CPAs & BUSINESS ADVISORS

PHYSICIAN COMPENSATION MODELS IN A CHANGING ENVIRONMENT

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AGENDA

Changing Environment Situation

Different models
- Pros and Cons

Reimbursement and Cost Report Considerations

Take aways

Q&A

CHANGING ENVIRONMENT SITUATION

CHANGING ENVIRONMENT SITUATION

Economic center of community
- Largest employer

Reimbursement can be different in each setting, place of service or payer
- Free Standing Clinic
- Free Standing RHC
- Provider Based RHC
- Provider based Clinic

Costs continue to go up
- Patient balances increase

CHANGING ENVIRONMENT SITUATION

Harder to recruit physicians in all markets

- Urban
- Rural

More difficult to get call coverage/ED in rural settings

Information can be difficult to attain and administer

CHANGING ENVIRONMENT SITUATION

Why should we talk about this now?

- Changing reimbursement
- Population health
- Availability of Physicians
- Model for alternative providers

MODELS FOR PHYSICIAN/PROVIDER COMPENSATION

MODELS

Salary

Production only

Salary plus production bonus

Salary plus quality bonus

Salary plus administrative function pay

MODELS

KNOW YOUR DATA

Only get one shot

Is the data the right data?

Does it make sense?

Is it Accurate?

How are you going to have this conversation with providers?
WHO is going to have the conversation?

MODELS- SALARY

Pros

Easier to Recruit

Easier to administer

Less risk of Stark/anti-kick back violations

Patient Satisfaction

Used for first year/transition to other models

Cons

Less incentive to produce

Less patients=less revenue

Can be difficult to get provider engagement

MODELS- SALARY

Example

Data from MGMA-2016 Data- Family Practice- WRVU's, Encounters, Compensation and Your Data

Specialty	All Practice Types- WRVU's								
	Group Count	Count	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Family Medicine (with OB)	88	462	5,020	1,877	2,918	3,793	4,763	6,026	7,650
Family Medicine (without OB)	852	5,833	4,980	1,904	2,850	3,885	4,850	5,947	7,150
Family Medicine: Ambulatory Only (No Inpatient Work)	183	1,140	4,883	1,854	2,857	3,815	4,818	5,810	6,976

Specialty	All Practice Types- Encounters								
	Group Count	Count	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Family Medicine (with OB)	32	188	3,338	1,606	1,682	2,165	3,124	4,260	5,351
Family Medicine (without OB)	190	1,811	3,756	1,986	1,946	2,696	3,495	4,412	5,512
Family Medicine: Ambulatory Only (No Inpatient Work)	35	379	3,732	1,706	1,729	2,609	3,378	4,620	6,234

Specialty	All Practice Types- Total Compensation								
	Group Count	Count	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Family Medicine (with OB)	122	632	$257,320	$92,238	$159,706	$196,717	$238,511	$303,010	$378,463
Family Medicine (without OB)	1,123	6,948	$254,734	$96,504	$163,608	$195,987	$233,770	$294,416	$373,010
Family Medicine: Ambulatory Only (No Inpatient Work)	197	1,277	$247,380	$98,879	$160,590	$191,077	$228,409	$281,324	$359,790

MODELS- PRODUCTION ONLY

Pros

Physicians incentivized to see patients

Revenue increase

More appointments available

Cons

Quality may suffer

Harder to recruit

Patient Satisfaction

Staffing/Costs

Stark and Anti-Kick back risk

MODELS- PRODUCTION ONLY

Example

MGMA- 2016 Data Family Practice

Compensation to WRVU, Total WRVU's and Your data

Specialty	All Practice Types- Compensation to Wrvu Ration								
	Group Count	Count	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Family Medicine (with OB)	87	456	$55.30	$21.96	$36.74	$42.71	$50.84	$60.56	$78.57
Family Medicine (without OB)	849	5,773	$55.74	$31.64	$37.90	$43.38	$49.49	$58.73	$73.84
Family Medicine: Ambulatory Only (No Inpatient Work)	181	1,129	$54.68	$31.57	$37.88	$43.78	$48.53	$56.20	$72.26

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MODEL- SALARY PLUS PRODUCTION BONUS

Pros	Cons
Incentive	Quality
Appointments	Stark risk
Easier to recruit	Administer
Revenue increase	Staffing
	Patient Satisfaction

MODEL- SALARY PLUS PRODUCTION BONUS

Example

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MODEL- SALARY PLUS PRODUCTION BONUS

Example Continued

Speciality	Base Salary	Wrvu Threshold		Dollar per WRVU	
		Tier One	Tier Two	Tier One	Tier Two
Family Medicine (without OB)	$195,987	4,850	5,947	$49.49	$58.73

Providers	Base Salary	Total Wrvu's	Wrvu's Over 4850	Paid Tier One	Wrvu's over 5947	Paid Tier Two	Total Compensation
Provider One	$195,987	7000	2,150	$106,403.50	1,053	$61,842.69	$364,233.19
Provider Two	$195,987	5000	150	$7,423.50	0	0	$203,410.50

	Low	Mod	High
FMV Range	$195,987	$233,770	$373,010

MODELS- SALARY PLUS QUALITY BONUS

Pros

Provider input on definition

Not ALL based on numbers

Patient Satisfaction

Aligned with CMS incentives

Cons

Define Quality

Need provider input

Harder to recruit

Administer

Need staff by in

Anti-Kick back risk

Patient Satisfaction

MODELS- SALARY PLUS QUALITY BONUS

Example

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Quality Measure	Threshold Encounters	100%	80%	50%
Blood Pressure	1,682	$31.65	$30.29	$25.45
BMI	1,682	$31.65	$30.29	$25.45
DM pts- Education	1,682	$31.65	$30.29	$25.45
Total		$94.95	$90.86	$76.35

FMV Range	Low	Mod	High
	$76.35	**$90.86**	**$94.95**

MODELS- SALARY PLUS ADMINISTRATIVE PAY

Pros

- Physician Engagement
- Quality/Risk measures with meaning
- Relationship with Administration/Leadership

Cons

- Need detailed contract
- Administration
- Audit
- Clinic Time
- Stark/Anti-Kick Back Risk

MODELS- SALARY PLUS ADMINISTRATIVE PAY

Example

Specialty	Group Count	Count	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Family Medicine (with OB)	122	632	$257,320	$92,238	$159,706	$196,717	$238,511	$303,010	$378,463
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Family Medicine: Ambulatory Only (No Inpatient Work)	197	1,277	$247,380	$98,879	$160,590	$191,077	$228,409	$281,324	$359,790

Specialty	All Practice Types Medical Directorship Paymeent per hour								
	Group Count	Count	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Family Medicine: All	30	95	$131.13	$38.32	$100.00	$117.00	$128.32	$130.00	$166.00

Family Medicine: Ambulatory Only (No Inpatient Work) Salary	Low	Mod	High
	$228,409	$281,324	$359,790
Hours Worked	2080	2500	3000
Dollar Per Hour	$119.93	$112.53	$109.81

MODELS- SALARY PLUS ADMINISTRATIVE PAY

Example

Contract should state exact duties

Quality measures team participation vs. 40 hours spent annually in work directing and participating in the quality measures committee

Supervision of Mid-Level Providers vs. Supervision of 3 min-level providers to include but no limited to 20 hours per quarter in chart review and clinical competency evaluation

COMMENTS ABOUT COMPENSATION

- Consistent Methodology
- Proof of Contract Review and Audit
- Reasons WHY?
  - Make sure you document
- Survey Data
  - Use it WISELY and Properly
- COMMON SENSE FACTOR
  - Commercially Reasonable
- Consider obtaining third party opinion

REIMBURSEMENT AND COST REPORT CONSIDERATIONS

REIMBURSEMENT CONSIDERATIONS IN CONTRACT LANGUAGE

Background

Areas of Concern

Strategies/Examples

BACKGROUND

Contract negotiations/discussions may include many significant details in the construction of a compensation package

- Professional services
  - Clinic
  - Emergency Room
- On-call services
  - Emergency Room
  - Other
- Administrative
  - Hospital
  - Clinics
  - Mid-level Supervision

BACKGROUND

Unfortunately, much of this detail may be lost in the development of the final contract

- Roles and responsibilities
- Compensation for each role and responsibility

Failure to capture this level of detail in the final contract =

- Inability to clearly identify cost assignment by function
- Ability for MAC to create its own assumptions
- Potential for lost reimbursement

AREAS OF CONCERN

Best practice is to proactively document all components of compensation in the contract

- Preserve reimbursement opportunities
- Provide documentation for allocations
- Decrease ability for outside parties to challenge the methodology of cost allocation on the cost report.

AREAS OF CONCERN – FREESTANDING CLINICS

No cost based reimbursement in freestanding clinic

Risk MAC will disallow/limit any allocation of costs out of freestanding clinic

- Concern for CAHs (less important for PPS providers)
  - Emergency Room on-call
  - Hospital administrative functions

AREAS OF CONCERN – PROVIDER BASED CLINICS

No cost based reimbursement in provider based clinic for PPS providers

No cost based reimbursement in provider based clinic for professional component for CAH providers

Risk MAC will disallow/limit any allocation of costs out of provider based clinic

- Emergency Room on-call
- Hospital administrative functions
- Clinic administrative functions

AREAS OF CONCERN – PROVIDER BASED RURAL HEALTH CLINICS

- Provider based rural health clinics
  - Cost based reimbursement in provider based rural health clinic for professional component
  - Risk MAC will disallow/limit any allocation of costs in provider based rural health clinic
    - This is a different issue than in the other clinic settings
      - Professional costs are allowed
      - Medicare and Medicaid utilization by department is the opportunity/risk
    - Areas
      - Emergency Room on-call
      - Hospital administrative functions
      - Clinic administrative functions

STRATEGIES/EXAMPLES – FREESTANDING CLINICS

Provide documentation of cost and time for:

- ER
- On-call
- Hospital Administrative

STRATEGIES/EXAMPLES – FREESTANDING CLINICS

Example:

- $25 million 25 bed CAH
  - FS clinic
  - RHC
- $300,000 contract with FS clinic provider
  - $200,000 Clinic
  - $10,000 Medical Director
- $90,000 ER call

STRATEGIES/EXAMPLES – FREESTANDING CLINICS

Example: - Nothing specified in contract for breakdown of compensation and no records to substantiate an allocation

No reimbursement through the cost report for any of the $300,000 in cost

STRATEGIES/EXAMPLES – FREESTANDING CLINICS

Example: - Nothing specified in contract for breakdown of compensation, but an attempt to determine and allocate costs for Medical Director and ER call.

Fortunate to be able to support $10,000 of Medical Director allocation – $5,686 reimbursed by Medicare.

Challenges in being able to support an allocation for ER call

How to handle patient care hours in clinic, etc. versus on-call hours?

Open to interpretation and challenge.

Ultimately able to support $30,000 of direct time in ER, but nothing for call hours - $0 reimbursement on the cost report.

Additional reimbursement possible from Medicaid – depending on your state methodology.

STRATEGIES/EXAMPLES – FREESTANDING CLINICS

Example: - Contract has specific breakdown of compensation with ER on-call time studies showing 75% standby time.

$10,000 of Medical Director allocation – $5,686 reimbursed by Medicare.

$90,000 of Emergency Call allocation - $29,101 reimbursed by Medicare.

Additional reimbursement possible from Medicaid – depending on your state methodology.

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

Provide documentation of cost and time for:

- ER
- On-call
- Hospital Administrative
- Clinic Administrative

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

Example:

- $18 million 25 bed CAH
  - PB Clinic
- $320,000 contract with PB clinic provider
  - $200,000 Clinic
  - $15,000 Medical Director
  - $15,000 Clinic Administrative
  - $90,000 ER call

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

Example: - Nothing specified in contract for breakdown of compensation and no records to substantiate an allocation

- No reimbursement through the cost report for any of the $320,000 in cost

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

Example: - Nothing specified in contract for breakdown of compensation, but an attempt to determine and allocate costs for Medical Director, Clinic Administrative and ER call.

Fortunate to be able to support $15,000 of Medical Director allocation – $4,202 reimbursed by Medicare.

No documentation to support $15,000 of Clinic Administrative allocation - $0 reimbursed by Medicare.

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

Challenges in being able to support an allocation for ER call

- How to handle patient care hours in clinic, etc. versus on-call hours?
- Open to interpretation and challenge.
- Ultimately able to support $30,000 of direct time in ER, but nothing for call hours - $0 reimbursement on the cost report.

Additional reimbursement possible from Medicaid – depending on your state methodology.

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

Example: - Contract has specific breakdown of compensation with ER on-call time studies showing 75% standby time.

$15,000 Medical Director allocation – $4,202 reimbursed by Medicare.

$15,000 of Clinic Administrative allocation - $2,293 reimbursed by Medicare.

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

$90,000 of Emergency Call allocation - $23,992 reimbursed by Medicare.

Additional reimbursement possible from Medicaid – depending on your state methodology.

STRATEGIES/EXAMPLES – PROVIDER BASED RURAL HEALTH CLINICS

Provide documentation of cost and time for:

- ER
- On-call
- Hospital Administrative
- Clinic Administrative

STRATEGIES/EXAMPLES – PROVIDER BASED RURAL HEALTH CLINICS

Example:

- $25 million 25 bed CAH
  - FS clinic
  - RHC

- $320,000 contract with FS clinic provider
  - $200,000 Clinic
  - $15,000 Medical Director
  - $15,000 Clinic Administrative
  - $90,000 ER call

STRATEGIES/EXAMPLES – PROVIDER BASED RURAL HEALTH CLINICS

Example: - Nothing specified in contract for breakdown of compensation and no records to substantiate an allocation

Cost remains in RHC and Medicare reimburses based on cost report – Remember 80% cost!

No Medicaid impacts

Risk Medicare may determine portion of costs should be offset.

Medicare would determine the methodology

STRATEGIES/EXAMPLES – PROVIDER BASED RURAL HEALTH CLINICS

Example: - Nothing specified in contract for breakdown of compensation, but an attempt to determine and allocate costs for Medical Director, Clinic Administrative and ER call.

Fortunate to be able to support $15,000 of Medical Director allocation – $4,681 reimbursed by Medicare.

No documentation to support $15,000 of Clinic Administrative allocation - $0 reimbursed by Medicare, but may have impact if hit by productivity standard.

STRATEGIES/EXAMPLES – PROVIDER BASED RURAL HEALTH CLINICS

Challenges in being able to support an allocation for ER call

- How to handle patient care hours in clinic, etc. versus on-call hours?
- Open to interpretation and challenge.
- Ultimately able to support $30,000 of direct time in ER, but nothing for call hours - $6,009 reduction in reimbursement on the cost report.

Additional reimbursement impacts possible from Medicaid – depending on your state methodology.

STRATEGIES/EXAMPLES – PROVIDER BASED RURAL HEALTH CLINICS

Example: - Contract has specific breakdown of compensation with ER on-call time studies showing 75% standby time.

$15,000 Medical Director allocation – $4,681reimbursed by Medicare.

$15,000 of Clinic Administrative allocation - $0 additional reimbursed by Medicare as already in RHC. May be an impact if hit by the productivity standard.

STRATEGIES/EXAMPLES – PROVIDER BASED CLINICS

$90,000 of Emergency Call allocation - $5,703 reimbursed by Medicare.

Additional reimbursement possible from Medicaid – depending on your state methodology.

COST REPORT CONSIDERATIONS

Each facility will have different impacts

- Type of clinics
- Size of entity
- Cost structure
- Variety of services
- Payor mix
- Productivity
- Etc.

Do not assume – Identify the potential impacts to determine the specific strategies for your organization.

TAKE AWAYS

TAKE AWAYS

Know your market

Know your providers

Know your clinic

Know your cost report

KNOW THE RULES!

Document, Document, Document

Ask for help when warranted

QUESTIONS?

This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general information purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.

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THANK YOU!