Trending Topics in Provider Compensation

2022 HCAA Spring Conference

June 23, 2022

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Agenda

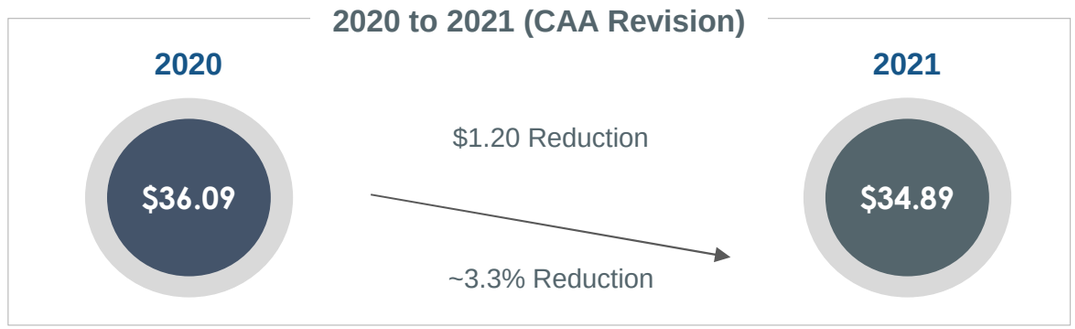
1. 2021 (and 2022) Medicare Physician Fee Schedule
2. Value-Based Compensation
3. Advanced Practice Providers
4. Group Practice – Profits from DHS
5. Future of Physician Compensation

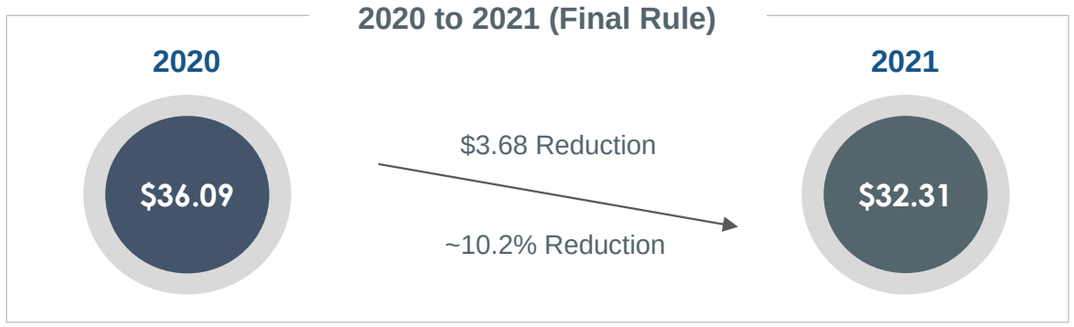
The 2021 (and 2022) Medicare Physician Fee Schedule (MPFS)

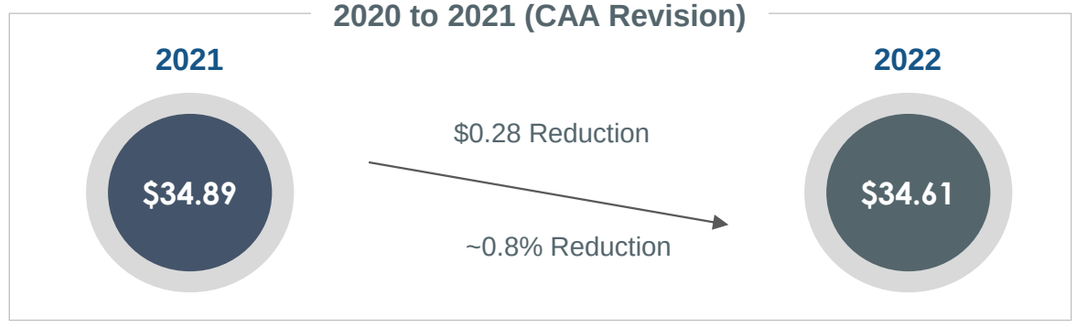
2022 MPFS Final Rule

- On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) published the 2022 Medicare Physician Fee Schedule Final Rule
- **Items of Interest**
  - 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 History







Key MPFS Updates Impacting Fair Market Value

- **Hospital-Employed Side**
  - With an increase in wRVU values, physicians on a compensation per wRVU productivity model may earn more compensation, and employers may have less income/greater losses absent any mitigating changes to physician compensation agreements.
  - Without any physician compensation adjustments, physicians who primarily bill E/M codes, and who are on a wRVU productivity model with a wRVU threshold, may meet that threshold faster, thus earning additional compensation for which they were ineligible historically.
- **Private Practice Side**
  - Depending on the physician specialty and type of services being provided at the private practice, certain providers could see a significant reduction in Medicare reimbursement, due to the reduction in reimbursement through the MPFS.
  - Private practice physician compensation is typically tied to collections or encounters, and not wRVUs. As such, physicians are less likely to earn additional compensation from the MPFS changes compared to physicians who are functioning in a compensation per wRVU compensation model.

Key MPFS Updates Impacting Fair Market Value

- The full impact of these changes may not be seen in physician compensation and productivity benchmark data for several years and may be difficult to pinpoint with the simultaneous impact of COVID-19.
- Using 2021 physician compensation benchmark survey data (based on 2020 responses) without adjustment or consideration of the MPFS impact in 2021 or 2022 (if implemented) may lead to compensation that is above fair market value.

Additional Highlights

- In the 2022 MPFS Final Rule (Final Rule), CMS announced new rules for split/shared visits in the facility setting.
- For 2022, such visits may be billed under the National Provider Identifier (NPI) of the physician or non-physician practitioner (NPP) who either:
  - Documents the support for the history, exam, or medical decision-making for the visit; or
  - Provides more than 50% of the service time.
- For 2023, split/shared visits must be billed under the NPI of the individual who provides more than 50% of total visit time.

Value-Based Compensation

What Are the Key Definitions Associated with the Value-Based Exceptions?

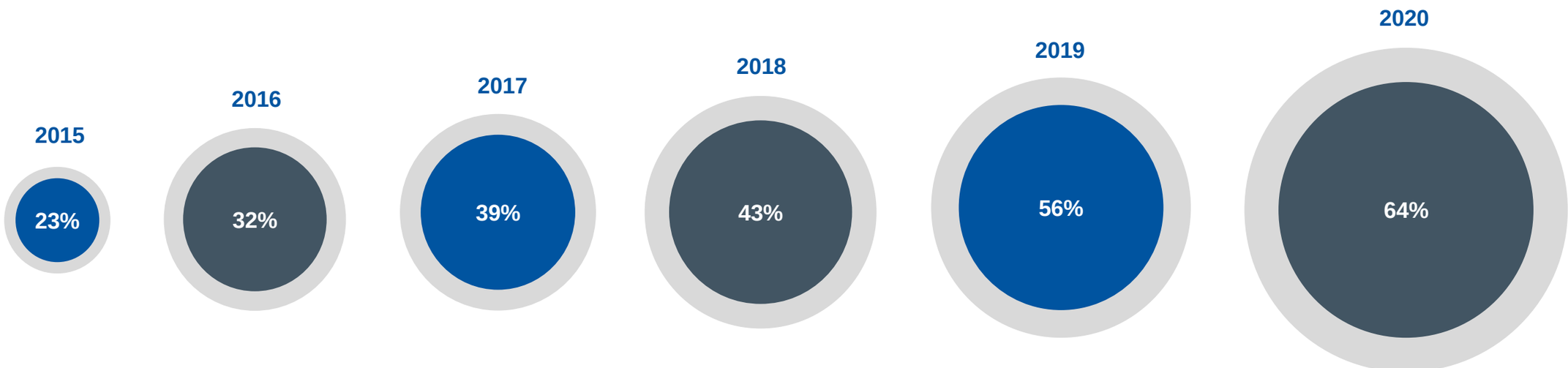
- **Value-based enterprise (VBE):** Includes 2+ VBE participants, accountable person/entity over finance and operations, has governance document
- **Value-based purpose:** Coordination/ management of care, improving quality of care, reducing costs, transition from volume to value, excludes making a referral
- **Value-based activity:** Provision of service/ item, taking of action, not taking of an action
- **Target patient population:** Identified patient population, selected by VBE using legitimate and verifiable outcomes, set in advance in writing
- **Value-based arrangement:** Provides at least one value-based activity, must be for a target population, between a VBE and VBE population

What Are the Valued-Based Exceptions?

- In January 2021, CMS finalized three new value-based care exceptions specific to the Stark Law:
  - **Full financial risk exception:** Applies to VBE participants where the VBE accepts full financial risk for the cost of all patient care items and services covered in their target patient population for a specified period of time.
  - **Meaningful downside financial risk exception:** Protects value-based arrangements where physicians are at risk for at least 10% of the total value of the remuneration the physician receives under the value-based arrangement.
  - **Value-based arrangements exception:** Applies to value-based arrangements, regardless of the level of risk undertaken by the VBE or VBE participants. This exception does not require physicians or other entities to accept any financial risk.

Quality/Value-Based Compensation Models

- A growing number of physician arrangements are focused on encouraging and incentivizing physicians to provide “quality” care.
- The use of value/quality-based payment incentives in production bonuses is on the rise.[1]



1) Merritt Hawkins 2015 – 2019 Review of Physician and Advanced Practitioner Recruiting Incentives and Merritt Hawkins 2020 Review of Physician and Advanced Practitioner Recruiting Incentives and the Impact of COVID-19

Advanced Practice Providers (APPs)

Personally-Performed Services

- Under the 2022 MPFS, CMS provided some clarity regarding personally-performed services.
  - CMS expressed concerns related to compensation for certain services that were provided by APPs.
  - Examples of situations in which a physician may be paid for work not personally performed:
    - Services billed incident-to;
    - A split/shared service where services are not fully performed by the physician; or
    - Services billed globally such that some services performed by the physician and by the APP.
- Based on these changes, physicians may see a change in compensation structure.
- Compensating a physician for services that were not personally performed could create a commercial reasonableness issue, depending on whether the physician's compensation is based on referral or business generated by the physician.

Results

- **Two overall impacts**
  - Due to the split/shared billing change previously described
  - Due to the emphasis on personally-performed services

Hospital-Employed Side

- Possibility for decreased reimbursement as the APPs will be deemed the rendering provider. Services rendered by APPs are reimbursed by CMS at 85% of the physician's reimbursement rate.
- Physicians paid under a productivity model may be less likely to leverage APPs and/or may receive less productivity-based compensation.
- Additional focus should be paid to the accumulation and attribution of wRVUs to providers.

Private Practice Side

- CMS will be reviewing the incident-to rules for the use of APPs in the future. For now, the private practice has more flexibility.
- The impact does not apply to practices who meet the group practice standards and in-office ancillary services exception.

Group Practice – Profits from DHS

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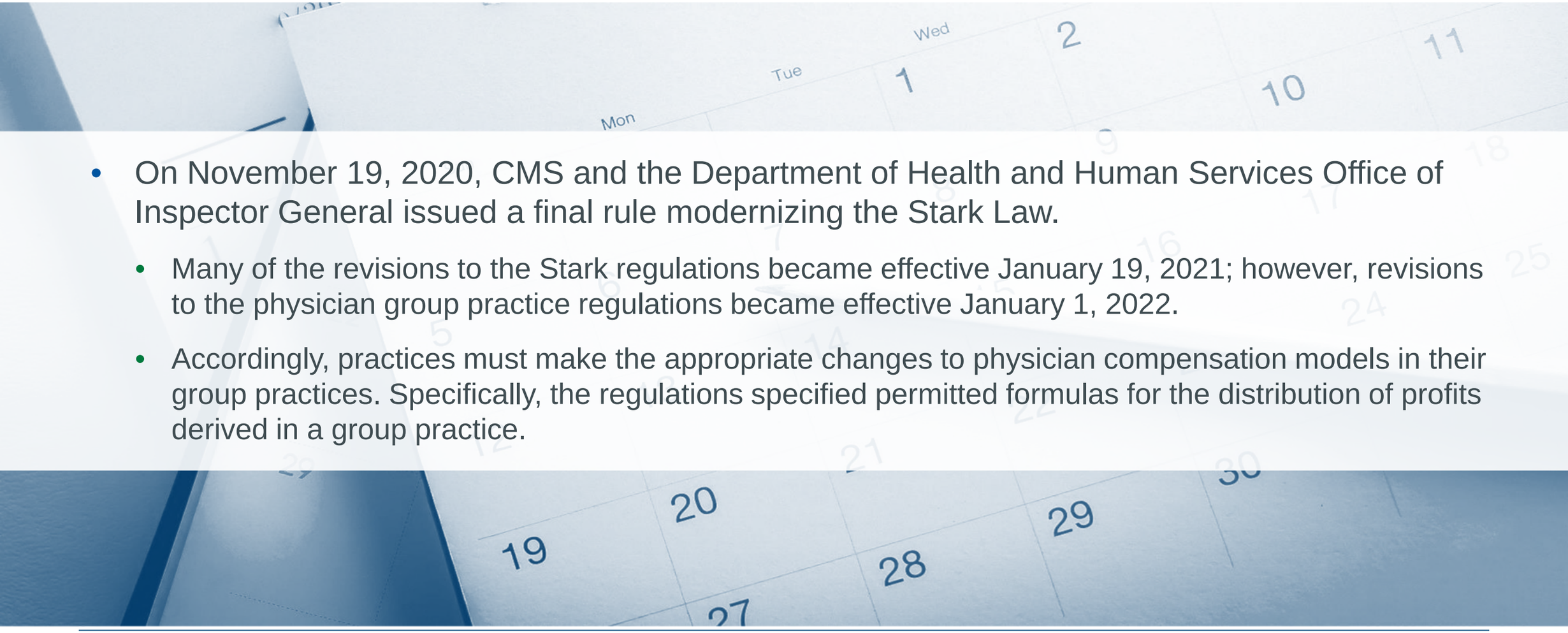

- On November 19, 2020, CMS and the Department of Health and Human Services Office of Inspector General issued a final rule modernizing the Stark Law.
  - Many of the revisions to the Stark regulations became effective January 19, 2021; however, revisions to the physician group practice regulations became effective January 1, 2022.
  - Accordingly, practices must make the appropriate changes to physician compensation models in their group practices. Specifically, the regulations specified permitted formulas for the distribution of profits derived in a group practice.

Group Practice – Profits from DHS (*cont.*)

- 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.
- Why these revisions are important to group practices providing DHS is that existing profit distributions might be prohibited under the revised standards.
- Compliance with these revisions will help determine what qualifies as a “group practice” to be eligible for protection under the Stark Law’s referral prohibition for the in-office ancillary services exception.
  - We recommend enlisting experienced healthcare counsel to make this determination.

Group Practice – Profits from DHS (*cont.*)

- Group practices are free to distribute all non-Medicare revenues in any manner they choose.
- Many of these group practices were distributing DHS based on revenues, relying on CMS's interchangeable use of the terms "revenue" and "profits" in previous guidance. This type of DHS distribution methodology will no longer be permissible.
- 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.
- Once a provider is eligible for DHS profit distributions, all distributions must be calculated in a manner that does not take into account the volume or value of the DHS services.

Example – Non-Compliant vs. Compliant

- **Example 1 (Non-Compliant)**
  - Five family medicine physicians are owners in a private practice. Due to their interest in sharing revenue based on the level of work performed and value added to the entity, the physicians have decided to distribute the profits of DHS based on the DHS revenues that each provider is individually responsible for generating.
- **Example 2 (Compliant)**
  - Five family medicine physicians are owners in a private practice. The physicians have decided to distribute any DHS profit to physician owners based on the ownership each physician has in the practice. For example, if Physician 1 owns 30% of the practice, and the DHS profit generated as a group is $1,000,000, Physician 1 would receive $300,000 in DHS profit.

Future Physician Compensation

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 downturn.

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%.[6]

With benchmark data that is currently inconsistent, extra care is needed when determining what is fair market value compensation.

Compensation Trends:

- Many providers are looking for a larger amount of guaranteed compensation in their contracts.
- Contemporary compensation models emphasize productivity less and mission/goal outcomes more, with minimum work standards clearly defined.
  - What is the future of the wRVU?
- Compensation models are beginning to consider citizenship, participation in virtual health, community outreach, and coordination of care.
- Increase in value-based reimbursement and related provider compensation.

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

Thank you!

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