Compensation and Benefits for Employed Physicians

Webinar Series

Part One: December 6, 2011

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Program Overview

> Part One – December 6, 2011:
  – Trends in employment (and other hospital-physician integration) relationships
  – Emerging integration options and structural and regulatory parameters

> Part Two – December 8, 2011:
  – Benefits arrangements for physicians: 2012 and beyond
  – Approval and administration of compensation for physicians

Trends: Why Hospital-Physician Employment (and Other Integrated) Relationships are Coming Back
Emerging Trends – Physician Perspective

> Expenses increasing faster than revenue and income
  - Malpractice insurance
  - Non-physician payroll

> Downward pressure on reimbursement and income

> Diminishing returns
  - Seeing more patients
  - Minimal growth of income
  - Loss of personal time

> Response to Health Reform

Emerging Trends – Physician Perspective

> Physicians seeking:
  - Ancillary business opportunities
    - Diagnostic imaging, physical therapy, clinical trials
  - Compensation from hospitals
    - Hospital-based physicians seeking subsidies due to high level of charity care
    - Compensation for duties historically not paid for such as on-call and administrative meetings
  - Physician recruitment
    - Stark Law restrictions not appealing to existing physician groups
Emerging Trends – Physician Perspective

> Physicians seeking (continued):
  – Joint venture or management service arrangements with hospitals
    • Regulatory compliance creates unexpected obstacles
    • Purchasing organizations, MSO services

Emerging Trends – Hospital Perspective

> Shortages of critical medical specialties
> Required specialty coverage for trauma/emergency departments
> Increasing competition and shrinking market share
  – Other hospitals
  – Physicians
    • Nibbling away at market share
    • Typically hospitals’ highest margin business
> Physician defections to other organizations
> Response to Health Reform
Emerging Trends – Responses

> Hospitals and physicians continue to move toward employment and other integrated arrangements
> Hospitals and physician groups also are developing mutually beneficial but less integrated arrangements
  - Clinical Institutes/co-management agreements
> Physicians are demanding compensation from hospitals for their time and effort related to:
  - Hospital/departmental administration
  - Call coverage for the ED
  - Other non-clinical activities

Hospitals employ physicians again – why?

> Posture for Health Reform
> Enhance physician recruitment
> Stabilize medical staff
> Recruit high-dollar, in-demand specialties
> Defensive strategy; protect high-revenue specialties/service lines
> Improve physician cooperation on programs (e.g., medical error reduction)
> Rescue distressed practices
Physicians becoming employed again – why?

> Posture for Health Reform
> Stabilize and secure income
> Reduce risks and exposure
> Workload relief
> Improved lifestyle and personal time (esp. younger physicians)
> More input
> More control
> Improved efficiency
> Access to alternative revenue sources

Emerging Trends – Responses

> While hospital-physician integration continues, Health Reform and the need to prepare for the future healthcare landscape drive new approaches to hospital/physician relationships:
  > Shift from productivity-based compensation to qualitative models
  > Focus on efficiency
  > Shift risk of utilization from payors to providers
  > Reward based on patient satisfaction, communication, operational efficiency, quality, and other qualitative indicators
### Hospital-Physician Employment and Other Integration Models

#### Overview of Physician Alignment Options

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**Less Integration**

**Full Integration**
Physician Employment/Integration Structural Options

> Physician employment/integration generally can be structured using one of several options. Examples include:
  - Direct hospital employment
  - Employment in hospital subsidiary/affiliate group practice
  - Professional Services Agreement
  - Co-Management Arrangement

> Organizational structure will dictate the potential compensation and other relationships between physicians and the hospital/affiliate employer
  - In other words, desired relationship components may dictate choice of organizational structure

Important Factors In Selecting Model

> Group (pooled) compensation or individual compensation model?
> Compensation to include revenues for in-office ancillaries?
> Physician desire to participate in practice governance?
> Employer desire to modify certain behaviors through incentives/penalties?
  - Clinical productivity
  - Quality incentives
  - Expense savings
  - Outreach
  - Call coverage
  - Teamwork
Direct Employment by Hospital

OVERVIEW
- Hospital purchases medical practice assets for fair market value (FMV) and operates medical practices
- Individual physicians employed directly by Hospital (not employed by Hospital subsidiary)
- Hospital bills and collects for physician services
- All services (professional and ancillary) may be performed in a provider-based setting
- All practice overhead and physician compensation treated as expenses of Hospital

Stark Law and Anti-Kickback Statute offer broadest compensation exception/safe harbor for *bona fide* employment
- Overall compensation must be:
  - Consistent with fair market value
  - Not based directly or indirectly on the volume or value of designated health service ("DHS") referrals
  - Compensation may include fixed salary and productivity bonuses based on services personally performed
- Aggregate compensation need not be set in advance
- Permissible to require referrals to employer or other related entities
Stark Law offers an additional exception for physicians employed by a group practice affiliate of a hospital or health system.

More flexibility than under direct employment in structuring physician compensation models.

- Compensation can be structured to include:
  - Revenue from services performed “incident to” a physician’s service
  - DHS revenue generated within the practice (if aggregated with enough other MDs)
  - Overall profits of group practice
    - But, consider tax implications if tax-exempt
**Professional Services Agreement**

**OVERVIEW**
- Independent contractor model may be used as an alternative to employment for physician group
- Physicians remain in private practice and receive compensation and benefits from private practice
- Hospital or existing Foundation enters into a professional services agreement with the physician practice where Foundation leases 100% of the work effort of all physicians on an independent contractor basis
- Hospital/Foundation bills for the professional services of the physicians
- Hospital/Foundation pays a service fee to the practice for all clinical and other services performed by physicians
- Ancillary services may be performed in the Foundation or in Hospital setting, as determined by Hospital
- Transaction could include the purchase of practice assets or lease of practice assets by Hospital/Foundation
- Practice staff could be employed by Hospital/Foundation or remain employed by private practice.
  - Subject to provider-based requirements, if applicable

**HOSPITAL**
- Employs Physicians
- Buys Medical Practice Assets

**FOUNDATION**
- Employs Physicians

**GROUP PRACTICE**

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**Co-Management Arrangement**

**OVERVIEW**
- Physicians remain in private practice (can be several private practices).
- Physicians form a new management company (MSO) with physicians/groups as equity participants
- Hospital also acts as investor in MSO
- Hospital contracts with MSO to provide a broad range of management services in connection with one or more Hospital service lines
- MSO services could include medical direction, administrative, management, quality improvement, outreach, etc.
- Hospital pays MSO FMV management fee
- Physicians earn distributions through the profits of the management company
- Physicians agree to not compete with the technical services provided by the applicable Hospital service line.
Co-Management Agreements

> Co-management agreements are designed to:
  - Further integrate physicians into the management of hospital services
  - Provide opportunity for physicians directly to impact quality and efficiency
  - Provide opportunity for Hospital and physicians jointly to negotiate performance parameters

> Key issues to consider/define:
  - What are the duties and responsibilities?
  - Do the duties overlap with other services that are already paid for (or required by Medical Staff bylaws)?
  - How much time is required for each of the duties?
  - Are they necessary for the operation of the service line?
  - What are the expected outcomes?:
    - Efficiency
    - Quality
    - Can these outcomes be measured today? If not, when?
    - Will the required outcomes vary from year to year?
  - Is the compensation reasonable and within FMV?
  - Does structure of compensation formula comply with applicable law?
    - Anti-Kickback Statute
    - Stark Law
    - Gainsharing CMP

Regulatory challenges include:
  - Must be commercially reasonable
  - The services must actually be performed
  - At-risk compensation fails the anti-kickback safe harbor
  - Difficult to determine FMV for achievement of efficiency goals
  - Difficult to determine FMV for achievement of quality goals
  - Does the physician effort required to achieve initial goals decline over time (thus impacting the value of their total work effort)?
  - Once key efficiency and operating goals are achieved, should they be sustained? Or measure continuous improvement?
Compensation Models

On the Front End

> Sign-on bonuses
  - Outright
    - Typically paid upon signing
    - Immediately taxed as additional W-2 compensation
  - Forgivable loan
    - Should bear market rate of interest
    - Typically repaid or forgiven over 2-3 year period (initial term of employment)
    - Forgiven principal amounts plus interest will be additional W-2 income in year forgiven
On the Front End (cont’d)

> Housing or relocation assistance
  - Nature of assistance
    - Direct payment
    - Reimbursement of costs incurred by physician
    - Loans (forgivable or otherwise)
  - Tax results depend on scope of payments
    - Possibly may qualify as non-taxable qualified moving expense reimbursement under IRC Sections 132 and 217
    - Limited to reasonable costs of moving household goods and personal effects and reasonable costs of traveling (including lodging) from former residence to new residence
    - Does not include temporary living expenses (taxable)

On the Front End (cont’d)

> Assistance with immigration costs
  - Up-front payment (typically forgivable loan) to cover legal and other expenses incurred by physician in obtaining or retaining visa/green card as necessary to commence or continue employment
  - Important to define applicable time period during which expenses may be incurred
  - Pay only upon submission of appropriate documentation
Guaranteed Base Salary

> Commitments vary
  - Multi-year (over term of employment)
  - Year-to-year, based on prior year’s performance (or rolling average)

> For several years, prevailing practice
  - Many employers learned a hard lesson
  - Still find in certain prestigious, physician-driven systems

> Considerable risks to employer
  - Economic and non-economic

> Recently, seeing renewed interest
  - Shift to ACO, quality-based reimbursement environment

Performance-Based (Incentive) Comp

> Measuring performance based on production:
  - wRVUs
  - Net charges
  - Net collections
  - Net income
Performance-Based (Incentive) Comp (cont’d)

> wRVUs often favored
  - Gives physicians little incentive to care about a patient’s payor source (if any)
  - Considered a better reflection of true work effort
  - Challenges
    • CMS periodic adjustments in wRVUs
    • Procedures for which no wRVUs are assigned
    • “Deemed” wRVUs

Performance-Based (Incentive) Comp (cont’d)

> wRVUs (cont’d)
  - Need to translate wRVUs to dollars
  - Conversion factor is key
    • Best practice is to adjust CF periodically to ensure comp remains consistent with market (without need for amendment of employment agreement)
    • Consider using “tiered” conversion factors to incentivize higher levels of performance
Performance-Based (Incentive) Comp (cont’d)

> Other production-based measures:
  – Net charges – virtually meaningless
  – Net collections – often used, but:
    • Gives physicians a reason to care about a patient’s payor source (disincentive for charity care)
    • Ignores the expense side of the equation
  – Net income – certain regulatory risks, but:
    • Effective approach to getting physician engagement for controlling practice costs
    • Particularly useful for primary care (office-based)
    • Still must address the charity care/payor source concern

Performance-Based (Incentive) Comp (cont’d)

> Unique considerations in production-based comp settings:
  – Office-based physicians versus proceduralists
    • Dynamic, context, motivations and expectations differ greatly
    • What works for primary care may not work for specialists and subspecialists
  – Hospitalists, ED or other “shift” physicians
    • Fixed salary, or per-shift wage
    • Keep on production-based model, but guarantee base
> Unique considerations (cont’d):

- New recruits, or strategic relocations
  - Often give fixed guarantee for initial time period sufficient to build new practice site
  - May permit movement to production-based model sooner, if successful earlier than anticipated
  - May need “protection” for existing physicians already at that site
    - Absolute guarantee, or
    - Guarantee conditioned on achieving at least X% of past production levels

- Part-time physicians, or “reduced producers”
  - Considerations (e.g., family commitments, health concerns, desire to wind down before full retirement, etc.) cause production to consistently fall below full-time levels
  - Important not to ostracize or alienate; still valuable contributors
  - Yet, recognize economic and logistical challenges for employer
  - May apply a reduced wRVU conversion factor, for example
  - Cooperation and collaboration (including practice intervention measures) essential
Performance-Based (Incentive) Comp (cont’d)

> Measuring “performance” in terms other than production
  – Qualitative performance considerations
    • Quality of care
    • Patient satisfaction
    • Good citizenship
      *Challenge*: Reduce subjectivity; the more objective, the better
  – Reflects shift from fee-for-service to pay-for-performance

Other Types of Payments

> Administrative services
  – Medical direction, program development, etc.
  – Alternatives:
    • Pay fixed amount, with required minimum number of hours
    • Pay hourly
  – Key: control and clarify expectations

> Supervision of physician extenders
  – Must consider totality of arrangement
    • Fixed salary, versus credit for amounts billed
    • Watch for compliance concerns
Other Types of Payments

> On-call services
  - Slippery slope
  - Distinguish between responsibilities as member of medical staff and additional obligations taken on as employee
  - Avoid duplicative payments
    • *E.g.*, paying for on-call services while physician is in office seeing patients
  - Perceived inequities abound

> Outside income
  - Examples:
    • Medical direction of dialysis facility or nursing home
    • Deposition or expert witness fees
    • Honoraria for speeches or papers
    • Moonlighting
    • Pharma payments
    • Part-time employment or self-employment
Other Types of Payments

> Outside income (cont’d):
  – Potential concerns:
    • Application of liability insurance
    • Reputation of employer or physician
    • Compliance with law/regulation
    • Misuse of employer resources
    • Scheduling concerns
    • Patient access and quality of care
  – Key question: within the scope of employment?
    • Paper arrangement accordingly

Other Types of Payments

> Outside income (cont’d):
  – Alternatives for payment:
    • Pay to employer, and either:
      – Employer passes full payment on to physician
      – Employer passes full, some or no portion on to physician, depending on other considerations
    • Pay directly to physician
Other Types of Payments

> Medical records
  - Increasingly common for employers to reward or punish for timely completion of patient medical records
  - Alternatives
    ▪ Incentive payment
    ▪ Withholding or docking salary
  - Should include appropriate language in employment agreements

Practical Considerations

> Logistics for payment of compensation
  - Draws
    ▪ Typically set based on prior year production (to avoid overpayment, may apply factor such as 90%)
    ▪ Cannot apply in vacuum; must consider reasonable expectations for coming year
  - Periodic payments
    ▪ Typically quarterly payouts of incentive comp, with year-end reconciliation
  - Repayment or recoupment
    ▪ Mandatory or discretionary
Practical Considerations

> “Right to deviate” provision
  - Allow adjustments (including mid-year) based on:
    - Market changes unique to a particular specialty
    - Assignment of wRVUs for services where no CPT code assigned or survey data does not reflect services
    - Practice location
    - Significance to strategic plan objectives
    - Recruitment/departure of other physicians in the specialty
    - Practice revenues and expenses
    - Compliance with law
    - Other (e.g., physician faces substantial over-draw)

Practical Considerations

> Caps
  - Aimed at ensuring that overall comp does not exceed FMV, reasonable levels
    - Regulators want to see, even if set relatively high
  - Nature of cap
    - Hard cap – may be counterproductive, however
    - Soft cap – trigger internal review to confirm:
      - Accuracy and integrity of production data, administrative hours, etc.
      - No declines in clinical quality or patient satisfaction
      - Aggregate amounts remain FMV (may require review and opinion of outside consultant)
Prevailing Practices

> Predominant physician comp models**:
  - Salary plus incentive (40%)
  - Production-based (34%)
  - Fixed salary (14%)
    - Shift toward ACO model (focus on quality over production)
    - Patient volume in certain areas?

** Health Leaders Media Intelligence Report, Physician Compensation: Shifting Incentives (2011)
Prevailing Practices

> Prevailing comp plan incentives**: 
  - Productivity (75%)
    - Primary measure = wRVUs (66%)
  - Quality (57%)
  - Patient satisfaction (50%)
  - Administrative duties (47%)
    - Note: 48% of respondents don’t pay for administrative duties but still expect physician participation
  - Chart completion (23%)

** Health Leaders Media Intelligence Report, Physician Compensation: Shifting Incentives (2011)

Prevailing Practices

> Frequency of changes to physician comp models**: 
  - Every year or two (41%)
  - Every three to five years (38%)
  - More than five years (21%)

** Health Leaders Media Intelligence Report, Physician Compensation: Shifting Incentives (2011)
Market Trends/Outlook

> Drivers of physician comp models**:
  - Medicare/Medicaid (76%)
    - Commercial payors typically will follow (though, in some cases, may lead)
  - Healthcare reform (59%)
  - Market competition (49%)
  - Local economy (38%)
  - ACOs (38%)
  - Medical home model (27%)

** Health Leaders Media Intelligence Report, Physician Compensation: Shifting Incentives (2011)

Market Trends/Outlook

> Anticipated physician comp changes for 2012**:
  - Increase 10-20% (6%)
  - Increase 5-9% (20%)
  - Same or COLA of 1-4% (65%)
  - Decrease of 1-4% (4%)

** Health Leaders Media Intelligence Report, Physician Compensation: Shifting Incentives (2011)
Market Trends/Outlook

> Comp models will continue to focus on production
  - However, shift from FFS to PFP will mean movement from pay based on volumes to pay based on quality, patient satisfaction, and citizenship

> Primary care physicians will be in demand
  - Key role in ACOs and medical homes
  - National shortage
  - Anticipate market competition and salary growth

Market Trends/Outlook

> The most recent practice acquisition frenzy will mean adjustments to comp of other physicians in the same specialty
  - Necessary to achieve internal parity

> Will see significantly greater need for physician administrative leadership
  - Increased time commitment will warrant change in compensation accordingly
Implications of Health Reform on Physician Compensation

> Focus on *quality* rather than *quantity* of care
> Objective to reduce healthcare expenditures of assigned beneficiaries
> Implications for both primary care and specialists (although different)

Transitioning to Health Reform Future

> Reasons to move toward alternative compensation models:
  - Commercial payors already shifting toward payment for quality and outcomes, ahead of CMS
  - Greater lead time for employers and physicians to identify and become comfortable with appropriate quality and outcomes measures
  - May soften impact of cultural/economic shifts associated with future ACO implementation
  - Anecdotally:
    • Large physician entities are modifying physician compensation model to require 5%, 20% or even 50% to be at risk based on factors other than production
Transitioning to Health Reform Future

> What remains the same:
  - Compensation tied solely to services personally performed by physician or those under physician’s direct supervision (no compensation for ancillaries)
  - Annual adjustments to ensure FMV
  - Stipend for administrative services and/or supervision of extenders
  - Cap on total compensation

> What changes – the key question:
  - How to reward physicians for individual performance

Transitioning to Health Reform Future

> Potential compensation “building blocks”
  - Fixed guaranteed salary
  - Production-based compensation (wRVUs, collections, etc.)
  - Quality incentives
  - Patient satisfaction incentives
  - Incentives tied to other individual performance considerations
  - Incentives tied to other group or hospital/system performance considerations
Transitioning to Health Reform Future

> Objectives of compensation plan:
  - Reward physicians at FMV
  - Encourage diligent work efforts
  - Provide reasonable income stability/continuity during transition to “reformed” healthcare industry
  - Promote quality
  - Reward collaboration with other providers and caregivers
  - Encourage better communication with patients
  - Promote care in the “right” setting
  - Reward effective/efficient use of limited hospital/system resources

> Maybe not a one-sized fits all proposition (e.g., primary care vs. specialists)
  - Consider how compensation plan objectives vary between specialty areas
  - If objectives vary, may need to also differentiate the specific building blocks accordingly
Transitioning to Health Reform Future

> Primary care:
  – Emphasis on management of patient health (esp. chronic conditions)
  – Expanded roles for physician extenders and specially-trained RNs
  – Broad use of “medical home” model
  – Continuous education, communication and monitoring to enhance patient health and avoid expensive episodes of care

> Specialists:
  – Focus on adherence to clinical protocols designed to ensure consistent, high-quality care while achieving cost efficiencies
  – Results matter, i.e., outcomes will be measured and will be condition for payment of financial incentives
Regulatory Considerations

> Net revenue/collections:
  - wRVUs
  - Quality
  - Benefits
  - Other cash compensation

> Productivity compensation (wRVUs and collections):
  - Under Stark Employment Exception can use productivity compensation only for personally performed services
  - Cannot reward physician for volume of work of others but can pay for effort in supervising

> Quality metrics:
  - Difficult to determine FMV for performance related to quality
  - Challenge in measuring/tracking outcomes
  - More time/effort at outset of achieving quality
  - Reset over time; may reduce quality component
  - Physician role in quality achievement

TOTAL compensation must be FMV
Evolving Regulatory Concerns: Payment for Quality Metrics – PSA Model

> Fails AKS safe harbor if aggregate compensation not “set in advance” (RISK?)
> May meet Stark definition of “set in advance” if formula can be set forth in agreement
> Both AKS and Stark require compensation to be at FMV and not take into account volume or value of referrals or other business
> Both AKS and Stark require overall arrangement to be “commercially reasonable”

Measuring/tracking performance outcomes
> Compensation for time spent developing benchmarks, clinical protocols, materials at FMV at outset
> Readjust compensation for time as services completed
> Relevance/evolution of quality metrics over time and FMV as program matures
> Need to “reset” or advance type and measure for time-based performance based metrics
Evolving Regulatory Concerns:
Payment for Quality Metrics – Employment Model

> Growing trend to add quality achievement duties
> But, total compensation package must remain at FMV
  - Adding or including performance-based quality compensation cannot increase total beyond FMV
> Consider both quality and clinical duties together:
  - Can all be achieved in a possible day?
  - Salaried versus shift employee

Evolving Regulatory Concerns:
Payment for Efficiency – Co-Management Model

> Implicates Gainsharing CMP to extent payment could be viewed as incentive to reduce or limit services to beneficiaries
> See OIG Special Advisory Board and Advisory Opinions on Gain Sharing, suggesting program standards:
  - Avoid “cherry picking” patients
  - Avoid “stinting” on care, “steering” patient and early discharge
  - Maintain clinician choice of treatment options/supplies
  - Look to recognized, objective clinical guidelines/protocols
  - Transparency
  - Payments per capita and limited duration
> Waiver/new exception from CMP
Evolving Regulatory Concerns: Payment for Efficiency – Co-Management Model

> Stark compliance uncertain:
  – Historically, no Stark exception for gainsharing
  – 2009 MDFS proposed Stark exception for incentive payment and shared savings programs (gainsharing, PAP, value-based purchasing), not finalized
  – Indirect compensation option
  – Waiver/new exception for Stark law?

> No anti-kickback safe harbor; not “set in advance”

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Qualitative Incentives/Examples
PSA Dollar Per wRVU Incremental Incentives

> 8-physician cardiology practice compensated for clinical services under PSA based on $/wRVU conversion factor

> Hospital desires to align interests around qualitative and operational goals, including:
  - quality
  - patient satisfaction
  - financial/operational efficiency

> $4 per wRVU conditioned on achieving agreed-upon benchmarks

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PSA Dollar Per wRVU Incremental Incentives

> YR1 benchmarks include the following:
  - $2/wRVU conditioned upon all physicians reporting to CMS’ Physicians Quality Reporting initiative (PQRI) and achieving 90% of all available incentives (Quality)
  - $1/wRVU conditioned upon all physicians participating in Hospital’s ambulatory patient satisfaction program and achieving “excellent” rating at or above 85th percentile of peer group (Patient Satisfaction)
  - $1/wRVU conditioned upon charges being entered within 4 business days after date of service (on average) and less than 2% of all claims returned not paid

> Key Considerations:
  - Total compensation (base wRVU value + quality incentives) per wRVU remains FMV
  - Metrics could be understood and implemented by physicians
  - Metrics could easily be operationalized by Hospital
  - Metrics advance program objectives and/or contract implementation and efficiencies
Employment Model Percent of Base Compensation Incentive

> Large academic medical center faculty practice plan
> Faculty historically compensated based on fixed salary(ies) with limited incentives
> AMC desires to introduce variable compensation components, including:
  - clinical productivity
  - clinical quality
  - patient satisfaction (inpatient and outpatient)
  - cost efficiency
  - collegiality
  - research
  - quality of medical education

Employment Model Percent of Base Compensation Incentive

> X% of each physician’s base salary available for payment of incentives
> Total potential incentive allocated among several metrics (for YR1, performance measured on department or organizational level only, and not individually):
  - 20% - achieve departmental productivity target based on peer organizations (Productivity)
  - 20% - organization achieves identified improvement in risk adjusted mortality index (Clinical Quality)
  - 20% - achieve identified targets for inpatient (operational) and ambulatory (department) patient satisfaction reported by Press Ganey (Patient Satisfaction)
  - 10% - organization achieves target cost savings (Cost Efficiency)
  - 10% - department achieves identified score based on Morehead Commitment Indicator (Collegiality)
  - 10% - organization improves NIH hospital research rank (Research)
Employment Model Percent of Base Compensation Incentive

> Key Considerations:
  - Total compensation to each individual remains within FMV
  - Concept of gradualism
  - Pay attention to regulatory considerations (for example, cost efficiency metric evaluated under CMP)
  - Metrics reflect the several organizational missions (clinical, research, teaching)
  - Substantial attention to ability to operationalize

Co-Management Model Fixed Incentives

> Co-management agreement between hospital and 5-physician vascular surgery group in connection with the development and management of a vascular Center of Excellence
> Physician management group to be paid on a combination of fixed/hourly fees and incentives
> Incentive opportunity of up to 20% of total compensation based on achieving established performance benchmarks in each of 5 categories:
  - Leadership
  - Quality
  - Service
  - Growth
  - Finance
> Physician management group receives annual incremental payment based on performance in each category at a threshold, target or maximum performance level
Co-Management Model Fixed Incentives

> Year 1 benchmarks include:
  - Employee satisfaction, meeting attendance, annual conference attendance benchmarks for Center staff (leadership)
  - Implementation of evidence-based care model (implementation of clinical protocols) and development of vascular registry (quality)
  - Achieving patient satisfaction targets (patient satisfaction)
  - Development and implementation of market assessments and market strategies for Center (growth)
  - Explore pilot projects with managed care plans for Center as center of excellence and establish contracts with managed care plans (finance)

> Key Considerations:
  - Total compensation (fixed/hourly + incentives) remains within FMV
  - Quality incentives structured within existing health system 5-component management evaluation structure
  - Assure growth and finance benchmarks not tied to value or volume of referrals

QUESTIONS?