Mission Possible: An Effective Provider Compensation Plan

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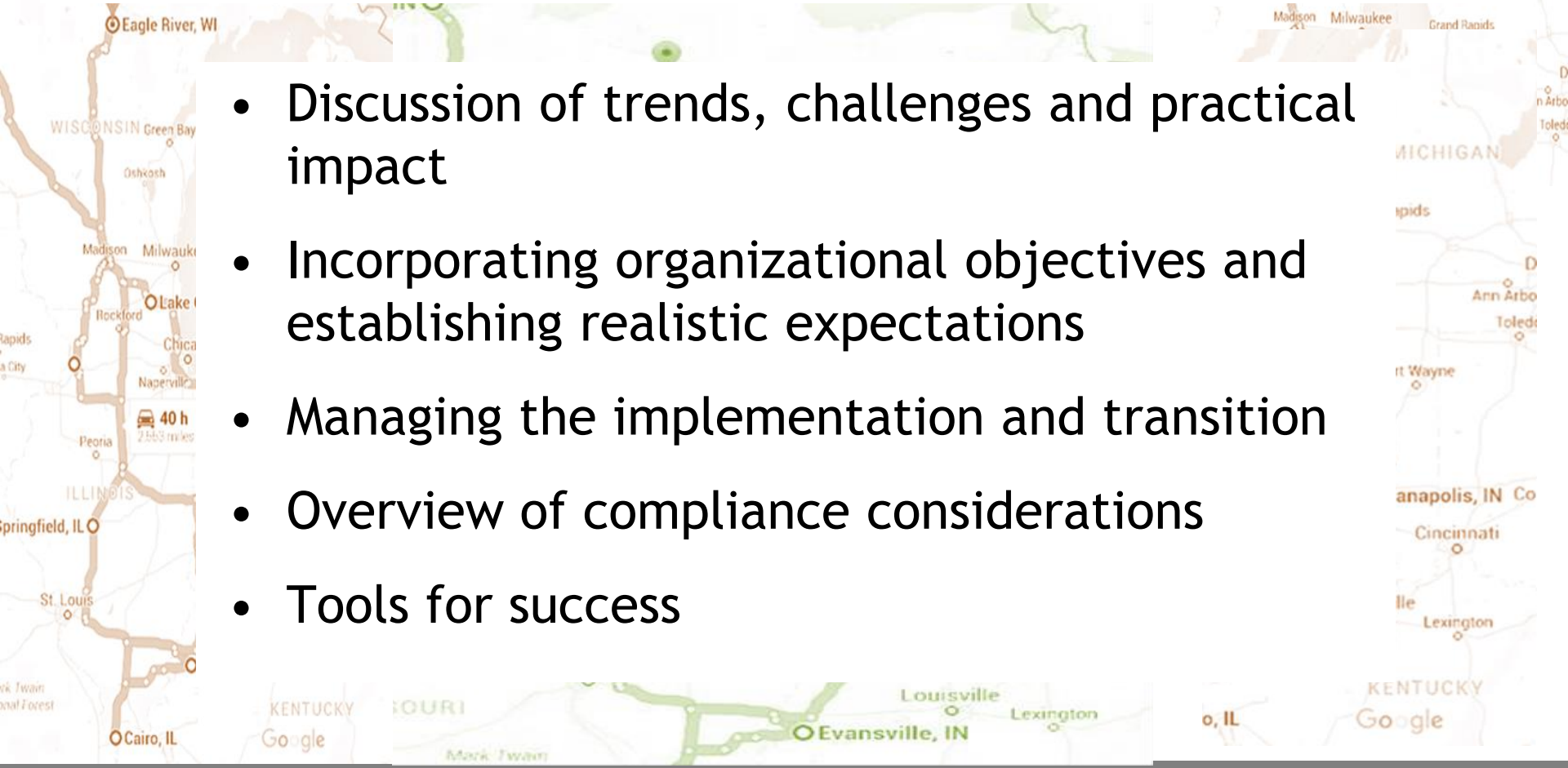
Road Map for Today



- Discussion of trends, challenges and practical impact
- Incorporating organizational objectives and establishing realistic expectations
- Managing the implementation and transition
- Overview of compliance considerations
- Tools for success

Provider Compensation Trends

Environment Trends

1. Reimbursement focus is more on value-based methods.
2. Indiana and Wisconsin[1] are among states with the highest physician compensation.
3. Compensation continues to rise for most specialties (3%-12%)[2].
4. Cash/Concierge practices are ⇔ ACO participation is ⇑

Plan Design Trends

1. Organizations are incorporating non-productivity incentives…
2. … But nonproductivity incentives remain less than 35% of total pay.
3. Traditional productivity incentives remain primary indicator of compensation.
4. Models reward higher practice revenue and emphasize minimizing expenses.
5. Service line performance and group/pooled performance is increasing.

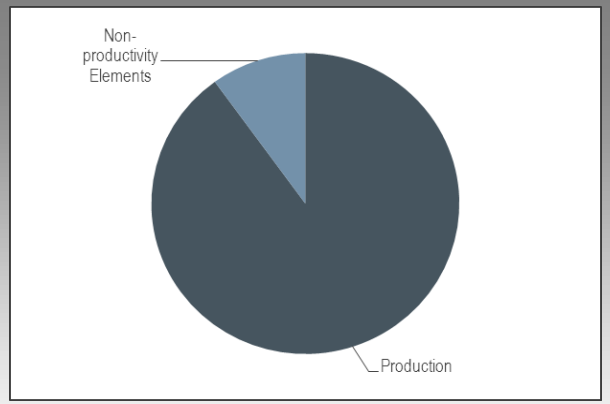
1: #6 & 7 respectively (Medscape Physician Compensation Report 2016 (MPCR16))

2: Specialties with declining or flat compensation: allergy, pulmonology, pathology, plastic surgery, anesthesia, infectious disease and general surgery ((11%) to +1%) (MPCR16)

Evolution of Volume to Value in Compensation

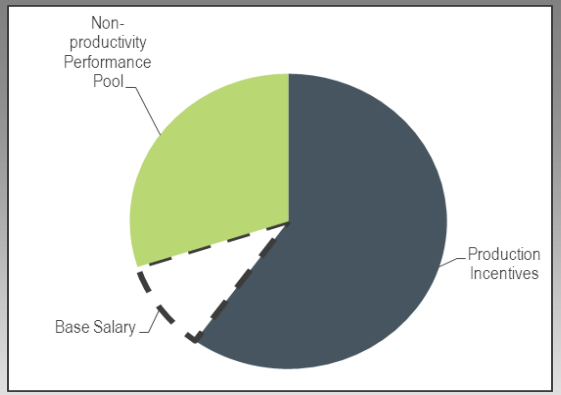
Production-driven plans need to evolve to reflect changing reimbursement, but there is a reluctance to move too far ahead of reimbursement changes.

Circa 2011



- Physician productivity was the primary incentive.
- Tiered compensation disproportionately rewarded high production.
- Non-productivity elements provided a small supplement.

Circa 2016

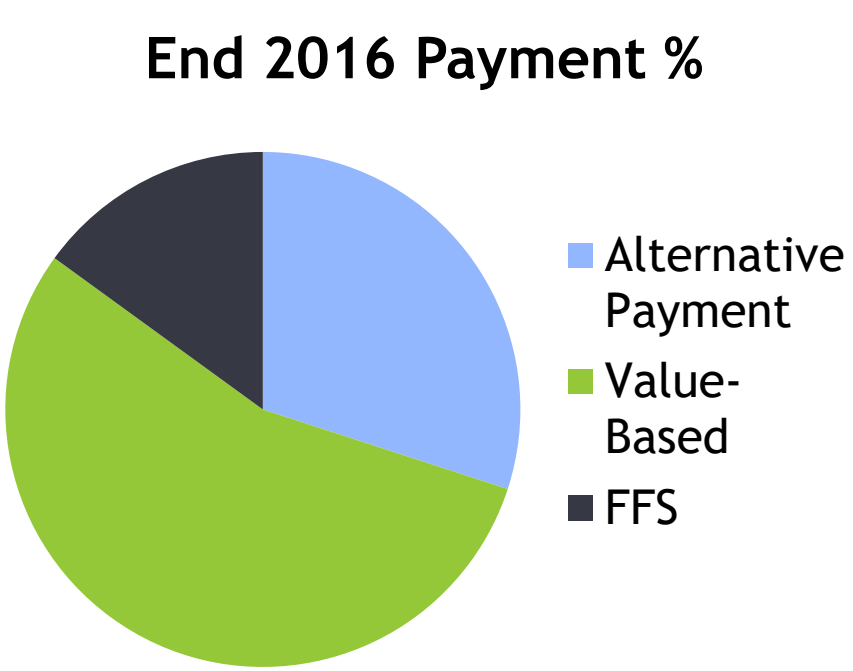


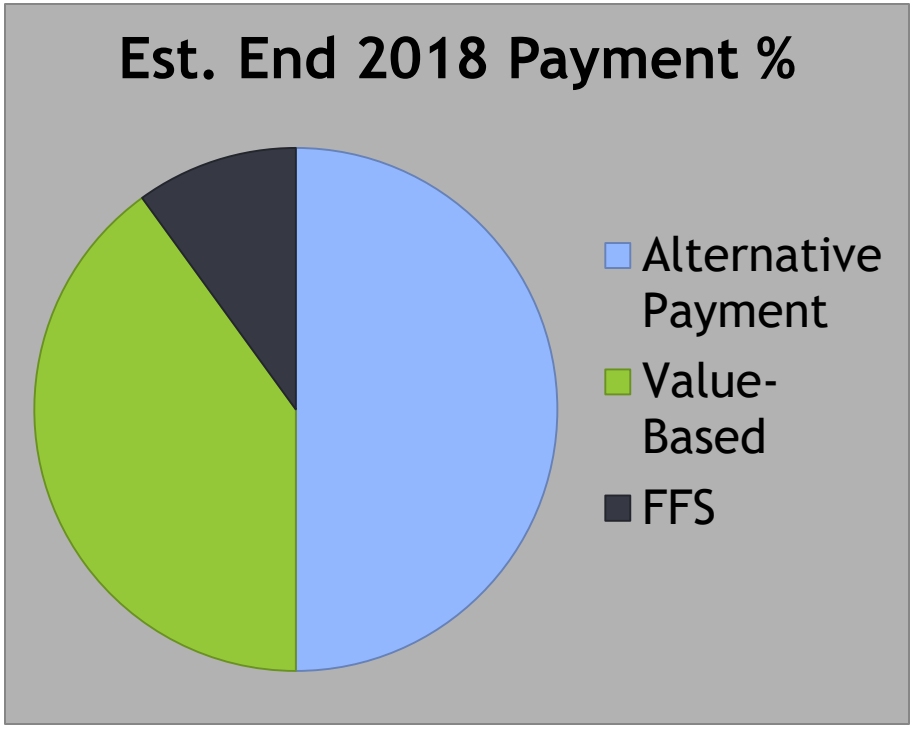
- Productivity remains an important element of compensation.
- Nonproductivity metrics are expanded and drive a larger portion of total compensation.
- Base salary may be included, tied to performance thresholds/new reimbursement programs.

Source: Graphs Developed by ECG Management Consultants

Evolution of Volume to Value in Reimbursement

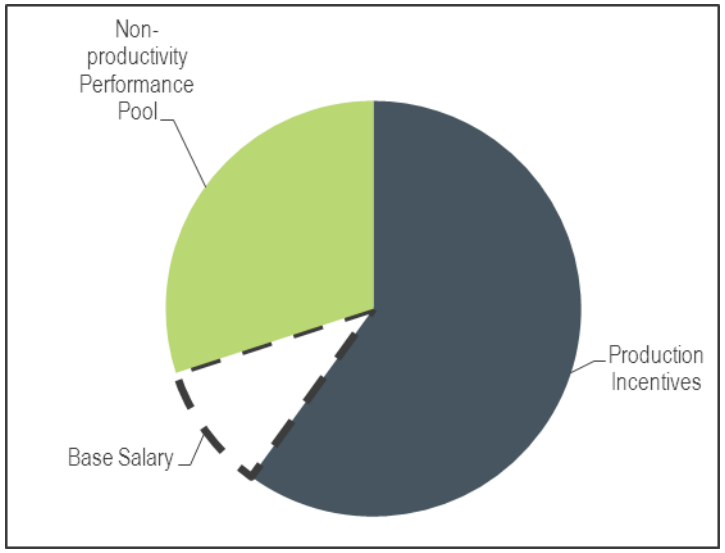
Medicare Fee-for-Service Goals



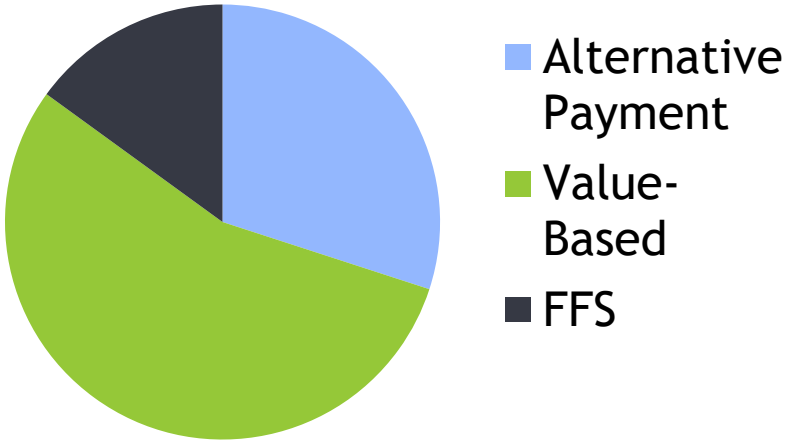


Compensation ≠ Reimbursement 2016

Compensation Elements



Reimbursement Elements



CMS's Laboratories: Innovation Center & MACRA

Accountable Care Organizations (ACOs)	Merit-Based Incentive Payment System (MIPS)
Bundled Payments for Care Improvement (BPCI)	Physician-Focused Payment Model (PFPM)
Comprehensive Primary Care Plus (CPC+)	Physician Quality Reporting System (PQRS)
Comprehensive Care for Joint Replacement (CJR)	Oncology Care Model (OCR)
Diabetes Prevention Program (DPP)	Value-Based Purchasing (VBP)

Incorporating Organizational Objectives
(Improve/Maintain/Implement)

- Patient access
- Growth and strategic positioning
- Culture/Provider leadership
- Provider Engagement
- Use of technology and practice tools adopted by organization
- Efficiency and process improvement
- Coordination of care
- Top of license patient care
- Provider recruitment and retention
- Fiscal stewardship
- Reduce patient leakage to competition
- Patient satisfaction
- Quality/Outcomes
- Transition to value based and alternative payment models

Considerations for Plan Change

Culture – Culture (whole group or parts of a group) plays a significant role in determining what type of compensation incentives are feasible and necessary.

Performance Measures – There are numerous metrics that may be included in compensation models. Establishing the most appropriate mix and the weighting of metrics is crucial in establishing a plan that promotes organizational goals.

- Consider past performance vs. baseline performance expectations
- Limit variation vs. customization
- Manageable goals vs. stretch goals
- Static vs. dynamic

Transition Planning – Managing the transition to a new compensation plan will be critical to its acceptance and future success.

Performance Categories & Goals/Considerations

Category	Goals/Considerations
Productivity	• Extremely common, easy to measure, and largely understood by providers. • Many options to measure production: WRVUs, patient visits, collections or panel size. • Contributes to financial viability, stewardship and supports mission.
Clinical Quality	• Aligns with changes in the reimbursement environment. • Supports embrace of best practice care protocols and adoption of evidence based care. • Requires baseline performance, effective care coordination and use of technology.
Patient Satisfaction	• Contributes to positive public image. • Aligns with patients obtaining all available care within organization. • May include compliance with processes and enhanced efficiency/perceived value.
Access	• Supports patient satisfaction/experience and improved outcomes. • May require alternative care settings, broader outreach and non-traditional operations (“retail”-type facilities, after-hour availability and fixed-fee/pre-set fee structure).
Teamwork and Citizenship	• Recognizes and rewards provider leadership, collaboration and relationship-enhancing functions. • May include department/team incentives; shared incentives for satisfying organizational goals, reducing expenses and improving efficiency. • Including incentives for “Co-Management” type measures may enhance provider and team engagement.

Transition Planning

Providers select stakeholders/provider leaders to participate with organizational leaders in planning and identifying goals/objectives.
Organization (executive team, board and stakeholders) develops list of goals, prioritize goals and align with incentives/metrics for compensation plan.
Data (aggregate and individual) showing historical and projected performance along with comparisons (both internal/peer and benchmarks) is available and explained to providers.
Organization must be realistic about its ability to accurately track and measure results and tie to incentives.

Plan Development

Alternative Compensation Models/Approaches	Education & Investment
Multiple compensation models may be necessary to align incentives with desired outcomes, changes in behavior and to maximize reimbursement under various programs and contracts.	Understanding how high productivity may negatively impact other measures is important to education and behavior changes.
Some incentives may apply to multiple plans and other measures may apply only to some groups/specialties.	Effective plans will largely eliminate conflict between different incentives, balance reward between conflicting incentives or allow reward for extra effort to achieve conflicting incentives.
Emphasis on traditional measures of productivity should continue with balanced reinforcement of other factors.	Data collection and dissemination of information to provide transparency and to support education may require additional human resources and tools/software.

Process Map

Assemble Work Group
(Compensation Committee)

Determine Guiding Principles

Select Consultant(s)

Access Data

Prioritize Performance Measures

Define Performance Categories

Establish Performance Targets

Design Plan/Test Results
= FMV, CR and Legal Opinions

Consultant(s)

Present to Board & Obtain Board Approval

Ongoing Maintenance

Outside Experts & Board Approval

Consultant & Legal
Outside experts are familiar with multiple plans, have seen what works/trouble areas and may provide “cover” for desired but unpopular change and message.
Consultants and counsel offer guidance and expertise regarding plan development, testing, the plan’s capacity to provide desired results and compliance factors.
Consultants should provide a written opinion that the plan is designed to yield **fair market value** compensation and is **commercially reasonable**.
Legal counsel should confirm (in writing) that the plan is compliant with relevant laws.

Board Approval Process
Board should be informed that the Compensation Committee (or other delegated committee of the board) is reviewing provider compensation plan.
Completed plan should be presented to the Board (without providers who are directors) for review and approval.
Many boards will not approve without outside consultant report and opinion and legal review/opinion (exercise duty of care).
New compensation plans should not be implemented without independent board (no provider involvement) approval.

Compliance

- Stark
- Anti-Kickback
- False Claims
- Tax Exemption (for some)

Keys to Compliance = FMV & CR

Total compensation to each provider should be fair market value AND commercially reasonable.

- Generally based on work personally performed (projected, current or previous performance) (exclude all ancillary service revenue)
- Specialty specific
- All compensation not based on services rendered should be completely void of any connection to referrals and DHS
- Determination of FMV and CR should consider ALL compensation paid (from all sources and for all services: extra call/after-hours services/add-on bonus, administrative responsibilities, quality, patient satisfaction, EMR use, insurance bonus payments, etc.)

Fair Market Value & Commercially Reasonable

Fair Market Value: the value in arm's-length transactions, consistent with the general market value

CR: An arrangement that would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential business referrals between the parties.

Related, but different!

FMV = Commercially Reasonable

Commercially Reasonable ≠ FMV

Physician Self-Referral Statute ("Stark Law")

Prohibits physicians from making referrals of designated health services ("DHS") to any entity with which the physician has a direct or indirect financial relationship, unless the arrangement satisfies one of the available exceptions. Employment for fair market value compensation satisfies an exception.

Anti-Kickback Statute

Prohibits anyone from offering, paying, soliciting or receiving any remuneration for referring an individual for services or for arranging for services under the Medicare or Medicaid program

- Intent required
- Broadly construed
- "Remuneration" broadly defined to include cash or any benefit whether direct or indirect

AKS vs. Stark

AKS	STARK
Criminal/Civil Requires Proof of Improper Intent	Civil Only
Applies to Any Referral Source	Strict Liability (like getting a speeding ticket; do not have to prove you intended to speed, just that you were driving over the speed limit)
Safe Harbors	Must be a doctor of medicine/osteopathy, dentist, chiropractor, optometrist, or podiatrist involved
Best practice to meet a safe harbor	At least one Stark Exception must be satisfied
OIG Advisory Opinions	CMS Advisory Opinions

False Claims Act

FCA prohibits knowingly presenting or causing to be presented any false or fraudulent claim for payment or approval to the federal government.
• Requires actual knowledge or deliberate ignorance of the truth or falsity of the information. Proof of intent to defraud is NOT required.
• Private citizen (whistleblower) may bring suit on behalf of the federal government (government may intervene and receive damages).
• Falsely certifying compliance when submitting a claim for payment to the federal government may implicate FCA.
• Civil and criminal penalties and monetary damages.

Tax Exemption

Private Benefit: If a tax exempt organization provides more than fair value and incidental benefits to employees/others, it is no longer organized and operated exclusively for exempt purposes.	**Excess Benefit:** Occurs when excessive compensation is paid by an exempt organization to a "disqualified person“. A "disqualified person" is a person in a position to influence an exempt organization.
Private Inurement: No part of the net earnings of a tax exempt organization may inure for the benefit of an "insider" (someone with a personal interest in the affairs of the organization).	**Intermediate Sanctions**: IRS may impose an excise tax on excess benefit transactions between a disqualified person and an applicable tax-exempt organization. The disqualified person who benefits from an excess benefit transaction is liable for the excise tax. The organization’s officers and directors may also be liable for an excise tax on the excess benefit transaction.

Compensation Caution Areas

Factors to Avoid in Plans	
Bonus pool includes technical revenue (DHS). (Halifax settlement: $86M)	Payment for services unnecessary to the organization
Compensation overlap (paying for same function more than once)	Lack of documentation for paid services
Exceeding caps set in the plan	Shared bonus pools divide among too few providers (all or 5 minimum)
Not including all compensation in determining FMV and CR	Provider's compensation exceeds revenue generated – careful review
Medical necessity (especially in highly productive providers)	Provider is compensated beyond the terms/scope of the plan
Excessive compensation compared to work effort	**Provider payments owed to the organization are not paid/collected**

Tools for Success

Transition Slowly – As outlined earlier, a slow transition will be critical to accommodate any cultural shifts and introduction of new performance metrics.

Encourage Provider Engagement & Leadership – The development of a new or refined plan demands broad provider involvement. They will help to identify what is working, what needs change and may offer insight to solutions that might otherwise go unidentified. Those who are part of the process should become champions of the change and may be better equipped to secure buy-in from others. Empower and encourage providers to communicate roll-out, educate others and lead/participate in discussions when possible.

Find the Right Balance – Effective incentive plans strike the right balance between production/non-production, clinical/nonclinical measures, individual/team goals and a reasonable number of new measures. Too few measures may fail to properly address the strategic goals of the organization, while an excessive number of measures may result in too little emphasis being placed on any one measure by physicians.

Tools for Success *(continued)*

Provide Financial Incentives and Manage Downside - Successful plans offer meaningful reward and opportunity to achieve the reward. If providers will encounter or may encounter diminished earning opportunity, phase in the decline with notice and opportunity to replace compensation when feasible.

Leverage Existing Measures – Physicians are naturally apprehensive in relation to tying compensation to performance. These concerns can be mitigated by providing existing performance data, projections showing future performance under the new plan, using familiar measures where possible and providing tools to perform well under the new plan.

Regular Communication and Information on Performance – Organizations should provide regular updates on actual performance and data to support compensation. If providers are performing poorly, the organization may offer training or other support to encourage improvement. Where reasonable, gradual downward adjustments to compensation may be more welcome than a sharp decline at year end. Careful and respectful discussions with individual providers who are struggling may be warranted when the provider is unaware or lacking engagement to improve.

Thank you
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Questions