Adapting Employed Physician Compensation Models on the Road to Accountable Care

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Taft /
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Objectives

I. Overview of Compensation Models
II. New Initiatives Driving Change
III. Review Metrics within Emerging Physician Payment Models
IV. Legal Issues around Employed Compensation Models
V. Case Study on Changing an Employed Group's Compensation Model
VI. Sample Questions
I. Overview

EVOLUTION OF PHYSICIAN COMPENSATION MODELS

1990s

- Rapid employment of Physicians and purchase of practices in early 1990s by Health Systems/Hospitals as reaction to growth of Managed Care
- Physician Employment Strategy fails with Health Systems sustaining large losses
- Most Health Systems divested practices by 2000
- Base Salary Compensation Model blamed for Physicians losing Productivity Incentive
- Other Factors include:
  - Lack of Accountability
  - Failure to create Compensation Model that drives necessary behaviors to succeed
What is Old is New Again

- Between 2007-2010, Physician employment becomes key alignment strategy again for Health Systems
- Address prior issues through creation of Productivity Based Employment Models
- Primary issues faced during this timeframe:
  - Notion of “Subsidy” and Drag to Health System Financial Performance
  - Lack of True Integration as Physicians operate autonomously and fail to feel engaged in Health System’s Strategic Plan
  - Lack of Measures to substantiate benefits of Employment Strategy (e.g. downstream revenue, care management)
  - Physicians lose accountability for Practice Expenses/Operations

Next Stage of Payment Transformation

- Develop Compensation Models that move past Productivity-only measures
- Establish Payment Metrics that align with System Goals
  - IT Adoption
  - Quality Improvement
  - Accountable Care
  - P4P or Value Based Reimbursement
  - Citizenship
  - Teaching
  - Research
  - New Market Development
  - Patient Centered Medical Home
**Sullivan, Cotter Study**

- Most Physician Employers (84%) use Incentive-Based Pay with allocation of 80-85% salary and 15-20% performance-based pay

<table>
<thead>
<tr>
<th>Productivity</th>
<th>Non-Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVUs (71%)</td>
<td>Quality (74%)</td>
</tr>
<tr>
<td>Collections (33%)</td>
<td>Patient Satisfaction (70%)</td>
</tr>
<tr>
<td>Net Income (29%)</td>
<td>Alignment with Org. Objs. (33%)</td>
</tr>
<tr>
<td>Patient Visits (17%)</td>
<td>Citizenship (25%)</td>
</tr>
</tbody>
</table>


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**Deployment of New Payment Metrics**

Source: The Advisory Board Company *The High-Performance Medical Group*
Deployment of New Payment Metrics (cont.)

<table>
<thead>
<tr>
<th>Mid-Level Performance</th>
<th>PCP Scorecard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incents efficient use of mid-level staff</td>
<td>Nine performance metrics incent PCPs on clinical performance and efficiency</td>
</tr>
<tr>
<td>Profitability of Nurse Midwives</td>
<td>$26,000 initial scorecard pool</td>
</tr>
</tbody>
</table>

PCP Scorecard Metrics

<table>
<thead>
<tr>
<th>Access Target: 15%</th>
<th>New Patients: 10%</th>
<th>Diabetes Management: 15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction: 5%</td>
<td>Expense per RVU: 10%</td>
<td>Hypertension: 15%</td>
</tr>
<tr>
<td>Budget Target: 10%</td>
<td>RVU Production: 10%</td>
<td>Medical Home: 10%</td>
</tr>
</tbody>
</table>

Source: The Advisory Board Company The High-Performance Medical Group

Physician Incentive Payment Guides

What does your organization use to guide the payment of physician incentives?

- Productivity Measures: 75%
- Quality metrics: 57%
- Patient satisfaction score: 50%
- Participation in administrative duties: 47%
- Chart completion: 23%
- Referrals: 4%

Base = 316
Multi-response

Source: HealthLeaders Intelligence
Advisory Board Study

- Review of 25 employed medical groups with history of high performance on Financial and Quality Indicators

- Participants include: Advocate Health Care, Sharp, North Shore, Baylor Health Care System, Marshfield Clinic

- Findings: The Groups do not utilize 1 predominant compensation model

- Lesson: Compensation Model needs to be tailored to Health System’s strategic goals and initiatives and be built based upon framework that includes key performance criteria

Advisory Board (cont.)

From The Advisory Board Company. “Next Generation Physician Compensation.”
A Range of Incentive Structures in Use

**At Risk for Population Health**
- **Dean Clinic:** More than 50 percent of primary care physician income at risk for quality, service, and panel size

**At Risk for Productivity**
- **Edith Smith Medical Group:** Compensation tied to productivity measured in RVUs with small quality bonus

**A Blended Approach:**
- **Falstaff Clinic:** Physicians paid on RVU basis, but responsible for any overdraft not deemed to improve quality; ancillary income is divided equally

**Revenue Minus Expenses**
- **St. John’s Clinic:** All physicians paid on net income model, with some incentive based on performance

**Rejecting Uniformity**
- **Beacon Medical Group:** Each of 26 specialty departments designs its own compensation model, which must include quality and patient satisfaction incentives

**Salary with Bonus**
- **Kelsey-Seybold Clinic:** Tiered salary model with productivity bonus based on both RVUs and patient visits

Source: Advisory Board

Compensation Models

How many types of physician compensation models do you support at your organization?

![Bar chart showing compensation models support distribution]

- 1 type: 33%
- 2-3 types: 50%
- 4-5 types: 11%
- 6-7 types: 1%
- 8 or more types: 5%

Base = 316

Source: HealthLeaders Intelligence
So Why Change?

- Move Past Recruitment to True Alignment
- Meet challenges of Affordable Care Act and Changing Reimbursement Structure
- Implementation of Accountable Care, P4P and other Value Based Purchasing Initiatives
- Payers hiring Physicians and moving into marketplace
- Match Payment metrics with Strategic Plan (e.g. remove barriers such as impact to RVUs from EMR implementation)
- Develop Culture of Accountability and a Sustainable Compensation Model

Core Issue

“COST OF SUBSIDY WITHOUT TRUE ALIGNMENT”
II. NEW INITIATIVES

DRIVING CHANGE: ON ROAD FROM VOLUME TO VALUE

Key Developments

- Enactment of Health Reform
- Accountable Care Organizations
- CMS Bundled/Episodic Payment Program
- Hospital Value Based Payment Program
- Electronic Medical Record Implementation
- Patient Centered Medical Home Certification
- Co-Management of Service Lines/Institutes
On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590), which extends healthcare coverage to 32 million people who are currently uninsured and begins to reform the payment system toward accountable, coordinated healthcare delivery.

Berwick “Triple Aim”

- Better Care
- Better Outcomes
- Lower Health Care Costs
Accountable Care Driver

Patients

Primary Care
Specialty Care
Ambulatory Care
Skilled Nursing
Nursing Home
Home Health

Premier Collaborative

[Map of the United States with various health care institutions marked]
Shared Savings Payments

ACO (set Medical Expenditure Targets and Pools)

- Hospital, SNF, and Rehabilitation Budgeted Pool
- Outpatient Ancillary Budgeted Pool
- Outpatient Services Budgeted Pool
- Outpatient Diagnostics Budgeted Pool

Pools are established using actuarial data tied to CMS filing

Actual claims expenditures are charged against the pool based on claims paid throughout the year

Surpluses available for distribution/Deficits absorbed by Payer

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CMS Bundled Payment Program

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>CONDITION</th>
<th>Payment/Expected Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1: Inpatient Hospital Stay</td>
<td>All MS-DRGs</td>
<td>Discounted IPPS payment; 0% for first 6 months, increasing to 2% in year 3</td>
</tr>
<tr>
<td>Model 2: Inpatient Stay + Post discharge Services</td>
<td>Applicant to propose based on MS-DRGs for inpatient hospital stay</td>
<td>Retrospective Comparison of Target Price/Actual FFS Payments; Minimum of 3% for 30-89 days post discharge; minimum 2% for &gt; 90 days post discharge</td>
</tr>
<tr>
<td>Model 3: Post discharge Services Only</td>
<td></td>
<td>To be proposed by applicant</td>
</tr>
<tr>
<td>Model 4: Inpatient Stay Only</td>
<td></td>
<td>To be proposed by application, subject to minimum 3% discount</td>
</tr>
</tbody>
</table>
Patient Center Medical Home ("PCMH")

The Affordable Care Act Main Objectives
- Focus on Measurably Improving Population Health
- Organizational Accountability for Capacity, Cost and Quality
- Payment for Value, Not Volume
- Meaningful Measures of System Performance
- Right Workforce

The Overall Goal is to move healthcare cost from downstream to upstream

ACO

Healthy Consumer

Continued Health

Preventable Condition

No Hospitalization

Acute Care Episodes

Successful Outcome

High Cost Outcome

Complications, Readmissions

Hospital Value-Based Purchasing

- Program funded through reduction of base DRG rates
  - One percent in FY 2013
  - Increases by 0.25% per year to two percent in FY 2017 and after
  - Hospital notification of 1% reduction amount to be in FY 2013 IPPS final rule

- Metrics for FY 2013 payments
  - 12 clinical process of care measures on heart failure, AMI, pneumonia and surgical care and 8 HCAHPS dimensions

- Metrics for FY 2014 payments
  - 13 clinical process measures; 8 HCAHPS dimensions; 3 outcomes measures – 30-day mortality

- Metrics proposed and delayed
  - AHRQ composite measures and hospital-acquired conditions
  - Spending per beneficiary - episode of care from 3 days pre-admission to 30 days post-discharge
Co-Management

- Agreements to reward Physicians for managing and improving Hospital Service lines. Payment metrics typically include the following:
  - Supply Chain Standardization (e.g. product standardization)
  - Quality Improvement through meeting benchmarks including clinical care guidelines
  - Cost Containment (e.g. OR efficiency, staffing efficiency)
  - Patient/Staff Satisfaction
  - Disease Management/Population Health Programs

Open Issue

- Will Dollars Generated from these Initiatives serve as Bonus to Physicians in a Productivity Plan for their participation?
- Or as Funding for New Compensation Model?
## III. Emerging Physician Compensation Models

### RESPONSE TO NEW REIMBURSEMENT SYSTEM

<table>
<thead>
<tr>
<th>Model</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Revenue-Expenses (Net Revenues)</td>
<td></td>
</tr>
<tr>
<td>wRVU Production</td>
<td></td>
</tr>
<tr>
<td>Internally Defined RVUs</td>
<td></td>
</tr>
<tr>
<td>Percentage of Collections</td>
<td></td>
</tr>
<tr>
<td>Base Salary</td>
<td></td>
</tr>
<tr>
<td>Base Salary+Bonus</td>
<td></td>
</tr>
</tbody>
</table>

29

30
Challenges of Current Models

- Net Revenue model functions like “virtual private practice” and penalizes physician for delivering mission based care
- RVU model blind to payer mix increasing charity care burden to Health Systems
- In RVU model, Physicians not accountable for practice expenses
- RVU model does not promote other System goals and continues to perpetuate fragmented system

New Models

<table>
<thead>
<tr>
<th>Metric</th>
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</thead>
<tbody>
<tr>
<td>wRVU Production+Other Metrics</td>
</tr>
<tr>
<td>Base Salary+Bonus for Other Metrics</td>
</tr>
<tr>
<td>Decrease Base+Withhold Pending Performance on Other Metrics</td>
</tr>
<tr>
<td>Blended Model of wRVUs and Other Metrics</td>
</tr>
</tbody>
</table>
Impact of New Models

- Create Compensation Models more aligned with reimbursement system to ensure long-term viability
- Align Compensation Models with future trending of Health Care Reimbursement
- Develop new Physician leaders to implement strategic goals
- Create culture of Accountability across multiple parameters
- Reward PCPs for their role in Care Coordination/Management
- Potential decrease in Specialist Compensation

New Metrics: PCPs

<table>
<thead>
<tr>
<th>METRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Access</td>
</tr>
<tr>
<td>Panel Size</td>
</tr>
<tr>
<td>Mid-Level Provider Supervision</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Medical Home</td>
</tr>
<tr>
<td>Chronic Disease Management (e.g. Diabetes)</td>
</tr>
</tbody>
</table>
New Metrics: Specialists

<table>
<thead>
<tr>
<th>METRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Consults (measured by PCP survey or set timeframe)</td>
</tr>
<tr>
<td>Clinical Co-Management Services</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Post-Acute Care</td>
</tr>
<tr>
<td>Readmissions</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>On-Time Surgical Starts</td>
</tr>
<tr>
<td>Discharge Planning</td>
</tr>
</tbody>
</table>

Quality Metrics

- Challenges include Information Technology to capture data
- Development of Specialist Metrics

<table>
<thead>
<tr>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient SCIP &amp; Core Measures</td>
</tr>
<tr>
<td>NCQA/HEDIS/PQRS/GRPO</td>
</tr>
<tr>
<td>Care Model Development</td>
</tr>
<tr>
<td>Patient Outcomes</td>
</tr>
<tr>
<td>Completed Health Risk Assessments</td>
</tr>
<tr>
<td>Screening Exams</td>
</tr>
</tbody>
</table>
### Quality Metrics (cont.)

<table>
<thead>
<tr>
<th>Preventive Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram Screening</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
</tr>
<tr>
<td>Cervical Screening</td>
</tr>
<tr>
<td>Osteoporosis Screening</td>
</tr>
<tr>
<td>Influenza Vaccination</td>
</tr>
<tr>
<td>Pneumonia Vaccination</td>
</tr>
<tr>
<td>Blood Pressure Screening</td>
</tr>
<tr>
<td>Eye/Foot Exams</td>
</tr>
<tr>
<td>Cholesterol Screening</td>
</tr>
</tbody>
</table>

### Patient Satisfaction Metrics

- **Patient Satisfaction Metrics**

<table>
<thead>
<tr>
<th>Metrics</th>
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<tbody>
<tr>
<td>CG CAHPS</td>
</tr>
<tr>
<td>Press Ganey</td>
</tr>
<tr>
<td>Peer-Peer Reviews</td>
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<tr>
<td>Staff-Peer Reviews</td>
</tr>
<tr>
<td>Phone Surveys</td>
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</tbody>
</table>
Citizenship Metrics

- Citizenship Metrics: Contractual Requirement or Bonus for being Good Citizen?

<table>
<thead>
<tr>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Record Completion</td>
</tr>
<tr>
<td>Follow Standards of Behavior</td>
</tr>
<tr>
<td>Use of EMR</td>
</tr>
<tr>
<td>Meeting Attendance</td>
</tr>
<tr>
<td>Risk Management</td>
</tr>
<tr>
<td>Education</td>
</tr>
</tbody>
</table>

New Metrics: Other?

<table>
<thead>
<tr>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Outreach</td>
</tr>
<tr>
<td>Seniority</td>
</tr>
<tr>
<td>Protocol Development</td>
</tr>
<tr>
<td>Research</td>
</tr>
<tr>
<td>Administrative/Leadership</td>
</tr>
<tr>
<td>Teaching</td>
</tr>
</tbody>
</table>
Accountable Care Metrics

- **ACO Conditions of Participation**
  - Comply with Credentialing Requirements
  - Participate in ACO Educational Programs
  - Provide timely care consistent with Best Practices
  - Comply with ACO Policies and Procedures
  - Adhere to ACO Care Models/Protocols
  - Utilize ACO-approved EMR platform consistent with CMS Meaningful Use Guidelines
  - Exchange Clinical and Demographic Information through Secure Transaction Sets
  - Protect privacy of Patient PHI consistent with HIPAA
  - Measure and report on CMS Shared Savings Quality Metrics

**ACO Surplus Payment Criteria: PCP**

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Performance Measure</th>
<th>Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% PCP</td>
<td>Number of Enrollees</td>
<td>10 Enrollees per PCP</td>
</tr>
<tr>
<td>12.5% PCP</td>
<td>Patient Outcomes evidenced by HEDIS measures (e.g. Diabetes A1c control &gt;9), Blood Pressure Control &gt;140/90, Diabetes Cholesterol Control (LDL &lt;100)</td>
<td>Improve on existing % by 10% or exceed 75% of HEDIS regional threshold</td>
</tr>
<tr>
<td>12.5%</td>
<td>Advance Care Model development by integration of Care Model templates into practice and timely completion of Health Risk Assessments (&quot;HRA&quot;)</td>
<td>Complete 50% of HRAs by end of year</td>
</tr>
<tr>
<td>12.5%</td>
<td>Attend 1 education session on patient care process improvement</td>
<td>Documented Attendance</td>
</tr>
<tr>
<td>12.5%</td>
<td>CG CAHPS Survey (e.g. getting appts, Dr. communication, helpful office staff, Dr. rating, f/u test results)</td>
<td>Exceed benchmark in 3 of 5 categories</td>
</tr>
</tbody>
</table>
ACO Surplus Payment
Criteria: Specialist

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Performance Measure</th>
<th>Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% Specialist</td>
<td>Number of Enrollees</td>
<td>5 Enrollees per Specialist</td>
</tr>
<tr>
<td>12.5% Specialist</td>
<td>Patient Outcomes evidenced by Timely Consultation to PCP, and Standard Consult Report</td>
<td>20% of consultation reports received by PCP within 7 days</td>
</tr>
<tr>
<td>12.5% Specialist</td>
<td>Advance Care Model development by integration of Care Model templates into EMR</td>
<td>Introduction of charting templates into EMR</td>
</tr>
<tr>
<td>12.5% Specialist</td>
<td>Attend 1 education session on patient care process improvement</td>
<td>Documented Attendance</td>
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III. Legal Issues

LEGAL CHALLENGES PRESENTED IN EMERGING COMPENSATION MODELS
Overview of Laws

- State Corporate Practice of Medicine and Fee Splitting
- Federal and State Tax/Exempt Organization Laws
- State Corporate Law/Governance Issues
- Federal and State Anti-Kickback Laws
- Federal and State Stark/Physician Self-Referral Laws
- Federal CMP Law

CMP Law

- A civil money penalty may be imposed against a hospital that “knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who … are entitled to benefits under [Medicare or Medicaid] … and are under the direct care of the physician.”
- Hospitals and physicians liable for civil monetary penalties of up to $2000 per patient
- Basis for permissive exclusion from Medicare/Medicaid
- Applies to fee-for-service Medicare and Medicaid
CMP Law (cont.)

- OIG Broad Interpretation
  - No requirement that the prohibited payment be tied to a specific patient or to an actual reduction in care
  - Also irrelevant for purposes of CMP Law violation whether the care that may be reduced or limited as a result of an arrangement is necessary or prudent
  - Fixed fee payment for personal physician services permitted
  - Quality targets that don’t potentially induce reduction or limitation not affected
    - But many measures do have potential – e.g., cessation of antibiotics after surgery
  - Payment directly or indirectly from hospital – direct payment by payer to physicians/group does not implicate

CMP Law (cont.)

- Series of OIG Advisory Opinions (addressing CMP and Anti-Kickback Law)
  - OIG won’t pursue sanction – although would or could violate prohibition
  - Transparency and accountability
    - Specific, clearly identified actions targeted
  - Quality controls
    - Credible medical support and periodic reviews concerning impact on quality
    - Thresholds to protect against inappropriate reductions in service
  - No improper referral incentives
    - Participation limited to physicians on staff
    - Program limited to one year
CMP Law (cont.)

- **OIG Advisory Opinion 08-16; Commercial P4P**
  - Hospital payment of portion of its commercial payer P4P bonus to physician LLC
  - Physician LLC to provide services to aid in meeting P4P quality targets
  - Quality targets credible, based on collaboration of CMS and The Joint Commission
  - Physicians not penalized if quality target not met for patient for whom it is contraindicated
  - Transparency – quality targets specifically identified, patients notified
  - Hospital will monitor and protect against abuses

Federal Anti-Kickback Statute

- **Intent-driven**
- **Statutory exception and safe harbor provision for employment relationships**
  - Bona fide employees paid for furnishing items or services reimbursable under Medicare or Medicaid
  - No express FMV, commercial reasonableness, or lack of relationship to volume or value of referrals
  - Query if compensation above FMV, etc., constitutes compensation for furnishing items or services
- **OIG Gainsharing Advisory Opinions relevant**
  - Compensation to achieve hospital quality initiatives must be designed to avoid incentivizing or rewarding referrals
Stark Law

- Direct or Indirect Relationship with Hospital?
- If Direct, Meet Employment or Fair Market Value Exception
  - Employment - identifiable services; commercially reasonable agreement; compensation is FMV; compensation not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that productivity bonus based on services performed personally by the physician is permitted
  - FMV - signed, written agreement with identifiable services, all of which are covered; specified time frame, with no changes in less than one year; compensation set in advance, consistent with FMV, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician

Stark Law (cont.)

- If employed in hospital affiliate that meets Stark Law tests for a “group practice”
  - Physician relationship with hospital depends on indirect compensation relationship analysis
  - Physician referrals to group practice employer that provides DHS may be covered by in-office ancillary services exception
  - Physician in group practice may receive compensation indirectly related to volume or value of referrals – profit share or productivity bonus, and may receive compensation on services “incident to” his/her personal services
Stark Law (cont.)

- If indirect, does it meet Stark definition of “indirect compensation relationship”? 
  - Unbroken chain of financial relationships
  - Physician receives *aggregate* compensation that *varies with or takes into account* the *volume or value of referrals or other business generated* for the DHS entity
  - DHS entity has actual knowledge, or acts in reckless disregard or deliberate ignorance of the foregoing
- **Key issue will be second criteria**
  - Does compensation amount vary based on volume or value of hospital business? Is more efficient care more valuable to hospital?

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Stark Law (cont.)

- **Indirect compensation issue in Tuomey Case**
  - Part-time employment of surgeons by hospital affiliates, in response to formation of competing ASC
  - Base salary plus productivity bonus based on receipts from physician services or number of procedures performed by physicians
    - Resulted in compensation at 130% of net collections
  - Employment only for surgical services; required all outpatient surgery to be performed at Tuomey
  - Jury found Stark Law violation but no False Claims Act liability; judge awarded over $44 million repayment and ordered new trial on False Claims Act; Tuomey appealed. Fourth Circuit heard oral arguments on January 20, 2012
Stark Law (cont.)

- **Indirect compensation issue in Tuomey Case (Cont’d)**
  - One issue is whether productivity payment based on volume of professional surgical services is payment that varies with volume of referrals
  - Also argument that hospital took referrals into account because calculation of anticipated hospital revenues from surgeons taken into consideration in approving employment arrangement

Stark Law (cont.)

- **Exception for Indirect Compensation Arrangement**
  - Compensation is FMV for services and items actually provided
  - Compensation is not determined in a way that takes into account the volume or value of referrals or other business generated by the physician for the hospital
  - Arrangement is for identifiable services
  - Arrangement is commercially reasonable even if no referrals are made to the employer
  - No set in advance or written agreement requirement for employees
Stark Law (cont.)

- **Incentivizing Quality and Efficiency**
  - Comments in Phase II Regulations:
    - “no exception in the statute or in these regulations that would permit payments to [employed] physicians based on their utilization of DHS”
    - “nothing in the statutory exception bars payments based on quality measures …. For example, nothing in the statute or regulations would prohibit payments based on achieving certain benchmarks related to the provision of appropriate preventive health care services or patient satisfaction.”
  - 2008 Proposed Stark Exception
    - Never finalized
    - Extensive, detailed requirements to qualify for exception

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Stark Law (cont.)

- **Incentivizing Quality and Efficiency (cont.)**
  - CMS concerns mirror those of OIG:
    - “Stinting” – physicians limiting use of quality-improving but more costly devices
    - “Cherry picking” – treating only healthier patients
    - “Steering” – avoiding sicker patients at the participating hospital
    - “Quicker-sicker” – discharging patients earlier than clinically indicated
    - Use of program to foster physician loyalty and gain referrals
  - Need to analyze each proposed incentive metric that relates to hospital patients/DHS
    - Ambulatory treatment in office less problematic
  - Avoid broad measures, such as length of stay or cost per case
  - Exceptions are available for managed care patients
    - Physician incentive plan, prepaid plan, risk-sharing arrangements
Stark Law (cont.)

- **Requiring Referrals**
  - Stark Law regulations permit physician's compensation to be conditioned on physician's referrals to a particular provider if:
    - Compensation set in advance
    - Referral requirement is set forth in written agreement
    - Compensation "consistent with fair market value for services performed (that is, the payment does not take into account the volume or value of anticipated or required referrals)"
    - Referral requirement does not apply if patient expresses a preference for a different provider, patient's insurer determines provider, or referral is not in patient's best medical interests in physician's judgment
    - Required referrals relate solely to services in scope of the employment
    - Referral requirement is reasonably necessary to effectuate legitimate business purposes of the compensation relationship

Stark Law (cont.)

- **Requiring Referrals (cont.)**
  - Effect of requirement that "payment does not take into account the volume or value of anticipated or required referrals"
    - Variation in compensation based on compliance with the referral "condition" may be risky
  - What are legitimate business purposes? - "[S]ection 1877 of the Act was not intended to interfere with legitimate employment and health system structures."
    - Improved coordination and quality of care within a system?
Stark Law (cont.)

- **Waivers**
  - ACOs in the Medicare Shared Savings Program may take advantage of waivers of the CMP Law, Anti-Kickback Statute and Stark Law
  - MSSP waivers include a waiver for distribution of shared savings, a broad waiver for pre-participation arrangements and a broad waiver for participation arrangements
    - Covered arrangements are those among the ACO, its participants and/or its providers/suppliers
      - Thus, a hospital and its affiliated physician employees participating in an ACO may obtain coverage under the waiver
    - Requirements include ACO board determination that arrangement is reasonably related to purposes of the MSSP

Stark Law (cont.)

- **Waivers (cont.)**
  - Purposes of MSSP
    - promoting accountability for quality, cost and overall care for the Medicare patient population
    - managing and coordinating care for Medicare beneficiaries through the ACO
    - encouraging investment and infrastructure and redesigned care processes for high quality and efficient service delivery for patients, including Medicare beneficiaries
  - Participants in the Bundling Pilot also may obtain a waiver if the gainsharing proposals included in their applications are approved
    - Among other requirements, payments to physicians and other practitioners must be limited to 50% of the professional fees they would normally receive for cases included in the gainsharing program
Halifax Litigation

- **Government complaint in intervention:**
  - Physicians employed by Halifax Hospital and/or subsidiary, Halifax Staffing
  - Neurosurgeons compensation – fixed base plus incentive equal to collections in excess of base
    - Bonus compensation included services of nurse or PA
    - Employment agreements not signed, or signed after effective date
    - Total compensation over $1 million, mostly incentive
  - Hospital tracked neurosurgeon referrals and determined that although paid more than amount collected for their personally performed services, profitable based on income generated from referrals
  - Halifax could not have concluded compensation in excess of collections was FMV or commercially reasonable

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Halifax Litigation (cont.)

- Given that neurosurgeon compensation took into account referrals or other business generated, compensation was not set forth in advance in employment agreement, and many contracts signed after effective date, Halifax could not reasonably have concluded they did not violate the Stark Law (and thus FCA liability triggered)
- Medical oncologists compensation included equitable portion of bonus pool consisting of 85% of cash collections from oncologists' services above set amount. Also received equitable portion of fixed bonus pool if all oncologists combined exceeded targeted patient visits per month and patient visits scheduled within 10 days
  - Later amendments instituted a bonus pool based on operating margin of medical oncology program
  - Halifax analysis of compensation concluded at least one oncologist paid in excess of FMV
  - Halifax tracked referrals and raised question concerning oncologist with low referrals
Halifax Litigation (cont.)

- Halifax motion to dismiss
  - Government failed to allege indirect compensation relationship requirements
  - No allegation nurse or PA services were DHS, and no prohibition of compensation based on non-DHS services performed by others
  - Dollar amount of collections is not conclusive of fair market value – may be affected by services to indigent, uninsured, etc.
  - No allegation that oncologist bonus pools based on anything other than personally performed services
  - Signed agreement and set in advance not required for employees
  - State hospital – sovereign immunity

Halifax Litigation (cont.)

- Government brief in opposition
  - Complaint not required to identify particular type of financial arrangement or whether direct or indirect
  - Takes into account volume or value – there is a corresponding facility fee for a majority of the physicians’ professional services
  - Employment exception allows only personal productivity bonus, not bonus based on services performed by another
    - Excessive compensation prohibited especially if divorced from physician’s labor
Issues related to New Models

- Payment for Profitability
  - Physician Group
  - Health System
- Tracking of Physicians’ Referrals and “Leakage”
- Calculation of Contribution Margin of Physicians
- Sharing Ancillary Revenue with Physicians
- Selection of Metrics
  - Avoid reduction or limitation of care
  - Avoid incentivizing referrals
- Measurement of FMV

IV. Case Study: Summa Physicians

Who is Summa?
Who is Summa Physicians?
Change Process

I. Organizational Assessment
II. Development of Model-Consultant or Internal
III. Compare Old/New Model
IV. Create Physician Buy-In
V. System Approval Process
VI. Roll-Out/Operationalize

The Integrated Healthcare Delivery System

Hospitals
- Inpatient Facilities
  - Tertiary/Academic Campus
  - 3 Community Hospitals
  - 1 Affiliate Community Hospital
  - 2 JV Hospitals with Physicians
- Outpatient Facilities
  - Multiple ambulatory sites
  - Locations in 3 Counties
- Service Lines
  - Cardiac, Oncology, Neurology, Orthopaedics, Surgery, Seniors, Behavioral Health, Women’s, Emergency, Respiratory
- Key Statistics
  - 2,000+ Licensed Beds
  - 62,000 Inpatient Admissions
  - 47,000+ Surgeries
  - 660,000+ Outpatient Visits
  - 226,000+ ED Visits
  - 4,300+ Births
  - Over 220 Residents

Physicians
- Multiple Alignment Options
- Employment
- Joint Ventures
- EMR
- Clinical Integration
- Health Plan
- Summa Physicians, Inc.
  - 275+ Employed Physician Multi-Specialty Group
- Summa Health Network
  - PHO with over 1,000 physician members
  - EMR/Clinical Integration Program

Health Plan
- Geographic Reach
  - 19 Counties for Commercial
  - 18 Counties for Medicare
  - 60-hospital Commercial provider network
  - 41-hospital Medicare provider network
  - National accounts in multiple states
- 191,000 Total Members
  - Commercial Self Insured
  - Commercial Fully Insured
  - Group Process Outsourcing
  - Medicare Advantage
  - Individual PPO

Foundation
- System Foundation Focused On:
  - Development
  - Education
  - Research
  - Innovation
  - Community Benefit
  - Diversity
  - Government Relations
  - Advocacy
- Net Revenues: Over $1.5 Billion
- Total Employees: Nearly 11,000
Summa’s Service Area

SPI Overview

- Numbers:
  - 275 Physicians
  - 59 Advanced Practice Nurses and Physician Assistants
  - 671 non-Provider Employees

- Service Area: 5-County Market

- Utilize both Fully Employed and Physician Enterprise Model

- Physicians hired based on Community Need, Mission and Preventing Physician “leakage” from Community
Summa Physicians Inc.
Governance

- 501(c)(3) organization
- Independent Board of Directors which includes Physicians and Senior Management appointed by System Governance Committee
- Oversee all aspects of SPI operations and finance except compensation which is handled by System Compensation Committee
- Physician Advisory Council appointed by Chief Medical Officer to develop new Compensation Model

Growth of SPI:
December 2011

Number of Employed Physicians

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<td>2010</td>
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SPI Overview

Summa Physicians, Inc.
(275 physicians)

- Internal Medicine (39)
- Cardiology (30)
- Behavioral Health (25)
- Palliative Care (6)
- Family Medicine (45)
- Oncology (7)
- Critical Care (11)
- Gastroenterology (4)
- OB/Gyn (21)
- Surgery (35)
- Infectious Disease (7)
- Others (19)
- Geriatrics (11)
- Ortho/Sports (11)
- Endocrinology (4)

SPI Current Business Model

- Physician Compensation is Productivity Based
- Ancillary Services have transferred to Provider Based Billing under the Hospitals
- All physicians are employed under a Hospital or System approved business plan
Challenges for SPI

- Subsidy or “Investment” for Hospitals
- Hospitals desire to meet Budget Bottom Line vs. Institute Goals of creating System of Care
- Leased Model allows for Autonomy but also perpetuates lack of Standardization
- Increased level of charity care burden with Economic Downturn

Future Goals Drive Compensation Model Change

- Future Goals include:
  - Enhance Physician Engagement and System Integration
  - Expand Market Penetration (selectively and strategically) and Increase our Patient Population
  - Achieve superior Operative and Clinical Performance
  - Improve Population Health through ACO and Medical Homes
CHANGE OF PHYSICIAN COMPENSATION PLAN

Summa Physicians, Inc. (SPI)

Starting Point

Key Questions:

- Utilize Consultant and Roll-out Findings to Physicians?
- Create Committee combining Consultant and Physicians?
- Physician Committee develops Model and turns over to Physician/Health System Board or Compensation Committee for Approval?
- Take Incremental Approach or look to implement 1-time Change?
CMO Council

- High Performance Team appointed in late 2011 by new SPI President to outline a new compensation model by early 2012.
- Multispecialty group including representatives from the following areas:
  - Family Medicine
  - Psychiatry
  - Surgery (Colorectal)
  - Gastroenterology
  - Hematology / Oncology
  - Cardiology
  - General Internal Medicine
  - Geriatrics

PHYSICIAN-LED

- Began with weekly meetings with a goal for the finalization of new model in 3 months
- Agreement for a 1-year “shadow” program to see how the model works.
- Drafted a set of Guiding Principles and developed Incentive Plan Proposal
- Leverage Physician-Led Council to drive Compensation Transformation
- **Outcome:** Transparency, Trust, Physician Empowerment and Buy-In as we seek to Operationalize Model
Guiding Principles

- Principles:
  - Compensation Change should affect 20% of Base Compensation
  - Quality Metrics for PCP/Specialists will be different and use Committees to finalize development
  - Trial Mode for first 6 months, and full implementation in 2013
  - Annual Performance Review necessary to qualify for Bonus. Adjustments to Compensation made on Bi-Annual basis
  - Incentive Metrics will address:
    - Success of System/SPI
    - Citizenship
    - Information Management
    - Quality/Service
    - Patient Satisfaction

Guiding Principles (cont.)

- Incentive Dollars from ACO, Bundled Payments and other value based purchasing incentives will fund model
- Use of Scorecard to keep Physicians aware of progress towards Compensation goals
- New Compensation Model based on 6 Dimensions of Quality ("IOM")
  - Safe
  - Centered
  - Effective
  - Timely
  - Efficient
  - Equitable
Old Model

- **Hypothetical:**
  - Base Compensation: $300,000—assumes 8,000 wRVUs
  - Bonus: $100,000—assumes additional $ based on total wRVUs of 10,000
  - Total Compensation: $400,000

New Model

- **Hypothetical:**
  - Base Compensation: $300,000—assumes 8,000 wRVUs (adjusted bi-annually based on actual productivity)
  - 20% Bonus: $60,000—based on achievement of new metrics
  - Additional 2,000 wRVUs paid at lower conversion factor (look to lower productivity incentives)=$50,000
  - Total Compensation: $410,000
Key Finding

- Advisory Board suggests that 20% Compensation withhold necessary to drive behavior change

Withhold or Bonus?
Risk or Reward?

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Operationalize

- Need to Amend or Develop New Contracts
- Establish analytics and IT capabilities to measure new metrics
- Need to have sophisticated Coding process to ensure RVUs consistent with quality standards
- Create tools to trend performance data and incorporate appropriate targets/benchmarks to evaluate effectiveness of model
- Engage outside Compensation Consultant to validate model
- Take to SPI Board and then System Compensation Committee for final approval

Takeaways

- All Compensation Plans need to be Local
- May need to develop multiple models based upon Specialty or targeted areas of need
- Measurement Periods should be at least 1 year with interim feedback during period to modify behavior appropriately
- Compensation redesign is necessary as transition away from Fee-for-Service payment to avoid conflicting messages
- Need to account for PCP value as we participate in several New Initiatives
- Flexibility to adapt to future changes in Health Care Paradigm
V. Questions/Answers

HELLO, THIS IS YOUR CEO, I WANT TO PAY MY PHYSICIANS AS follows:

Question One

- Do we need to engage a Consultant or can we utilize a Physician Committee to create our Compensation Model? Do we need a 3rd party to validate our Physician-Led Compensation Model?
Question Two

- Can we pay our Physicians based on their Contribution Margin to the Health System? The cost or ALOS for cases that they bring to the Hospital?

Question Three

- Can we include an incentive based on a threshold number or percentage of cases to the Health System if we have a steerage provision in our Employment Agreement? Can we terminate based on a physician’s failure to provide a threshold number or percentage of cases to the Health System?
Question Four

- Do we need to keep time logs for our Physician Medical Administrative Leaders in an Employed Compensation Model?

Question Five

- Can we share with our Employed Physicians: Any expense reductions for their practice costs? For Savings in their Service Line? For Ancillary Production?
Question Six

- Can we pay our Cardiologists as a group for their collective work across our System or do we need to pay based on individual performance?

LAST CHANCE, QUESTIONS?
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