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# Provider Contracts: A Changing Environment

May 4, 2021



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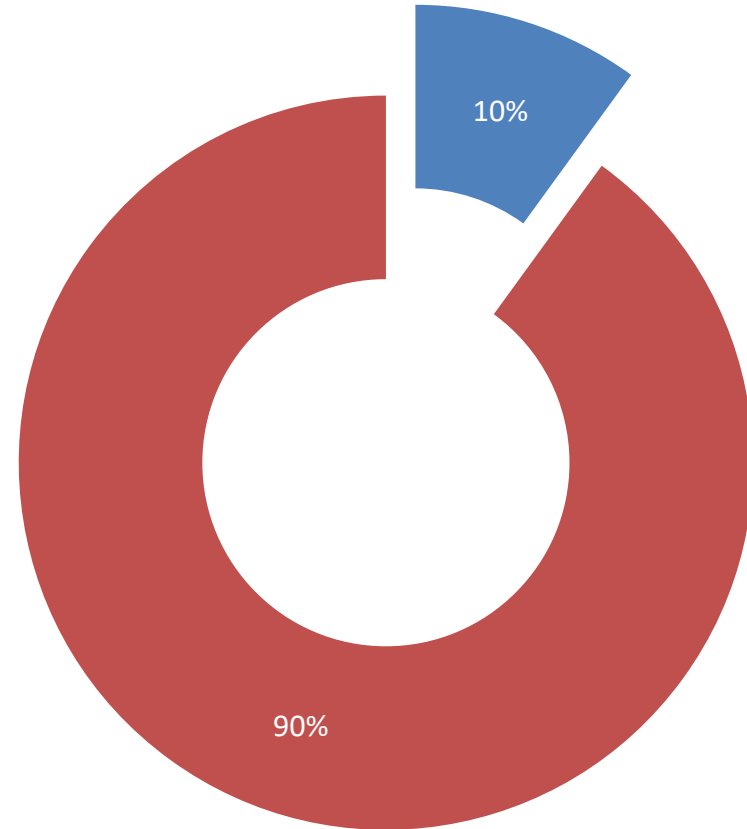
# Today's Agenda

Physician Contracts: Complex and Heavily Regulated

CMS Changes and COVID-19 Impacts

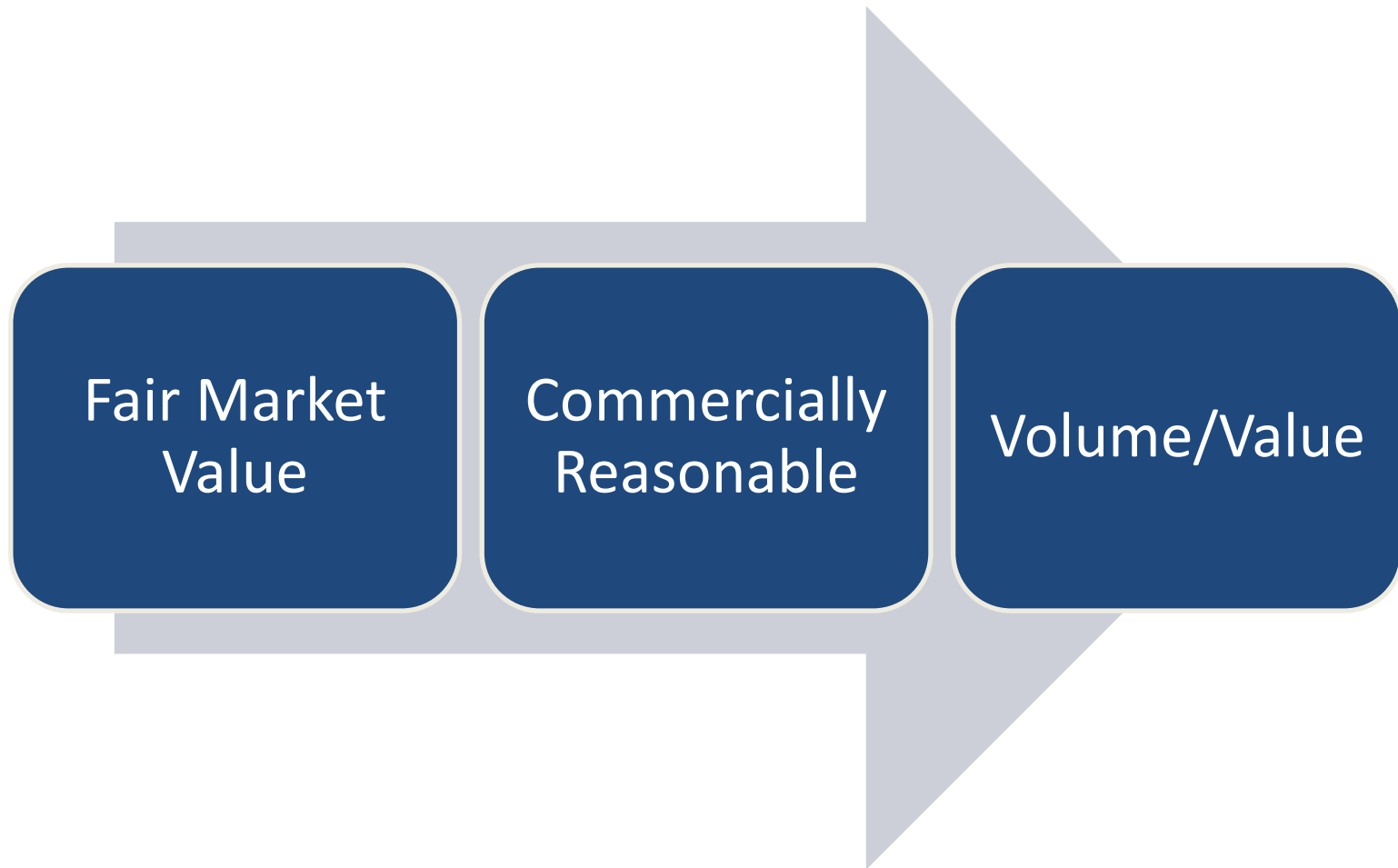
Compensation Strategy for Today and Tomorrow

- Physician expenditures equal 5-10% of the average hospital's net patient revenue and projected to grow at 5.4% annually



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

# Stark Requirements – The Big 3



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

## 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

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

BECKER'S

HOSPITAL REVIEW

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

February 2020

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

## Hospital considerations when determining FMV for physician services:

- Physician specialty/subspecialty
- Physician's duties and 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 fill position
- Physician's training and experience
- Compensation methodology

## Individual physician compensation

- Guaranteed compensation
- Individual performance determines compensation

## Group or specialty “pool” models

- Group or specialty’s performance and/or outcomes determine a pool of revenue. This pool is then distributed based on the individual physician’s performance based on set criteria.

## “Stacking” compensation

- ED call coverage
- Medical Directorships
- Clinical or service line management agreements
- APP supervision
- Teaching Agreements



# 2021: CMS AND COVID-19

- On December 2, 2020, CMS published the final rule for the 2021 Physician Fee Schedule.
- Changes are made annually to address revised CPT codes and corresponding Work Relative Value Units (“work RVUs”).
- 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 really been changed since 2007.
  - Changes were intended to address the ongoing documentation burden on physicians and the under-valuation of time and effort involved in these services.
    - Revises the times and medical decision-making process for all of 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 primarily used 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
<b>Total</b>				<b>248,535,265</b>	<b>1.000</b>	<b>0.358</b>

# Impact Across Specialties

- Based on MGMA's DataDive Procedural Profile, the increases in wRVUs due to the increases varies based on specialty.

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%

# 2021 CMS REIMBURSEMENT CHANGES

- On December 2, 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.
  - 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 PSA between a hospital system and a highly productive 6 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.

	<u>2020</u>	<u>2021</u> <u>Projection</u>	<u>Proposed</u>	<u>Break Even</u>	<u>Amended</u> <u>Contract</u>
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
Expected 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 has to 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
  - Removed 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<sup>1</sup>**
    - Reductions and suspensions to physician and other employee retirement and CME<sup>2</sup>
    - As of June 2020, 266 hospitals had furloughed employees<sup>3</sup>
  - 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 \(beckershospitalreview.com\)](#)



**58%**

of physicians often have feelings of burnout, up from 40% in 2018<sup>1</sup>

**18%**

of physicians have increased their use of drugs and alcohol as a result of COVID's impact on their employment situation<sup>1</sup>

**37%**

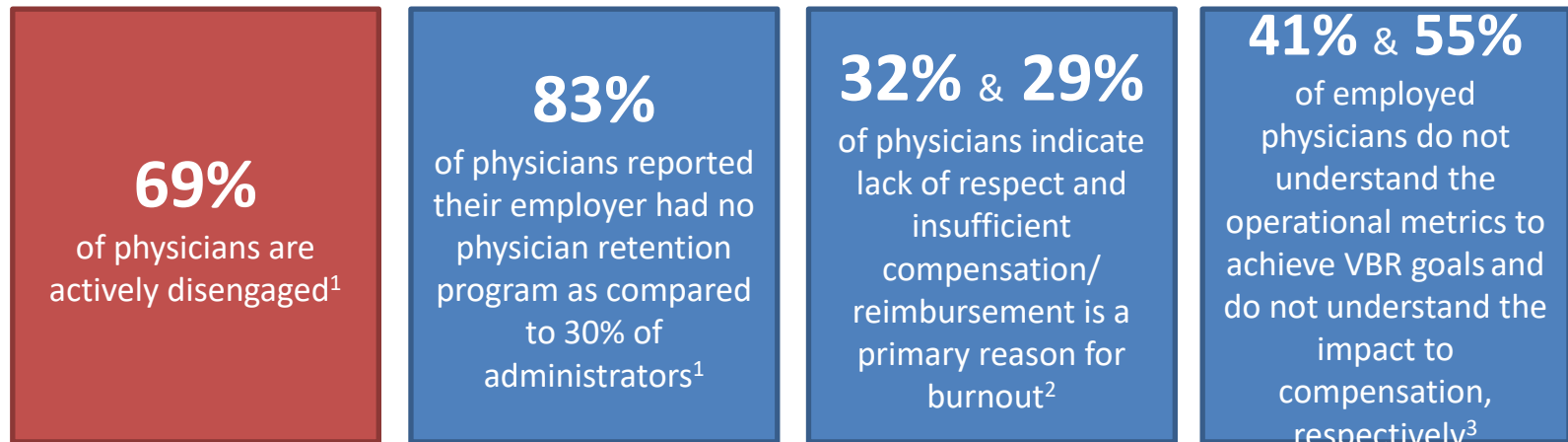
of physicians would like to retire in the next year<sup>2</sup>

**30%**

of administrators have lost one or more physicians<sup>3</sup>

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](#)

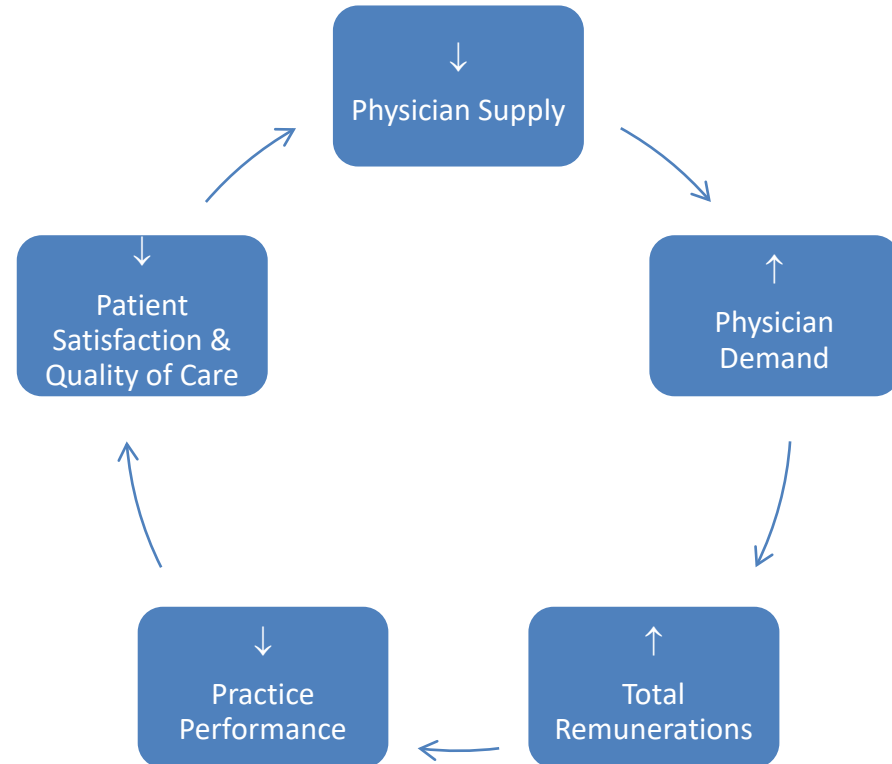
# Physician Engagement & Alignment Is Waning



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 is 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



**SO WHAT SHOULD  
ORGANIZATIONS DO?**

# So What Should Organizations Do?

- Continue under the 2020 Physician Fee Schedule for wRVU calculations.
- Continue under the 2020 PFS for a partial year (most commonly through June 2021)
- Adopt 2021 PFS
  - Adjust productivity incentive thresholds
  - Adjust wRVU compensation conversion factor
  - Adjust both
- Examine in the context of a larger compensation strategy
  - What type of protective language is in your contracts?
  - What will you do regarding future CMS changes?
  - How do you engage with your providers about compensation now?

# 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 do you when faced with future CMS changes?
  - How do you engage providers around compensation now?
  - Are you aligned with your providers?

- Is the physician impacted by the deferral of elective/non-essential procedures?
- Are the physician's services essential to the treatment of COVID-19 patients?
- Is a physician impacted by a "stay at home" order?
- **Will compensation be impacted by more than 15%?**
- Does telemedicine consults mitigate the change in physician comp?
- Was the physician redeployed to another service line? Could they be?
- Would the loss of the physician create any defaults?
- Could you lease the employed physician to another entity?
- Will the lack of the physician's service substantively disrupt the day-to-day operations of an entity?
- Are there no ways to expand the credentials of the physician to mitigate the loss of his/her compensation?
- **Will there be significant relocation/recruitment costs associated with replacing the physician if he/she were to leave after the ban on elective/non-essential procedures is lifted?**
- Would the intended economic support for the physician be the only payment for the physician's work effort (e.g., there is only one payment for a re-scheduled elective procedure, either now or in the future) during the COVID-19 pandemic?
- **Is it feasible for the physician to be able to leave and replace his/her desired income in the present situation?**



Value-Based Reimbursement (VBR) will have a direct impact on how we compensation physicians and APPs



Where is your organization on its transition to value?



Where is your organization in its compensation model?

Base salary only?

Quality incentives?

Payment for administrative duties?

Productivity incentives?



What do physicians in your area expect?

What is Allina Health doing?

What is Banner Health doing?

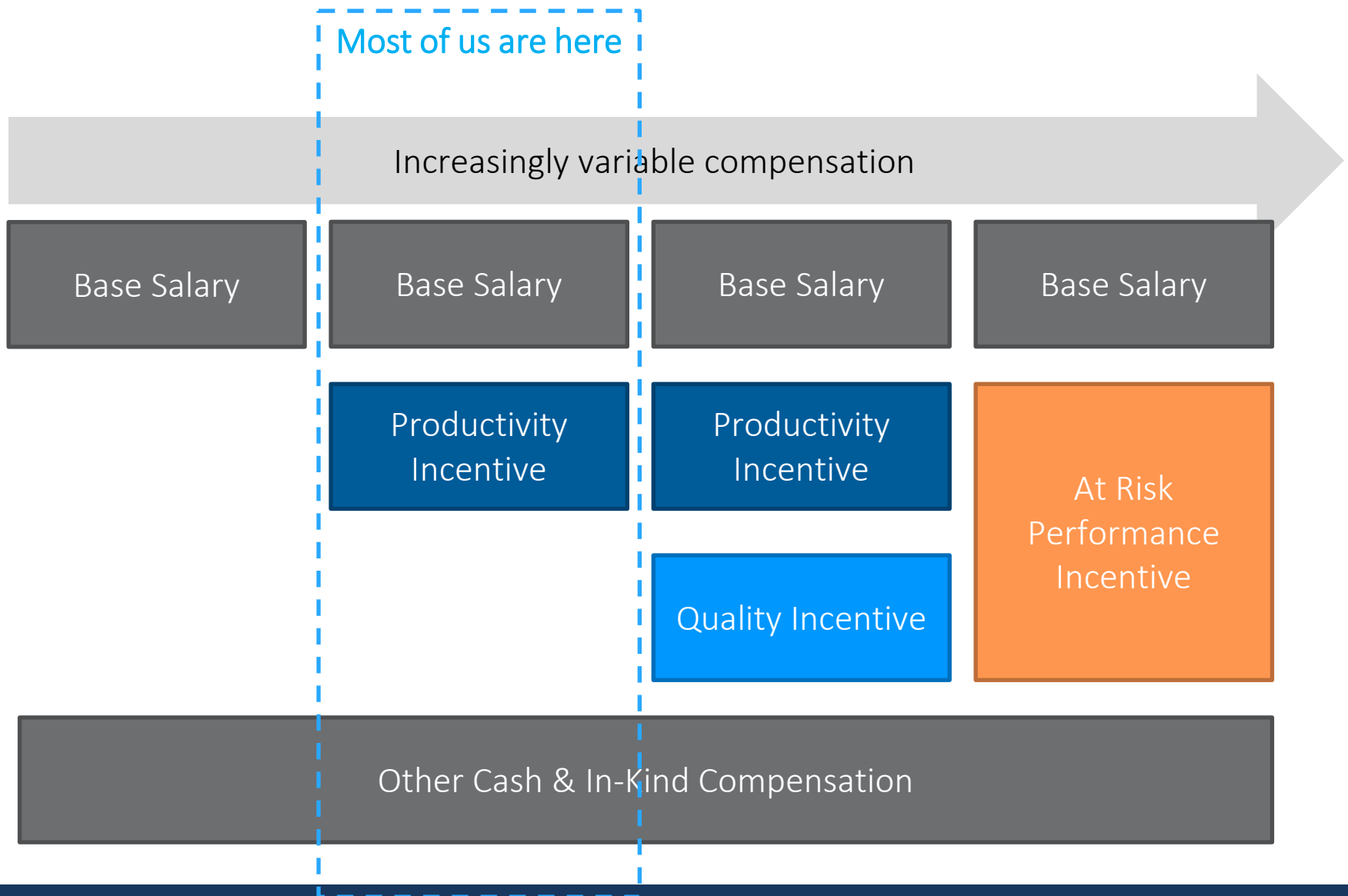
What is Aurora doing?



- Consistent documentation
- Guardrails for the outliers
- Identify your high-risk contracts
- Put in place a contract audit policy



# Transition of Compensation Scheme





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