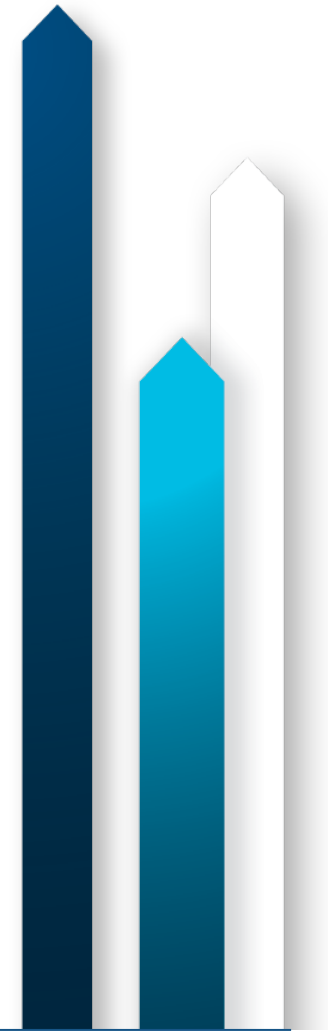
Predictions for Enforcement in 2022

- COVID-19 Relief Funds
- COVID-19 Waivers and Expiration of the PHE
- Telehealth



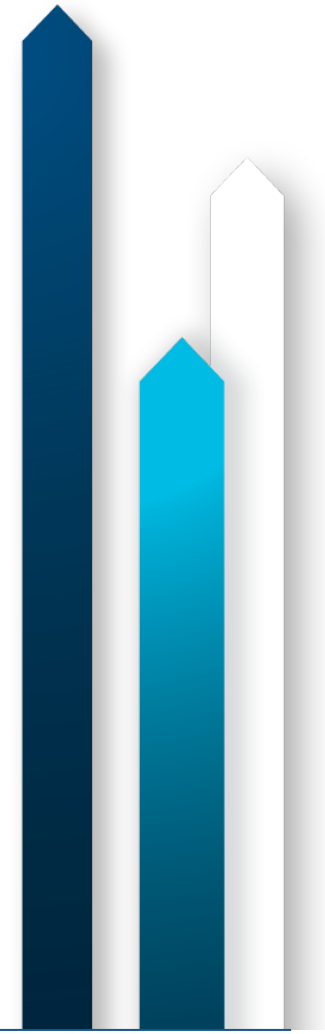
Group Practice – Profits from DHS

On November 19, 2020, CMS and DHS issued a final rule modernizing the Stark Law. Many of the revisions to the Stark regulations became effective January 19, 2021; however, revisions to the physician group practice regulations became effective January 1, 2022.



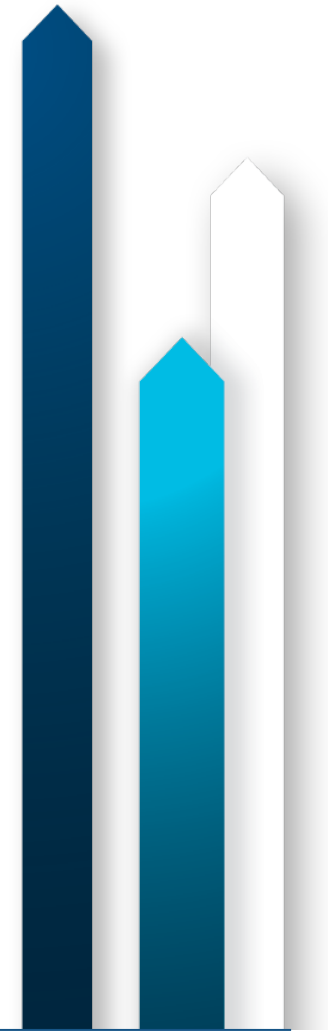
Group Practice – Profits from DHS

- A physician participating in a group practice is prohibited from sharing in the profits of DHS based on the number of DHS patient encounters (“the volume”) or the DHS revenues (“the value”) the provider is individually responsible for generating to the group practice.
- Existing profit distributions might be prohibited under the revised standards.
- The basic premise from CMS is to discourage inappropriate utilization of DHS just for the economic benefit of group practice physicians.



Group Practice – Profits from DHS

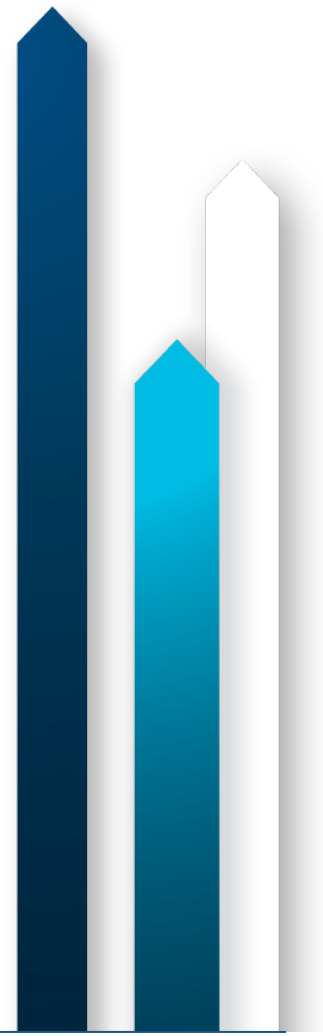
- Specifically, CMS defined “overall profits” to mean “the profits derived from all the designated health services.” The revision continues by stating, “furthermore the profits from all the designated health services of any component of the group that consists of at least five physicians must be aggregated before distribution.”
- Group practices may utilize eligibility standards as a gate (such as length of time in the practice, an owner, an employee, or if full-time or part-time) to determine if a physician is eligible for a profit share.



APP Supervision Compensation

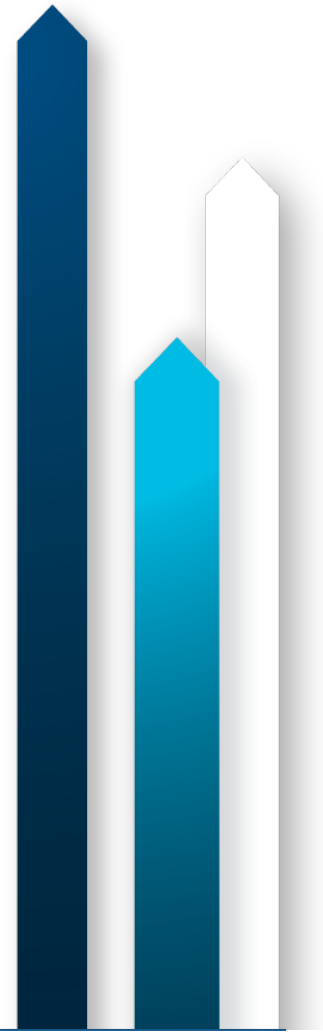
APP Supervision Compensation – Background

- Quick expansion of APP utilization at a substantial cost to employers
- Utilization of APP varies (i.e., personally-performed, incident-to, and split shared)
- Insurance payer reimbursement guidelines and government regulation have complicated the determination of who is doing what between the APP and physician
- 2022 MPFS implementation will change productivity attribution for APPs in the inpatient setting



APP Supervision Compensation – Compliance Best Practices

- Know who is doing what, where, and when
- Physician compensation should be for physician services provided by the physician
- If physicians are paid on a productivity basis, understand how the productivity will be attributed between physician and APP
- If supervision stipends are utilized, compensate reasonably and consistently
- Understand the commercial reasonableness of the physician-APP team



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