Prepared for:

hfma

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Practical Advice on Physician Compensation: Achieving Compliance and FMV

Jen Johnson, CFA

- *Perspective: 3rd party valuation expert with understanding of legal and compliance issues.*

- Managing Director at VMG Health & has led Professional Service Agreements Division for 10 years
- Integral in developing internal compensation solutions for some of the largest health systems in the country
- P4P Thought Leader
- Published and presented over 50 times related to physician compensation and fair market value
- Previously with KPMG's Litigation Services practice & Former Finance professor from the University of North Texas

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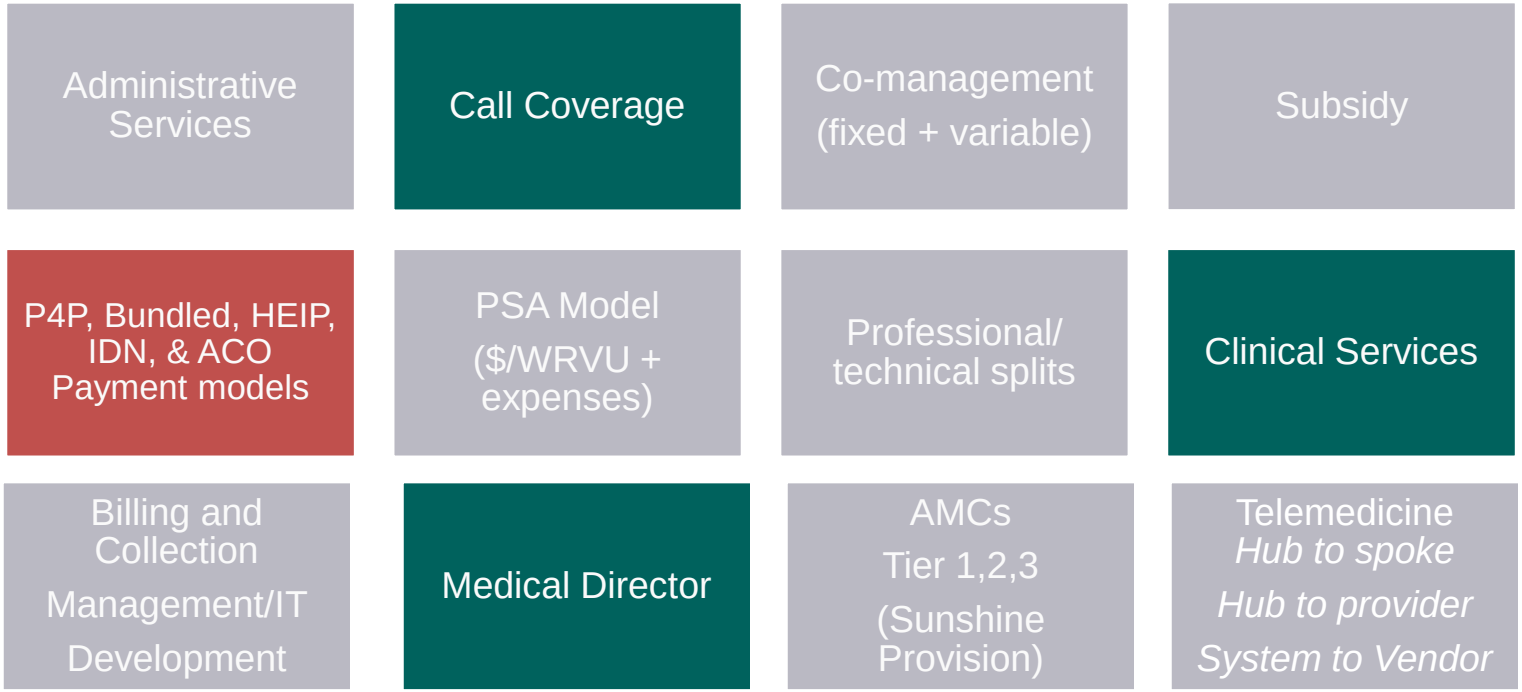
Compensation Arrangement Types



LATEST IN PHYSICIAN COMPENSATION

1 – Regulatory Scrutiny

2- Internal processes for setting compensation

2 - P4P components – newest challenges for determining FMV

Steps to FMV Compliance & Physician Compensation

1. **Outline what 'commercially reasonable' services will be provided and how parties will be compensated**
2. **Valuation should match the agreement - may require several valuations for one agreement (clinical, administrative, on-call, P4P)**
3. **Thorough valuation process to establish compensation should be tied to each of the services provided**
4. **Establish and monitor a compliant and consistent process for establishing FMV**
5. **Checklist when reviewing a valuation**
    - ✓ Understand recent settlements – beware of documentation regarding referrals or no documentation regarding services
    - ✓ Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating Fair Market Value
    - ✓ Valuation method and benchmarking is important
    - ✓ Consider regulatory guidance, recent settlements and OIG opinions (shared savings, on-call beeper rate, excessive losses)
    - ✓ Methods that won't hold up
        - Compensation models built on referrals
        - What hospital next door is paying
6. **New challenge – transition to compensate physicians on quality and cost-saving outcomes rather than being reimbursed solely for services and procedures. There is a lack of survey data and guidance here.**

Compliance Basics - Commercially Reasonable

- *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. (69 Federal Register (March 26, 2004), Page 16093)*
  - Pre-cursor to determining FMV
  - Arrangement must make business sense absent considering referrals
  - Hospital leadership must understand this standard since they will primarily be the individuals who assess CR. **Sample** considerations:
    - Operational assessment – does the community need this service/number of specialists?
    - Physician requirements – are the number of hours required?
    - Financial options – can you lease equipment from a third party vendor at a better rate than from a physician group?
  - Counsels role – did hospital leadership walk through the business considerations?
  - Valuation firm role – is the compensation at FMV?

What is Fair Market Value?

"Fair Market Value" is defined in Stark, 42 U.S.C. 1395nn(h)(3), as the value in arms-length transactions, consistent with the general market value…the compensation that would be included in a service agreement as the result of a 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 acquisition of the asset or at the time of the service agreement. (42. C.F.R. 411.351)

Stark II Phase II Commentary adds this clarification:

- *The methodology must exclude valuations where the parties to the transactions are at arm's-length but in a position to refer to one another. (69 Federal Register (March 26, 2004), Page 16107)*

Preamble Stark Phase I Commentary adds this clarification:

- *Depending on the circumstances, the "volume or value" restriction will preclude reliance on comparables that involve entities and healthcare providers in a position to refer or generate business. (66 Federal Register (January 4, 2001), Page 945)*

Compliance Basics - Fair Market Value

- **Agreements should carefully be constructed**
  - Compensation should not be tied to expected or actual referrals. This is important when establishing compensation or when setting mechanism to drive compensation.
  - Carefully construct alternative payment models (gainshare, MSSP, ACO, bundled payments) since often tied to other (non-physician) income streams.

- **Do not determine FMV based on**
  - What the hospital next door is paying.
  - Non-comparable services and associated fees (ie: management vs. co-management).
  - Solely on opportunity cost of the physician performing a different service, or their “going rate” (surgery vs administrative work).

Trends

1 - Increased regulatory scrutiny

- Huge surge in Qui Tam suits – physicians, compliance officers, etc…
- Federal funding for fraud and abuse investigations growing
- Numerous and material settlements over past several years (Tuomey, Citizens, Halifax, Bradford, Lexington, etc…)
- Personal accountability now a real thing

2 – New processes to streamline physician compensation

- Save time
- Save money
- Increase compliance

3 - New types of arrangements – APM, P4P, ACO, IDN

- Government and commercial payors continue to introduce payment models at a rapid rate.
- Market data and regulatory guidelines for these payments scarce
- Waivers conflict with Stark and only cover some deals
- FFS plus P4P – how to ensure its OK?

Recent Health Care Fraud Efforts

- **Why? For every $1 spent on healthcare fraud related investigations, government recovers $6.10**
- **2016 stats:**
  - Strike force teams in 9 areas targeting local doctors and large companies have resulted in 2,185 indictments and nearly $2 billion in recoveries
  - DOJ recovered $4.76 billion in FCA cases, 25% more than 2015
  - June 2016 – DOJ and HHS reports landmark charging 301 individuals for false billing of $900 million
- **Yates memo and OIG alerts warn individuals are at risk criminally and financially**

Real people, Real problems – New Area for Concern

- ✓ Columbus Regional in Georgia - Claims for payment to federal health care programs that misrepresented the level of services they provided - **Dr. Pippas** to pay **$425,000.**

- ✓ Tuomey – hospital settled case and over one year later, former **CEO** fined **$1 million.**

- ✓ North American Health Care Inc, - False claims to government health care programs for medically unnecessary rehabilitation therapy services - **chairman of the board** agreed to pay **$1 million** and the senior vice president agreed to pay **$500,000.**

- ✓ Sacred Heart Hospital - **Former executives and physicians** for alleged role in orchestration and participation in unlawful kickback compensation schemes - **convicted and sentenced to prison terms**.

- ✓ Recovery Home Care Inc - Former **Owner**, Mark T. Conklin allegedly paid dozens of physicians thousands of dollars per month to serve as sham medical directors - agreed to pay **$1.75 million** to settle lawsuit.

- ✓ **Physician Assistant**, Kyle D. Gandy - Sentenced to **14 months in prison** and ordered to pay **$18,030** in restitution for accepting illegal kickbacks for referring patients to medical clinics, physical therapy clinics, and a home health care agency.

Internal Processes for Setting Physician Compensation

Many health systems have a partially or fully automated opinion process primarily for traditional arrangements which remain at the forefront of scrutiny

1. Medical Director
2. On-call Coverage
3. Clinical Compensation

Options for determining and documenting FMV

1. Verify all arrangements internally
2. Split between internal process and outsourcing higher risk arrangements
3. Verify all externally

Not all health systems are structured alike, FMV process differs based upon:

- Risk tolerance (may change with leadership as well as external market forces) – where are thresholds, 75th ok?
- Health system's approach to physician agreements (consistent -> each unique)
- Structure of physician alignment team and decision process
  - Team dedicated to physician compensation
  - Legal, business development, compliance, or facility-level decisions
  - Decentralized or centralized opinion requests

Balancing Compliance with Internal Processes for Setting Physician Compensation

The 3 C's of FMV Deliverables – must be understood and balanced

- Cost – importance
- Compliance – risk tolerance
- Convenience – speed, need for assistance

- Benefits of building strong internal processes and compensation team
  - Shows consistency and lowers risk if set up properly
  - Saves money on outside valuations
  - Should speed up process to get deals done
- Disadvantages of relying solely on internal compensation team
  1. **Monitoring processes are properly developed and followed**
  2. **Complex deals may fall outside of many processes**
  3. **Risks of over-automation (software products)**
     - Raw Survey license restrictions may limit data usage
     - May eliminate all judgment
     - User error
  4. **New P4P may be difficult to streamline and value properly internally**
- Striking the balance should consider executive and compensation team structure, risk tolerance, and competitive environment

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FMV & COMPLIANCE TIPS

Medical Director Services - Valuation

- **Cost Approach**
  - Considers the cost of the physician's time based on clinical compensation
  - Considers multiple, published compensation surveys
  - Likely not what they earn during an hour of surgery
- **Market Approach – typically preferred approach**
  - Considers compensation data for similar services
  - Considers multiple, published medical director compensation surveys
  - Subject to some limitations (referral relationship)

Call Coverage Services - Valuation

- **Market Approach**
  - Considers available market survey data for call coverage services
  - Currently, there are two prevalent market surveys
  - Market Approach is subject to significant shortfalls, burden of call unknown, limited respondents, large variability. Use with caution.
- **Cost Approach – typically preferred approach**
  - Considers clinical compensation data and applies a beeper rate %
  - Meant to reflect burden of call as suggested by OIG opinions
  - Payor mix, volume of call, acuity, trauma designation, supply/demand of physicians is considered

Clinical Services - Valuation

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

Example, misuse of reported compensation per work RVU data

- Solo practitioner specialized in general orthopedic surgery
- No in-office ancillaries or mid-level providers
- 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***

Compliance Checklist – Traditional Arrangements

- **Best Practice - internal policies for compliance:**
  1. A consistent process to determine FMV, including written agreements
  2. Internal thresholds with triggers when a 3rd party appraisal may be needed
  3. Monitor to ensure that services were performed
  4. Review agreement to verify the need for services still exist
- **Medical Directorships - Document services and track time, pay hourly**
- **Call coverage – understand the burden of call per OIG opinions, caution on surveys**
- **Clinical services and employed compensation**
  - ✓Benchmark productivity – average productivity warrants average compensation
  - ✓Losses in a practice - understand reason (safety net hospital, restricted coverage, coordinated care costs)
  - ✓Stacking – total dollars and hours make sense?

FMV & P4P

Types of Arrangements

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Co-Management/Service line

- ✓ Understand and value each service
- ✓ Identify savings or quality metrics
- ✓ Suggest benchmarking
- ✓ Consider OIG's gainshare and co-management opinions

Bundled Payments/Individual/Employment

- ✓ Understand market reimbursement for physician services and quality
- ✓ Identify risk and responsibility of all parties
- ✓ Consider caps and stacking

ACO Type Model/Population/HEIP

- ***Balanced approach for overall model should be assessed***
  - ✓ Opinion on allocation to parties (physicians, hospital)
  - ✓ Opinion on distribution among physicians
- Value Drivers:
  - ✓ Third party funded or from hospital
  - ✓ Infrastructure cost recovery
  - ✓ Buy-in or participation Fee
  - ✓ Time spent/effort – hourly rate paid/existing compensation model
  - ✓ Split of savings – existence of minimum savings threshold
  - ✓ Split of quality - benchmarks utilized, targets tough
  - ✓ Upside and downside risk
  - ✓ Care coordinator payments – i.e.: Nurse care manager
  - ✓ Available data key to determining support for individual performance payments

Considerations when Setting Up a P4P Incentive Model

1. Understand where dollars are coming from and who is responsible for them.
2. Select performance metrics that directly align with the hospital's mission and values.
3. Benchmark performance against historical and national data in order to identify superior outcomes.
4. Understand how base level and maximum payouts relate to risk and responsibilities. Does it properly incentive the physician based on his/her level of risk, services and performance under that model?
5. Assess historical production and impact new outcomes based model will have on go-forward compensation (i.e. lower utilization = lower WRVU volume).
6. Create an infrastructure to track and monitor quality performance, responsibility for quality and expense incurred (i.e. nurse care managers, IT system, etc.).
7. Determine that the arrangement is commercial reasonable.
8. Make a FMV determination to ensure the various payouts under the agreement is reasonable.

Compliance Checklist – P4P Arrangements

Quality Payments

- Metrics outlined
- Primarily outcomes metrics (versus process or reporting)
- Be careful with low hanging fruit metrics
- Benchmark performance against medical credible evidence
- Ensure physician(s) will have demonstrable impact on quality
- Check for overlap of payments from co-management, bundled payments, etc…

Shared Savings

- No cherry picking or lemon dropping
- Identify separate identifiable cost savings opportunities in advance
- Ensure physician(s) will have demonstrable impact on cost savings

Understand the risk and responsibility of parties prior to determining split of quality or savings payments

4 Steps to Compliance

- 1 – Educate Team on written policies and processes
- 2 – Determine arrangement is Commercially Reasonable
  - Arrangement must make business sense absent considering referrals
  - Hospital leadership must understand this standard since they will primarily be the individuals who assess CR
  - Counsels role – did hospital leadership walk through the business considerations?
  - Valuation firm role – is the compensation at FMV?
- 3 – Establish FMV for Payments
  - Compensation should not be tied to expected or actual referrals.
  - Do not determine FMV based on
    - What the hospital next door is paying.
    - Non-comparable services and associated fees (ie: management vs. co-management).
  - Carefully construct alternative payment models
- 4 – Monitor arrangements to ensure policies and processes are followed

Compensation Arrangement Questions

- Did the appropriate party representatives to the arrangement review, understand and verify the assumptions and value drivers relied upon in the analysis?
- If there are multiple services provided, does each have a defensible valuation methodology outlined?
- Have multiple, objective market surveys been considered as part of the analysis (when available)? If only one survey is utilized, it is important that the valuation provide sufficient reasoning to explain the departure from use of multiple surveys.
- If comparable arrangements are relied upon, are they truly comparable?
- Does the valuation address whether it is an employed or independent contractor arrangement?
- If the services are billable, is it clear which party is retaining collections and are they considered in the analysis?
- If physician compensation data was considered, is a physician required based on the services outlined?
- Are the physicians required to document time and services prior to receiving payment for the services? Requiring physicians to submit time logs in order to receive payment is best practice from a compliance perspective.
- Commercially Reasonable questions (see chapter 3 for additional guidance):
  - ✓ Do the services being provided overlap with what the hospital or health system's staff is providing?
  - ✓ Was the physician chosen based on his or her expertise in a particular specialty?
  - ✓ Are there excess physicians engaged?

Questions & Discussion