September 11, 2020

How Hospitals and Health Systems Can Pandemic-Proof their Physician Compensation Agreements

By Anthony Domanico, MBA, VMG Health, Minneapolis, MN and Ben Ulrich, CVA, VMG Health, Dallas, TX

Share this:

While the healthcare industry has typically been only minimally affected by economic downturns, the COVID-19 outbreak is different, substantially and broadly impacting the industry. With bans on elective procedures lasting through much of the summer, strains on supply chains and needed resources, and many patients unable to see their doctors for regularly scheduled appointments, overall productivity and average revenue levels for many providers have been impacted.

According to the American Hospital Association (AHA), these revenue declines will be significant. In a report published in late June 2020, the AHA estimates that hospitals and health systems (together, "organizations") will lose $120.5 billion from July to December 2020, in addition to the $202.6 billion the AHA estimates these organizations already lost between March and June.[1]

This is consistent with a recent report from the Healthcare Financial Management Association, which found that nearly two-thirds of organizations expect volume and revenue decreases of greater than 15 percent in 2020 compared to 2019.[2]

Confronted with such large decreases in revenue, organizations are looking for ways to reduce expenses and are increasingly looking at physician compensation as one potential solution.

In June 2020, ThedaCare, Providence Health & Services, University Hospitals in Cleveland, Sentara Healthcare, Loyola Medicine and others revealed that their employed physicians would be taking pay cuts to help offset losses during the pandemic.[3] A report from recruiting firm Merritt Hawkins in July concluded that the COVID-19 pandemic had led to recruitment searches dropping by 30 percent for physicians and starting salaries for these physicians decreasing from 2019 levels.[4]

While not all organizations have taken steps to cut physician compensation during the pandemic, physicians and advanced practice providers (collectively, "physicians") may still experience significant decreases to their compensation in 2020 and 2021. Most organizations have physician compensation plans that pay physicians based on their personally performed productivity, typically either via the level of work relative value units (wRVUs) or professional revenue a physician generates. With patient volumes down significantly in 2020, these productivity-based compensation plans will translate to smaller paychecks for physicians.

Amid growing concerns from physicians regarding these compensation plans, organizations are doing a balancing act to determine what, if anything, they can do to reduce the volatility in physician compensation during a pandemic to ensure that these physicians don't jump ship once volumes recover, while also being mindful of the financial realities they're currently facing and remaining consistent with the fair market value[5] and commercial reasonableness[6] standards as

defined by the federal fraud and abuse laws, most notably the Stark Law[7] and the Anti-Kickback Statute.[8]

These regulatory considerations are important because, while there is an exception[9] to the Stark Law prohibition against self referrals and a safe harbor[10] under the Anti-Kickback Statute that cover physician employment, these protections may not apply if an organization pays a physician above fair market value. Traditionally, physician productivity plays a role in determining a physician's fair market value level of compensation; however, reasonable, cautious actions by organizations can ensure compensation remains consistent with fair market value even when compensation and productivity levels don't necessarily align.

This article outlines three ways organizations can modify their physician compensation programs to mitigate the instability a pandemic can create on a physician compensation model while remaining compliant with federal fraud and abuse laws.

Continue the Shift from Volume to Value

Over the last few years, reimbursement contracts between insurance companies and organizations have been shifting away from historical fee for service (FFS) models, which paid these organizations solely for their physicians' level of output. These contracts have been shifting to value-based contracts that rewards for both output and health outcomes, according to the latest report from Catalyst for Payment Reform.[11]

With more revenue tied to quality and other performance-based metrics, organizations have started to include such metrics in their physician compensation plans in order to maximize the revenue coming in the door. About five to ten percent of a physician's total cash compensation is now typically tied to these metrics. These totals can be as high as 20 percent of physician compensation at organizations with significant levels of payor revenue tied to value-based contracts.

The COVID-19 pandemic could serve as a catalyst to further move compensation away from volume and towards value. By both working with insurers to increase the role of value-based care in their reimbursement contracts and retooling their employed physician compensation plans to tie more of a physician's compensation to value-based metrics and less to productivity, organizations can mitigate some of the risk of decreased compensation physicians are currently experiencing due to decreased volumes, while potentially also driving more revenue to the organization via better performance on these value-based metrics in payor contracts.

As organizations consider changes to their compensation plans for 2021 and beyond, they should review their risk and value-based contracts with government and commercial payors for reimbursement triggers tied to savings and/or quality. This will help determine whether it makes sense to shift more of a physician's compensation from wRVU productivity to other performance-based metrics, like clinical outcomes metrics or patient satisfaction. If the amount of value-based reimbursement in an organization's payor contracts is less than five percent, for example, having a 20 percent incentive for quality outcomes will take physician focus away from the behaviors that drive more revenue to the organization, specifically productivity.

If an organization decides to move more of a physician's compensation into value-based metrics, organizational leaders must take care to ensure the resulting compensation remains consistent with fair market value and commercial reasonableness standards.

Implement Salary Floors or other Guardrails

Many traditional physician compensation models provide significant amounts of upside and downside potential based on physician performance relative to productivity. These sorts of models tend to work best when performance is within the physician's control. In these types of models, if a physician works harder and produces more wRVUs, the physician will get paid more, and if a physician works less, the physician gets paid less. During normal times, these types of models make sense.

During a pandemic or other emergency that impacts the ability of patients to physically come to a clinic, however, these factors move outside the physician's control. There is no "working harder" during a time when elective procedures are banned and patients cannot safely get to their physicians. With physician talent in such high demand under normal circumstances,[12] it is important for organizations to at least consider some level of protection to these physicians to ensure stability and retention in the physician workforce, as having several physicians leave an organization because they were not reasonably taken care of during a time of emergency might end up costing the organization more than if the organization only allowed physician compensation to decrease by five to ten percent. These protections do, however, need to be balanced against the financial realities of the situation.

There are a few ways these organizations can provide these protections. Organizations could start by putting emergency-related clauses into their employed physician compensation plan documents. These clauses outline an organization's approach to compensation during an emergency and will govern what protections may be provided when the next pandemic or public health emergency is declared.

The actual protection provided can take multiple forms and is subject to negotiation between organization and physician leadership. One option is to provide guardrails such that a physician's salary during an emergency year can only decrease by a certain percentage (for example, 20 to 30 percent) from the prior year amount. Another option is to set a minimum salary floor so that a physician's salary cannot drop below a certain level, such as the 10th or 25th percentile of the specialty-specific market data. Having these clauses set up in advance will lower the risk of the arrangement when the next major emergency hits, and by setting them at lower levels of the market and/or at levels consistent with prior performance, organizations can ensure that compensation remains consistent with fair market value when compensation no longer aligns well with productivity.

The decision as to whether to provide protections, and to what degree, should be balanced against the risk tolerance of the organization and potential economic impact on it. Moreover, care should be taken to ensure that any compensation structure results in a compensation plan that remains compliant with federal fraud and abuse laws.

Embrace Telehealth Solutions

Arguably one of the biggest impacts COVID-19 will have on the healthcare industry is pushing more health systems, physicians, and patients to embrace the practice of telehealth. Telehealth has become an incredibly valuable solution for physician practices and organizations impacted operationally and financially by COVID-19. This technology brings a safe and convenient access point to care while offering flexibility and efficiencies to providers.

One of the hurdles of telehealth adoption in the past has been the lagging reimbursement landscape. The Centers for Medicare & Medicaid Services (CMS) has historically only reimbursed for telehealth services rendered to Medicare

beneficiaries presenting to a qualifying site and located in a county outside of a metropolitan statistical area or in a rural health professional shortage area (HPSA).[13] With the Section 1135 waiver of the Social Security Act,[14] the rural requirement has been temporarily removed and patients can even be seen from their own homes during the pandemic. According to the U.S. Department of Health & Human Services, in researching primary care telehealth volumes through early June 2020, telehealth utilization surged at the onset of the pandemic and has continued even after in-person restrictions have been lifted.[15] This data suggests that providers are turning to telehealth as a safe and effective option of providing care while diminishing the impacts to productivity and billable activity the pandemic originally presented. The success and surge of telehealth solutions during the pandemic has pushed CMS to propose that the interim reimbursement expansion during the public health emergency will remain permanent post COVID-19.[16] Given the expanded reimbursement opportunity, providers adopting a telehealth strategy will be able transition from traditional face-to-face visits to virtual ones, resulting in reduced overhead, a potentially viable revenue stream and increased access points for their patients.

In terms of incorporating telehealth services into employment arrangements, physicians have flexibility depending on the in-place compensation structure. As these are reimbursed visits with associated wRVU weights, providers on variable compensation structures (i.e. $/WRVU or percentage of collections) would be compensated proportionally for the volume of visits performed. Providers on salary models can transition to telehealth patient care, assuming the expectations for hours worked and/or consults performed are comparable to in-office operations.

Certainly training, implementation and sourcing the right telehealth platform can potentially be burdensome. That said, both physicians and organizations that have opted to leverage technology have the opportunity to expand wider access to care out to their patients and communities and will be better situated for continued growth whether during a booming economy or a troubled one.

Conclusion

With lessons from COVID-19 fresh on the mind of organizational leaders, now may be a perfect time to consider implementing changes to physician compensation models. Organizational leaders can make small changes to their physician compensation plans that will set both their organizations and their employed physicians up to better weather potential pandemics and other disasters down the road.

1. The American Hospital Association's COVID-19 Financial Impact Report (June 2020): https://www.aha.org/system/files/media/file/2020/06/aha-covid19-financial-impact-report.pdf.

2. Hospitals forecast declining revenues, lower procedure volumes and greater telehealth adoption due to COVID-19, Healthcare Financial Management Association (July 30, 2020), https://www.hfma.org/topics/hfm/2020/august/hospitals-forecast-declining-revenues-lower-procedure-volumes.html.

3. Five Health Systems Cutting Physician Salaries, Becker's Hospital Review (June 22, 2020), https://www.beckershospitalreview.com/compensation-issues/5-health-systems-cutting-physician-salaries.html.

4. Report: COVID-19 Reducing Physician Compensation, Job Options, Merritt Hawkins (July 14, 2020), https://www.merritthawkins.com/news-and-insights/media-room/press/COVID-19-Reducing-Physician-Compensation-Job-Options-Report/?LangType=1033.

5 The Stark Law defines general market value as "The price that an asset would bring as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of the acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition...where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals."(42 C.F.R. § 411.651).

6 The Stark Law defines commercially reasonable as "An arrangement will be considered "commercially reasonable" in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS [designated health services] referrals." (Stark II; 69 Federal Register at 16093 (March 26, 2004)). The Anti-Kickback Statute defines commercially reasonable as "The purpose must be reasonably calculated to further the business of the purchaser/lessee. Space, equipment, or services the purchaser needs, intends to use, and does use in furtherance of its commercially reasonable business objectives." (64 Fed. Reg. 63518, 63525 (Nov. 19, 1999)).

7 Section 1877 of the Social Security Act (42 U.S.C. § 1395nn), also known as the physician self-referral law and commonly referred to as the "Stark Law" (January 5, 2015), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index?redirect=/physicianselfreferral/.

8 Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)], https://oig.hhs.gov/compliance/physician-education/01laws.asp.

9 The Stark Law includes an exception for bona fide employment relationships provided that the organization meets certain criteria, most notably that the compensation paid is consistent with the fair market value of the services. *See* https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol2/pdf/CFR-2017-title42-vol2-part411-subpartJ.pdf.

10 Electronic Code of Federal Regulations (Aug. 28, 2020), https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=90f45f0c857144405b17a43c35600c16&ty=HTML&h=L&mc=true&r=SECTION&n=se42.5.1001_1952.

11 Catalyst for Payment Reform (Dec. 4, 2019), https://www.catalyze.org/about-us/cpr-in-the-news/new-national-scorecards/.

12 "New Findings Confirm Predictions on Physician Shortage," AAMC (Apr. 23, 2019), https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage.

13 "Telehealth Services" – CMS Medicare Learning Network, published March 2020, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/telehealthsrvcsfctsht.pdf.

14 Section 1135 of the Social Security Act allows for temporary modifications or waivers of certain Medicare, Medicaid, CHIP, or HIPAA requirements during Public Health Emergencies. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers – Centers for Medicare & Medicaid Services (July 29, 2020), https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

15 Medicare Beneficiary Use of Telehealth Visits; Early Data from the Start of the COVID-19 Pandemic (July 28, 2020), https://aspe.hhs.gov/system/files/pdf/263866/HP_IssueBrief_MedicareTelehealth_final7.29.20.pdf.

16 Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas, Centers for Medicare & Medicaid Services (Aug. 3, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-proposes-expand-telehealth-benefits-permanently-medicare-beneficiaries-beyond#:~:text=CMS%20is%20proposing%20to%20permanently,for%20patients%20with%20cognitive%20impairments.

About the Authors

Anthony Domanico is a Director in the physician services division at VMG Health and is the head of VMG's provider compensation design and consulting service line. With over 12 years of experience in provider compensation spanning human resources, finance, and business development for both large health systems and industry-leading consulting firms, Mr. Domanico brings a broad perspective to his consulting practice. He is based in the Minneapolis area, and may be contacted by email at Anthony.domanico@vmghealth.com or by phone at 972-616-5861.

Ben Ulrich is a Managing Director in the physician services division at VMG Health and is based in the Dallas office. He specializes in providing his clients with valuation and consulting services for all manner of physician compensation and contracting-related issues within the healthcare services industry. He has particular expertise in valuations relating to employment compensation, hospital on-call and on-site coverage, telehealth, physician administrative and executive services, and quality initiatives. Mr. Ulrich is designated as a Certified Valuation Analyst (CVA) through the National Association of Certified Valuation Analysts. He may be contacted by email at Ben.Ulrich@vmghealth.com or by phone at 972-616-7798.

ABA American Bar Association | /content/aba-cms-dotorg/en/groups/health_law/publications/aba_health_esource/2020-2021/september-2020/hos-hea