Trends in Physician Compensation Arrangements: Compliance Tips and FMV

Health Care Compliance Association

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VMG HEALTH
WE VALUE HEALTHCARE

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- Partner at VMG Health, a healthcare valuation and consulting firm
  - Since 1995, offices in Dallas and Nashville.
  - 70 professionals, over 1,200 valuation per year.
  - Transactions, real estate, fixed assets & service agreements.
- Leads Professional Service Agreements Division
- Previously with KPMG's litigation department
- Former Finance professor from the University of North Texas
- Published and presented multiple times related to physician compensation and fair market value

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Why the Growth in Physician Alignment?

Association of American Medical Colleges work force projections indicate the U.S. will have a shortage of 91,500 physicians by 2020

Non-economic Reasons

- Security – healthcare reform, changing reimbursement
- Quality of Life – older and younger physicians, on average, working less hours

Economic Reasons

- Increased compensation: post employment or contracted arrangement
- Better hospital-based reimbursement
- Replace potential loss of ancillary earnings
- Investment requirements for information technology
- Participate in risk-based contracting, ACOs, quality initiatives

Physician Service Agreements

May be a result of joint ventures, acquisitions, employment or independent contractor arrangements

Administrative Services*	Call Coverage*	Clinical Management "Co-Management" (fixed + variable)*	Management*
ACOs and Bundled Payment models*	PSA Model ($/WRVU + expenses)*	Professional/ technical splits	Clinical Services (employed)*
Billing and Collection	Leasing Arrangements	Development	All combined! Stacking

*[illegible]m

It is now likely a combination of several valuations will be required for one agreement, choose the right data/analysis to reflect each of the services.
*P4P component often added

Hot Topics for PSA Division

Life Sciences (Academic Medical Center)/Sunshine Provision

Compensation Calculators

Commercially Reasonable

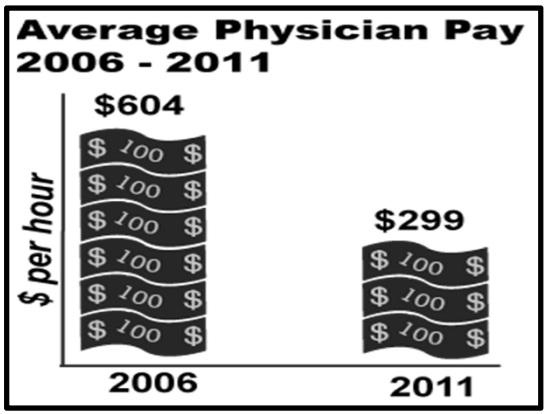
Quality & Shared Savings Payments

*May have a P4P component

ACOs/Bundled Payments

Life Sciences and Transparency – FMV gains importance

- Payments to physicians are dropping.
  - 2009 scrutiny
  - 2010 self-disclosure/state laws
  - 2011-2012 LOTS of Settlements
  - 50% Payment Drop - PolicyMed.com (6/17/11).



- Physician Payments Sunshine Provision: any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another transfer of value to a physician or teaching hospital must report details of payments.
  - Major catalyst to the transparency and disclosure movement in the life sciences industry; the government continues to increase its scrutiny of physician compensation arrangements.
  - August 2013 start date for tracking

- Disclosed payments to physicians are prompting investigation regarding amounts and necessity.

Compliance Infrastructure Tip

Establish Internal Thresholds

1. Calculators by specialty type and service
2. Third party opinion on individual arrangements falling outside calculator

- Great tool for call coverage and administrative services – saves time and money while enhancing compliance efforts.
- Clinical services possible, but inputs/assumptions for calculator must be clearly understood.
  - Sign-on bonus and loan repayment
  - Agreement structures with base, WRVU thresholds, and $/WRVU
- Compensation Calculators are based on systematic and unbiased overall guidelines which eliminate the user's ability to include its results
  - Each indication of value considers the specialty and reflects the service provided by the physician.
  - Utilizes multiple, objective national surveys reflecting compensation data by specialty.
  - Each indication delineates between employed and independent contractor agreements.
- Understand risk level of hospital before selecting a calculator
  - Flexibility in compensation required? If no, median tables may work.
  - Input error – internal calculator
  - 3rd party deliverable – external calculator
- Complex or unique arrangements will need a more robust approach

Valuation Starting Point

1. **Commercially Reasonable – Whose responsibility is it?**
    a. Facility needs – check for overlap of services (numerous medical directors needed)
    b. Operational assessment (quality metrics relevant for patient population)
    c. Understand total hours (reasonable)
2. **Agreement terms must be understood and are sometimes unclear at valuation stage, define:**
    a. What services will be provided?
    b. How parties will be compensated?
    c. Valuation should match the agreement – may require several valuations for one agreement.

Valuation Starting Point

3. **Understand there are no published standards for physician compensation valuations**
   - Appraisal firm should understand
     - Healthcare regulations
     - Valuation principles
   - Regulatory Guidance
     - Fair Market Value
     - Data considerations

Importance of Valuation - Tuomey Case Take-Aways

Hospital is at risk for relying on unsupportable valuations

Valuation methodology is as important as total compensation

Creative arrangements need to be carefully constructed, the government suggests getting an OIG Opinion

No opinion shopping, carefully choose your valuation firm

Logic Test – Tuomey examples:

- Do not pay fulltime benefits/malpractice premiums for part-time services
- Physicians paid above the 75th percentile of market data should demonstrate productivity consistent with other physicians in this percentile
- Understand arrangements where the provider is not making money
- Compensation for administrative duties should be based on significant duties
- Compensation must be set at Fair Market Value

Fair Market Value Definition

- Based on the anti kickback statute, and other healthcare regulations and guidelines, any transaction between hospitals and physicians must be at Fair Market Value.
- IRS definition - ***"the amount at which property would change hands between a willing seller and a willing buyer when the former is not under any compulsion to buy and the latter is not under any compulsion to sell and when both have reasonable knowledge of the relevant facts."***
- Provides a conclusion which should not reflect consideration for value or volume of referrals.
  - Offer equal opportunities to all providers
  - Do not tie compensation to expected referrals
  - Data relied upon should not reflect referral relationships - Competing Hospitals: Extra Caution

FMV – Regulatory Guidelines

- Based on our understanding of previous healthcare regulatory guidance, we know the following related to determining FMV:
  - Physician's "going rate" does not constitute FMV.
    - Historical compensation does not necessarily support payments are FMV.
    - Opportunity costs should not be relied upon as the sole FMV methodology.
  - The Fair Market Value of administrative services may differ from the Fair Market Value of clinical services. [Stark]
  - Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating Fair Market Value. [Stark]
  - Look to alternative valuation methodologies when all the available comparables or market data reflect transactions between entities that are in a position to refer or generate other business. [Challenge with new models – referral data]
  - Fair market value payment rates should be analyzed and developed using multiple valuation approaches. [Tuomey]
- OIG acknowledgment during February 2013 ABA conference that they are concerned of scenarios whereby physicians maintain, or grow fee for service, and share in savings from an ACO structure.

FMV & Clinical Services

- **The Latest Model – PSA (versus employment)**
  - $/WRVU to Group plus Expenses
  - Be cautious of including fixed expenses in the variable metric
  - Understand who is paying for what

- **Multiple, objective surveys suggested**

- **Historical Compensation drawbacks**

- **Income Approach challenges and relevance**

- **Cost-Market Approach – benchmark productivity (WRVUs and Professional Collections versus charges and encounters)**

FMV & Clinical Services

- Common benchmarking mistakes include:
  - Including mid-level provider productivity
  - Benchmarking total RVUs to reported *work RVUs*
  - Benchmarking total collections to reported *professional collections*

- Common mistake in using the reported compensation per work RVU:
  - Per MGMA, an inverse relationship exists between work RVU volume and compensation per work RVU
  - Paying a highly productive physician the 75th to 90th percentile compensation per work RVU may result in compensation outside of FMV.
  - See illustration on the following page.

FMV & Clinical Services

- Misuse of reported compensation per work RVU data
  - Solo practitioner specialized in general orthopedic surgery
  - No in-office ancillaries or mid-level providers
  - 2012 annual work RVU volume of 13,867
  - Hospital employer proposed MGMA 90th percentile compensation per work RVU

MGMA Physician Compensation and Production Survey				
	Compensation per Work RVU			
	25th	Median	75th	90th
Compensation per work RVU - Orthopedic Surgery: General	$47.74	$60.39	$77.39	$95.48
Times: Physician's Annual Work RVU Volume (equal to MGMA 90th)				13,867
Equals: Annual Physician Compensation				$1,324,021
	Physician Compensation			
	25th	Median	75th	90th
Total Compensation - Orthopedic Surgery: General	$372,437	$497,088	$658,842	$825,044
Annual Physician Compensation is more than 160% of the 90th percentile!!!				***$1,324,021***

Takeaways: *Always* test productivity models to ensure the selected metric and expected productivity result in FMV compensation.
Check WRVU thresholds are consistent with base salary.

FMV & Other Services

- Administrative Services – calculators useful
  - Multiple, objective surveys suggested
  - Medical Director data and Administrative Data
  - Does the role require a physician?
  - Does the role require a specific specialty?
  - Who is covering malpractice and benefits?
  - Non-physician personnel valuations / management
- Call Coverage Services – calculators useful
  - Multiple, objective surveys suggested
  - Findings from two surveys
  - OIG Opinion – Beeper rate/Burden of call
    - Payor Mix
    - Likelihood to come in
    - Guaranteed reimbursement

Quality Payments Overview

Hospitals critical success factors – shifting towards quality of clinical performance

History: massive surge in reporting initiatives. Initiated with PQRI now ASCs. Data provides support for outcomes based payments.

Congress authorized value-based purchasing (VBP) program to replace the RHQDAPU program

- Performance Incentives would be based on improving historical performance or attaining superior outcomes compared with national benchmarks
- Proposed ACOs include similar guidelines

Numerous third party payors provide quality payments to hospitals and physicians

C-Level executives' compensation may be subject to a hospital's quality outcomes

P4P In the News

- **HQID (CMS/Premier Hospital Quality Incentive Demonstration)**
  - Raised their overall quality by an average of 18.6 percent over six years
  - Incentive payments of almost $12 million in the final year 6 to 211 providers for top performance, as well as top improvement
- **UnitedHealth Group – largest US health insurer by sales**
  - Currently paying 21 different specialties based on quality
  - Expect to save twice as much than the quality payments due to healthier patients
- **WellPoint – largest US health insurer by membership**
  - Will increase primary care physician pay by 10%
  - Additional cost savings bonus of 20% to 30% of savings achieved
  - Total P4P increase could be as much as 50%

P4P In the News

- **Tennessee Surgical Quality Collaborative**
  - 10 hospitals experienced significant improved surgical outcomes
  - Millions in cost savings - $2.2 million per 10,000 surgery cases
- **Ohio's Medicaid Program – P4P component will be included when it rebids contracts for 2013**
- **February 2012 Committee on Ways and Means**
  - UnitedHealth Group discusses results of its Premium Designation Program (PD)
  - Results show over 50% decrease in some complication rates and 14% in savings for PD physicians
- **2012 and 2013** – numerous results show ACO type models are increasing quality and saving costs.
- **RESULT:** federal, state, third parties paying for quality and cost savings.
- **Strategies include:** Co-management, employment, ACO type models, add-ons to many agreements.

Co-Management

Fixed Fee + Variable Fee = Co-Management Fee Structure

Fixed Fee

- Time dedicated to meetings designed to improve the overall quality of care for a specific service line.
- Based on cost to engage a physician to provide similar services.
  - Clinical and administrative survey data considered
  - Hourly rate x meeting attendance hours
  - Physician service payments are justified by need for clinical expertise
- May also include
  - Medical Directorship
  - Call coverage
  - Non-physician services – Billing & Management/administration
- Check for overlap of services!

Co-Management

Fixed Fee + Variable Fee = Co-Management Fee Structure

Variable Fee

- Quality outcomes drive payments
- Improvement and superior outcomes may warrant incentive payment
- Valuation of fee typically requires understanding of
  - Historical outcomes
  - Benchmarking data
- Obtain industry-recognized benchmark data for the quality metrics, (average or median and top or 90th percentile)
- Understand who is responsible for developing and implementing the strategy
- Determine the appropriate market rates for improving and achieving superior quality care.
- Create payment tiers for incentives based on various outcomes

Co-Management FMV observations – valuation techniques**

Probably not a typical management fee!

Checklist – Paying for Quality in any arrangement

- Quality measures should be clearly and separately identified
- Quality measures should utilize an objective methodology verifiable by credible medical evidence
- Quality measures should be reasonably related to the hospital's practice and consider patient population
- Do not consider the value or volume of referrals. Consider an incentive program offered to all applicable providers

Checklist – Paying for Quality in any arrangement

- Thresholds should exist where no payment will accrue and should be updated annually based on new baseline data.
- Hospitals should monitor the incentive program to protect against the increase in patient fees and the reduction in patient care
- Incentive payments should consider the hospital's historical baseline data and target levels developed by national benchmarks
- Incentive payments should be set at FMV
  - Stick to regulatory guidance - benchmark
  - Governmental programs and third party payors are good market comparables

Gainsharing/Shared Savings Payments Overview

Valuation approach depends on type of initiative and physician involvement

Direct Cost Savings – gainsharing opinions

- Share cost savings, for example:
  - Lower supply costs
  - Lower staffing costs
- Simple to quantify
- Short-term

Quality Driven Expense Reductions – demonstration projects, data, logic

- Share costs saved from larger initiatives
  - Patient population costs (MSSP)
  - Bundled payment initiatives
  - Metrics must be measureable
- Allocation challenges
  - How to split amongst providers (specialists and primary care) and hospital?
  - Data available to assess?

Checklist – Gainsharing/Shared Savings

- Each member of the physician group should have medical staff privileges
- The arrangement should be administered by a program administrator, whose compensation was not tied in any way to the incentive compensation.
  - A program administrator should identify cost-savings metrics after reviewing historical practices and understanding its medical appropriateness.
  - The savings targets should be “re-based” at the end of each year in multi-year arrangements.
  - The hospital should calculate the cost savings separately for each group and for <u>each</u> cost savings recommendation.

Checklist – Gainsharing/Shared Savings

- Engage an independent reviewer or auditor to review the program prior to commencement and at least once per year.
- The arrangement should include objective measures to monitor quality (i.e., CMS Specification Manual for National Hospital Quality Measures).
- Cherry picking and lemon dropping focus
- Incentive payments should be set at FMV
  - Understand bundled payments vs. direct savings vs. Patient population.
  - Consider caps – demonstration projects.
  - Lack of strong guidance on determining FMV for these payments.

ACO Type Models

- The following payment allocations may be included within a clinical integration model
  - Quality and Shared Savings splits among ACO and hospital and physicians
  - Quality and Shared savings distribution among physicians
  - PMPM from ACO to physicians

- Balanced Approach for overall model should be assessed
  - Buy-in or participation Fee
  - Split of savings – existence of minimum savings threshold
  - Split of quality - benchmarks utilized
  - Time spent/effort – hourly rate paid
  - Infrastructure costs
  - Third party funded
  - PMPM fee – acuity and NCQA

Practical Considerations for Working with Physician

1. **Starting Engagement**
   - Introducing counsel and reason for process
   - Represent valuation firm as credible third party
2. **Data Submission**
   - Transparent Communications or NDA?
   - Ideally, data approved by both before issuing conclusions
3. **Preliminary Conclusions**
   - “Draft” / “For Discussion Purposes”
   - Opportunity to consider new data or facts
   - Read Qualifying Assumptions carefully
4. **Final FMV Opinion**
   - Avoid opinion shopping
   - How to explain to physicians

Final Thoughts for Compliance

- Intent is important – create a compliance program
- Monitor and enforce compliance program
- Utilize calculators to show systematic and consistent approach when possible
- Educate business development personnel on importance of FMV
- Is there a legitimate business need for the service(s)?
- Do not consider referral volume or technical revenue in making decisions
- Understand the services being provided to create a term sheet and tie valuation to services
- Careful consideration when valuing quality and cost savings
- Avoid opinion shopping

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Questions?