

Emerging Trends in Physician Compensation

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Introduction

- ▶ Goal - To provide an overview of the trends in physician compensation as employed physicians' compensation models are being adapted from RVU driven to include more quality metrics to align with changes we're seeing in health care reimbursement

Opening Statements

- ▶ Health care organizations are focused on providing high value services for lower costs. They intend to accomplish this goal through:
 - ▶ Physician alignment and integration
 - ▶ Quality
 - ▶ Patient services
 - ▶ Efficiency

Opening Statements

The culture of medicine is going through transformational change

Historical Culture of Medicine

- Competitive
- Volume-based
- Individual Goals

New Culture of Medicine

- Patient Centered
- Quality
- Value-based
- Collaborative

Opening Statements

- ▶ Many of the changes we will see in physician compensation will be driven by changes in reimbursement and health care financing.



- ▶ Physician compensation models will need to be frequently reviewed to make sure they align with changes in reimbursement and changes in financing.

Market Factors

- ▶ The following market factors will impact physician compensation:
 - ▶ Health care reform will expand access, increase demand and reduce reimbursement
 - ▶ The population is growing and aging which will also increase demand
 - ▶ The physician supply is aging and not increasing fast enough to keep up with demand - this will result in increased scarcity in many specialties
 - ▶ Physician scarcity and the trend toward to physician employment will result in upward pressure on physician compensation while reimbursement is declining (or flat)
 - ▶ Consolidation will continue to occur to better align physicians and hospital
 - ▶ Over 1,000 M&A transactions in the industry in 2011
 - ▶ Integration will support physician compensation levels in the short term

Market Factors

- ▶ Health care reform is starting to impact physician compensation practices
 - ▷ Employers are starting to put compensation at risk based on physicians' achievement of quality and patient satisfaction goals – there is still a strong emphasis on productivity though.
- ▶ Organizations on the forefront are building systems to measure and report quality outcomes and patient satisfaction.
- ▶ Mandatory incentive programs are being built around quality outcomes
- ▶ Quality incentive programs will not be comprised of soft measures; they'll be designed to produce measurable outcomes

Market Factors

- ▶ CMS pilot initiatives are creating new funding opportunities
 - ▷ Medicare Shared Savings initiatives:
 - ▶ Medicare Shared Savings Program
 - ▶ Pioneer ACOs
 - ▶ Physician Group Practices Transition Demonstration ACOs
 - ▷ Numerous lesser know programs as well – www.innovations.cms.gov
- ▶ Expect to see successful aspects of these programs make their way into both government and private health care reimbursement programs

Market Factors

- ▶ Reimbursement will go down and insurance exchanges will add to the complexity
 - ▷ Reimbursement from insurance exchanges will probably be less than other payors
 - ▷ What impact insurance exchanges have on the current insurance market place is still a big question
 - ▷ Inflation will outpace reimbursement
- ▶ The focus on preventative care is expected to increase while there is already a shortage of primary care physicians

Compensation Trends

Most physician employers use incentive based compensation (86% according to Sullivan Cotter).

Common Productivity Measures

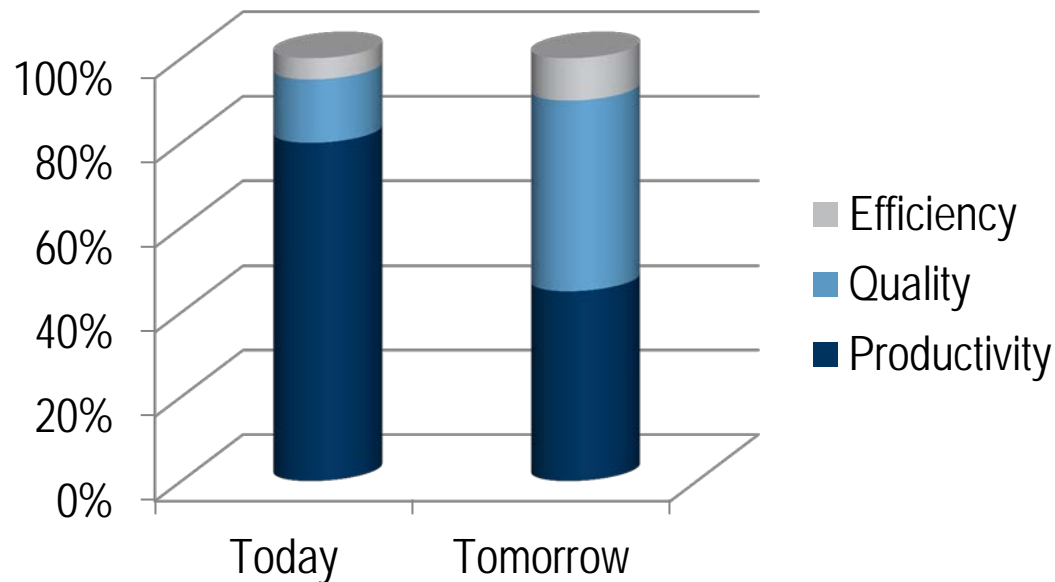
- wRVUs
- Collections
- Net Income
- Patient Visits

Common Performance Measures

- Patient Satisfaction
- Quality
- Citizenship

Compensation Trends

- ▶ Today → reimbursement is driven by reimbursement rates and the volume of procedures billed
- ▶ Tomorrow → reimbursement will be driven by performance and outcomes



Compensation Trends

- ▶ **Physician Workforce:** 75% of health care providers increased their physician workforces in the past year
 - ▶ 89% added specialists
 - ▶ 78% added primary care physicians
- ▶ **Non-Competition Agreements:** two-thirds of health care organizations require physicians to sign non-competition agreements and the typical term of those agreements is 2 years
- ▶ **Committee Participation:** 36% of health care organizations provide compensation for participation in committees; committee member rates are typically \$125 per hour or \$150 if chairing
 - ▶ Market Statistics from Sullivan Cotter's 2011 Physician Compensation and Productivity Survey

Compensation Trends

- ▶ **Hiring Bonuses:** 74% of health care organizations use hiring bonuses ; generally \$10,000 - \$50,000 with specialists receiving larger sign-on bonuses than primary care physicians
- ▶ **Retention Bonuses:** only used by 15% of health care organizations but this is an emerging area; mostly used in practice acquisitions
- ▶ **Compensation for Mid-Level Provider Supervision:** 36% of health care organizations pay physicians for supervising mid-level providers; generally range is from \$5,000 to \$12,000
- ▶ **Call Pay:** 65% of health care organizations provide on-call pay, however the trend is to only pay of “excess call”
- ▶ **Relocation Expenses:** 80% of health care organizations pay for relocation expenses; the typical amount is \$10,000

Compensation Trends

▶ Emerging Positions

▶ New and highly compensated positions are emerging for individuals with the skill sets necessary to impact cultural change:

- ▶ Chief Clinical/Physician Integration Officer
- ▶ Chief Clinical Transformation Officer
- ▶ Chief Clinical Officer

▶ Medical Director Compensation

- ▶ More physicians to manage
- ▶ More accountability and setting expectations related to outcomes
- ▶ The more complex the job, the higher the compensation

▶ Increased use of Mid-Level Providers

- ▶ Increased demand on physicians' services
- ▶ Leveraging to improve efficiency

Metrics

- ▶ Design Tips for Creating Physician Compensation Plans
 - ▷ Reward physicians appropriately and on metrics they believe allow them to add value to the health system
 - ▷ Get physicians invested by involving them in the development process
 - ▷ Metrics should positively influence physician behaviors and improve outcomes
 - ▷ Objective Metrics are better than Subjective Metrics
 - ▷ Make metrics consistent with measures required by reimbursement programs and system initiatives (e.g. ACO)
 - ▷ Work with payors interested in experimenting with new ways to award physicians – helps to have an affiliated payor
 - ▷ 10%-20% of base compensation at risk under the metrics

Metrics

- ▶ To be effective in attracting and retaining physicians, a compensation plan must be:
 - ▶ Fair
 - ▶ Equitable
 - ▶ Predictable
 - ▶ Market-based
 - ▶ Transparent to the physicians
 - ▶ Applied evenly

Metrics

- ▶ Sample Primary Care Metrics
 - ▷ Patient Access (e.g. time to get an appointment)
 - ▷ Panel Size (e.g. number of unique patients)
 - ▷ Mid-Level Provider Supervision
 - ▷ Care Coordination Fee (e.g. per patient per month)
 - ▷ Medical Home Development
 - ▷ Chronic Disease/Ambulatory Condition Management (e.g. Diabetes)

Metrics

- ▶ Sample Specialist Metrics
 - ▷ Timely consults (measured by PCP survey or set timeframe)
 - ▷ Clinical Co-Management Services (e.g. staffing efficiency)
 - ▷ Care coordination
 - ▷ Post-Discharge Telemonitoring/Summary to PCP
 - ▷ Readmission Reconciliation
 - ▷ On-Time Surgical Starts
 - ▷ Discharge Planning
 - ▷ Patient Access to Specialist Appointment
 - ▷ Supply Standardization

Metrics

- ▶ Quality Metrics
 - ▶ Inpatient SCIP & Core Measures
 - ▶ NCQA/HEDIS/NQF Standards
 - ▶ Care Model Development/Adoption
 - ▶ Patient Outcomes around Identified Conditions
 - ▶ Completed Health Risk Assessments/Screening Exams
 - ▶ 33 ACO Quality Metrics
 - ▶ Use of Disease Registries

Metrics

- ▶ Quality Metrics – Preventive Measures
 - ▶ Mammogram Screening
 - ▶ Colon Cancer Screening
 - ▶ Cervical Screening
 - ▶ Osteoporosis Screening
 - ▶ Flu Vaccination
 - ▶ Pneumonia Vaccination
 - ▶ Blood Pressure Screening
 - ▶ Eye/Foot Exams
 - ▶ Cholesterol Screening

Metrics

- ▶ Patient Satisfaction Metrics
 - ▷ Press Ganey
 - ▷ Peer-Peer Reviews
 - ▷ Staff-Peer Reviews
 - ▷ Patient Phone Surveys

Metrics

- ▶ Citizenship Metrics
 - ▶ Timely medical records completion
 - ▶ Successful Coding Audits
 - ▶ Call Coverage
 - ▶ Follow System Standards of Behavior
 - ▶ IT Adoption
 - ▶ Meeting Attendance
 - ▶ Risk Management/ Compliance Education

Metrics

- ▶ Finance Metrics
 - ▷ Expense Control
 - ▷ Meet or Exceed Budget
 - ▷ Profitability of Physician Group
 - ▷ Profitability of Hospital
 - ▷ ACO Shared Savings Distributions
 - ▷ Timely Submission of Billing Slips
 - ▷ Meaningful Use Dollars

Metrics

- ▶ ACO Conditions of Participation
 - ▶ Comply with Credentialing Requirements
 - ▶ Participate in ACO Educational Programs
 - ▶ Provide timely care consistent with Best Practices
 - ▶ Comply with ACO Policies and Procedures
 - ▶ Adhere to ACO Care Models/Protocols
 - ▶ Utilize ACO-approved EMR platform consistent with CMS Meaningful Use Guidelines
 - ▶ Exchange Clinical and Demographic Information through Secure Transaction Sets
 - ▶ Protect privacy of patient PHI consistent with HIPAA
 - ▶ Measure and report on CMS Shared Savings Quality Metrics

Benefits to Employers, Physicians and Patients

- ▶ Health care organizations that have implemented good quality and performance metrics into their physician compensation plans have seen the following results:
 - ▶ Decreased costs/increased operational efficiency
 - ▶ Decreased loss of patients to competitors due to increased patient satisfaction
 - ▶ Synergy between physician and system initiatives such as ACO, value-based purchasing and other pilot projects
 - ▶ Better reimbursement for achieving quality metrics
 - ▶ Improved coordination of care

Model Compensation Plans

▶ Summa Physicians

- ▶ Base Compensation – 85% of MGMA Median by Specialty
- ▶ RVU Bonus – \$ per wRVUs in excess of target amount
 - ▶ 3 tiers with decreasing payment per excess wRVUs
 - ▶ If a physician fails to produce 80% of his or her annual wRVU target, the physician is not eligible for any bonuses (either RVU or Quality)
- ▶ Quality Bonus – based on 20 metrics (separate from RVU production)
 - ▶ If meet 15 of 20 quality metrics, then eligible for 75% of Quality Bonus amount
 - ▶ Quality Pool is funded by excess wRVUs
- ▶ Program Participation
 - ▶ 15% add on for Primary Care participation in Pilot Projects
 - ▶ 20% add on for Specialist participation in Pilot Projects

Model Compensation Plans

▶ Geisinger Health System

- ▶ Base Component – paid monthly based on an expected wRVU target
 - ▶ Failure to meet wRVU target can result in a reduction in base salary
- ▶ Incentive Component – paid semi-annually for objectively measurable metrics
 - ▶ 40% quality
 - ▶ 35% teaching, research, growth
 - ▶ 25% financial/work effort
 - ▶ wRVU %ile between 50th and 60th → 33.3% of available amount
 - ▶ Between 60th and 70th → 100% of available amount
 - ▶ Between 70th and 80th → 105% of available amount
 - ▶ Between 80th and 90th → 110% of available amount
- ▶ Target ratio of 80% base and 20% incentive

Legal Considerations

- ▶ United States of America ex rel. Michael K. Drakeford, M.D. v. Toumey Healthcare System, Incorporated
 - ▶ Parties
 - ▶ Toumey Healthcare System: 301 bed medical center located in Sumter, SC
 - ▶ Dr. Drakeford: Qui tam relator; qui tam filed under seal in 2005
 - ▶ Government: joined action in 2007 by filing an amended complaint
 - ▶ What led to the case?
 - ▶ Toumey's response to competition from an ASC
 - ▶ Need to retain specialists' outpatient procedures for continued financial performance
 - ▶ Physician negotiations
 - ▶ Dr. Drakeford

Legal Considerations

- ▶ The *Toumey* case continued . . .
 - ▶ Toumey entered into compensation contracts with 19 specialist physicians (actually their LLCs). Each contract had the following terms:
 - ▶ Physician was required to provide outpatient procedures at Toumey
 - ▶ Toumey was solely responsible for billing and collecting for the procedures
 - ▶ Toumey paid each physician an annual base salary that fluctuated based on Toumey's net cash collections for the outpatient procedures
 - ▶ Toumey also paid each physician a "productivity bonus" equal to 80% of the net collections and each physician was eligible for an incentive bonus that could total up to 7% of the productivity bonus.

Legal Considerations

- ▶ The *Toumey* case continued . . .
 - ▷ The Decision – 4th Circuit, March 30, 2012
 - ▶ Remanded to trial court due to faulty jury instruction, but decided issues raised on appeal that were likely to recur
 - ▶ The facility component of the services performed by the physicians pursuant to the contracts, for which Toumey billed a facility fee to Medicare, constituted a referral within the meaning of the Stark Law.
 - ▷ Can't pay for bringing cases to the Hospital.
 - ▷ Court found that Toumey looked at physicians' services at Hospital and the technical fees generated by the physicians
 - ▶ Compensation arrangements that take into account anticipated referrals do implicate the Stark law's "volume or value standard"

Legal Considerations

- ▶ The *Toumey* case continued . . .
 - ▷ Other important take aways
 - ▶ Government position #1 – opinion shopping undermines reliance on advice of counsel defense
 - ▶ Government position #2 – develop compensation arrangements with care
 - ▷ Should have a built in “legality review” every few years or less
 - ▷ Should have significant administrative duties if part of the compensation is in exchange for performing those administrative duties
 - ▷ Productivity bonuses should not kick in with the first dollar earned
 - ▶ Government position #3 – compensation per wRVU should not exceed the 75th MGMA percentile without substantial justification
 - ▷ Median compensation per wRVU provides a reasonable indication of FMV at all levels of productivity
 - ▷ Previously assumed logical that a physician producing at the 90th %ile of wRVUs could be paid at the 90th %ile compensation per wRVU

Legal Considerations

- ▶ United States of America ex. rel. Elin Balid-Kunz v. Halifax Hospital and Medical Center (No. 6-09-CV-1002)
 - ▷ Parties
 - ▶ Halifax Hospital and Medical Center located in Daytona Beach, FL
 - ▶ Elin Balid-Kunz – Halifax Director of Physician Services; Qui Tam Relator; brought claim in June 2006
 - ▶ United States – joined the action in September 2009
 - ▷ What led to the case
 - ▶ Ms. Kunz alleged that Halifax paid kickbacks to key referring physicians in order to generate patient referrals to the hospital and entered into numerous improper financial relationships with physicians that are prohibited by the Stark law

Legal Considerations

- ▶ United States of America ex. rel. Elin Balid-Kunz v. Halifax Hospital and Medical Center (No. 6-09-CV-1002)
 - ▶ Case is on going but the Government's arguments indicate that it will challenge the following arrangements:
 - ▶ Compensation paid based on tracking referrals
 - ▶ Bonus pools based on operating margins of a service line
 - ▶ Payments for exceeding targeted patient visits per month
 - ▶ Compensation in excess of fair market value

Legal Considerations

- ▶ Group Practice (42 C.F.R. 411.352)
 - ▷ If physician entity qualifies as a “Group Practice”, then the Group can reward Physicians for services performed “incident to” a Physician’s services or have profit sharing or productivity bonuses indirectly related to services.
 - ▷ Requirements to be a “Group Practice”
 - ▶ *Single legal entity* – must be organized as a single legal entity operating primarily for the purpose of being a physician group practice
 - ▶ *Physicians* – must have at least 2 physicians who are members of the group (whether employees or direct or indirect owners)
 - ▶ *Range of care* – each physician who is a member of the group must furnish substantially the full range of patient care services that the physician routinely furnishes through the joint use of shared office space, facilities, equipment and personnel.

Legal Considerations

- ▶ Group Practice (42 C.F.R. 411.352)
 - ▷ “Group Practice” requirements continued
 - ▶ *“Substantially all” test* – at least 75% of the total patient care services of the Group members must be furnished through the group and billed under a billing number assigned to the Group, and amounts received must be treated as receipts of the Group
 - ▶ *Distribution of expenses and income* – the overhead expenses of, and income from, the practice must be distributed according to methods that are determined before the receipt of payment for the services giving rise to the overhead expenses and producing the income.
 - ▶ *Unified business* – must be a unified business with centralized decision making and consolidated billing, accounting and financial reporting
 - ▶ *Volume or value of referrals* – except as permitted under the special rule for productivity bonuses and profit shares, no member of the Group directly or indirectly receives compensation based on the volume or value of his or her referrals

Legal Considerations

- ▶ Group Practice (42 C.F.R. 411.352)
 - ▷ “Group Practice” requirements continued
 - ▶ *Physician-patient encounters* – members of the group must personally conduct no less than 75% of the physician-patient encounters of the Group
 - ▷ Special Rule for Productivity Bonuses and Profit Shares
 - ▶ *Profit Shares* → A physician in the Group may be paid a share of the overall profits of the Group, provided that the share is not determined in any manner that is directly related to the volume or value of referrals of DHS by the physician
 - ▶ *Productivity Bonuses* → a physician in the Group may be paid a productivity bonus based on services he or she has personally performed, or services “incident to” such personally performed services, or both, provided that the bonus is not determined in any manner that is directly related to the volume or value of referrals of DHS by the physician

Legal Considerations

▶ Civil Monetary Penalties

- ▶ CMP Statute established a civil monetary penalty against any hospital that knowingly makes a payment directly or indirectly to a physician (and any physician that receives such a payment) as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's direct care (42 U.S.C. 1320a-7a(b))
- ▶ Don't reward physicians for reducing cost of cases without objective medical criteria and sufficient controls that ensure transparency

Legal Considerations

▶ Civil Monetary Penalties

▶ OIG Advisory Opinion 08-16

- ▶ Proposed Arrangement – hospital shared with a physician-owned entity certain performance based compensation available to the hospital under a quality and efficiency agreement with a private insurer
- ▶ Issue – whether the Proposed Arrangement would constitute grounds for sanctions arising under the CMP for a hospital's payment to a physician to induce reductions or limitations of services to Medicare or Medicaid beneficiaries under the physician's direct care.
- ▶ Conclusion – the Proposed Arrangement could constitute an improper payment to induce reduction or limitation of services but the OIG would not impose sanctions on the Requestor in connection with the Proposed Arrangement.

Legal Considerations

- ▶ Civil Monetary Penalties

 - ▶ OIG Advisory Opinion 08-16

 - ▶ Legal Analysis

 - ▶ Notwithstanding their purpose of improving patient care, compensation from the Hospital to the physician entity for achieving the quality targets might implicate the CMP by inducing physicians to reduce or limited the current level of certain items or services provided to Federal health care beneficiaries at the Hospital.
 - ▶ However, certain features of the Proposed Arrangement provided sufficient safeguards so that the OIG would not impose sanctions under the CMP

Legal Considerations

▶ Civil Monetary Penalties

▷ OIG Advisory Opinion 08-16

▶ Safeguards

- ▷ Credible medical support that the Proposed Arrangement had the potential to improve patient care and was unlikely to have adverse effects on it
- ▷ No incentive for a physician to apply a specific standard in medically inappropriate circumstances
- ▷ The quality targets were reasonably related to the practices and patient population of the Hospital and procedures monitored were procedures typically performed by the Hospital (e.g. no cherry picking healthy patients to meet standards)
- ▷ The performance measures that could result in compensation to the physician entity were clearly and separately identified, and affected patients were notified
- ▷ The Hospital certified that it will monitor the quality targets and their implementation throughout the term of the Agreement, to protect against inappropriate reductions or limitations of services, and will take appropriate steps if problems arise

Questions?

Thank you!