THOUGHTWARE®

Health Care

Everyone needs a trusted advisor. Who's yours?

1

Practical Design Approaches and Elements for Compliant Compensation Arrangements

Randy Biernat, CPA/ABV
Partner
rbiernat@bkd.com | 317.383.4271

October 4, 2019

BKD

2

THOUGHTWARE®

Health Care

Everyone needs a trusted advisor. Who's yours?

3

Practical Design Approaches and Elements for Compliant Compensation Arrangements

Randy Biernat, CPA/ABV
Partner
rbiernat@bkd.com | 317.383.4271

October 4, 2019

BKD

4

Discussion Agenda

- Internal Control Needs for Compensation Plan Design
- Strategies for Aligning Work Effort with Compensation Terms
- Differences between “Cost” and “Value”
- Best Practices in Compensation Caps

FUNDMENTAL QUESTION IN COMPLIANCE: “MAY WE?”

5

5

INTERNAL CONTROL NEEDS FOR COMPENSATION PLAN DESIGN

6

Compensation Plan Design Needs

Strategic

- Encourage Productivity
- Enhance Engagement
- Promote Care Coordination
- Improve Network Integrity
- Manage Population Health
- Promote Team-Based Care
- Improve Recruiting & Retention

Compliance

- Accurate
- Replicable
- Reliable
- Predictable
- Fair Market Value
- Commercially Reasonable
- Financially Sustainable

7

7

Key Control Areas

WHERE IS MAJORITY OF RISK? PRICE OR QUANTITY??

- Key regulatory tenets of physician compensation include:
  - Stacking: a physician can only be paid for one thing at a time
  - Existence: payments must only be for work actually performed
  - Necessary: the work performed must be a needed service or otherwise rational in light of the organization's mission, etc.
  - One-Person Test: the sum payments for each individual service need to be reasonable when considering all in aggregate
  - Commercially Reasonable: the business arrangement makes sense in the absence of a referral relationship, including consideration of partner selection & business rationale

PRIOR SLIDE COMPLIANCE ELEMENTS TRYING TO CONTROL FOR THESE RISKS

BKD

8

Recommendations

- Policies and Procedures must exist with respect to administering physician compensation arrangements that define:
  - Sources of information
  - Applicable date ranges
  - Control over, review of, and application of functional data for contract adjudication, including
    - Billing information
    - Quality information
    - Operations / scheduling (such as call shifts, ER shifts, etc.)
    - Human resources (time off, phantom credits, disability, etc.)
    - Accounts payable (allowable expenses)
  - Applicable reconciliation periods

HAVING A "CONTROLLED" SANDBOX IS A MUST FOR PROJECTING FUTURE ANTICIPATED COMPENSATION

BKD

9

Data Integrity Example for Compensation Design Planning

Current Pay Structure:

- 120 12-hour shifts paid at $200 per hour or $2,400 per shift
- Extra Shift pay at $250 per hour or $3,000 per shift
- Any hours over 12 hours in a single shift are paid at $300 per hour

Proposed Pay Structure:

- Physician required to serve 1,500 hours of baseline work for base pay of $300,000
- All hours in excess of 1,500 are paid at $275 per hour

What is the economic impact of this change if work effort is as follows:

- Physician works 120 normal shifts
- Physician works 30 extra shifts
- Physician works beyond a twelve hour shift by 100 hours

10

BKD

10

Method Change Impact Example "A"

	Current	%		Proposed	
Base Pay	$ 288,000	71%		$ 300,000	70%
Extra Shift Pay	90,000	22%		-	0%
Extra Hourly Pay	30,000	7%		126,500	30%
	$ 408,000	100%		$ 426,500	100%
Difference	**$ 18,500**				
Percent Difference	**4.5%**				

BKD

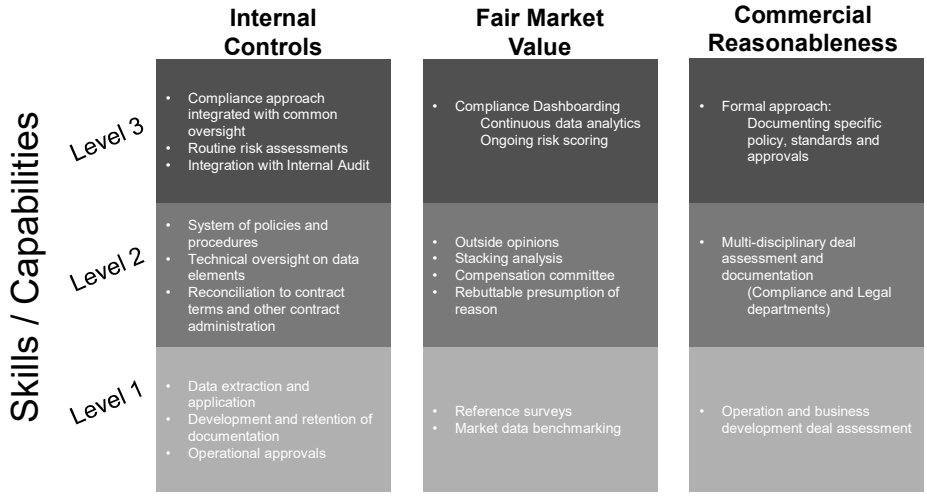
Method Change Impact Example "B"

WHAT IF RECORD KEEPING IS INDICATES THAT A NORMAL SHIFT IS 11 HOURS??

	Current	%		Proposed	
Base Pay	$ 288,000	71%		$ 300,000	81%
Extra Shift Pay	90,000	22%		-	0%
Extra Hourly Pay	30,000	7%		68,750	19%
	$ 408,000	100%		$ 368,750	100%
Difference	**$ (39,250)**				
Percent Difference	**-9.6%**				

BKD

Risk Management – Internal Skillsets



13

Policy Control Procedures

- The policy control process (“PCP”) for physician compensation should give detailed consideration to:
  - Contract detail verification process
  - Productivity input process (e.g. verifying wRVU levels)
  - Work effort documentation procedures (shift, hourly time & administrative input verification processes)
  - Quality & outcomes measures verification process
  - Compensation & bonus accuracy verification processes
  - Financial reporting & accrual verification process
  - Allowance & Benefits Team (allowance input & payment verification process)
- The PCP should be tailored to fit each hospital’s risk profile

14

BKD

14

STRATEGIES FOR ALIGNING WORK EFFORT WITH COMPENSATION

15

Compensation & Work Effort Should

- Be Fair Market Value (Commensurate)
- Reward Personally Performed Services
- Not take into account the value or volume of Designated Heath Services
- Not take into account profit or downstream revenue
- Have internal equity (?)

16

BKD

16

What is an FMV Compliant Arrangement?

- Three Parts to a FMV Analysis
  1. Anticipated compensation per contract(s)
  2. Benchmarking of work effort as informed by relevant facts and circumstances under a standard of value
  3. Comparison of anticipated compensation to benchmarked range
- Compensation Plan Design Relates to Item 1
- Compliance Relates to Item 2

STRATEGIC ALIGNMENT OF 1 & 2 THEN NECESSITATES CONTRACT PAYMENT STRUCTURE IS BASED ON STRUCTURED, CONTROLLED DATA FOR WHICH A MARKET VALUE CAN BE ASSIGNED

BKD

17

Work Effort Types

- Clinical
- Supervisory
- Teaching
- Administrative
- Leadership
- Call Coverage
- Medical Direction

"RATES" CAN BE ASSIGNED TO ALL OF THESE, BUT CAN UNITS BE OBTAINED RELIABLY?

18

BKD

18

Compensation Plan Design Truths

- More Complexity Requires More Controls
- More Complexity Adds Time and Cost
- Less Complexity Drives a Gap Between Compensation and Work Effort
- Use of Third Party Surveys Invites Volatility in Results
- Most providers do not like change

KEY IS TO FIND SWEET SPOT WHERE ALIGNMENT IS CLOSE ENOUGH, BUT CONTRACT ADMINISTRATION IS REASONABLE

19

BKD

19

Recommendations

- Compliance Team Needs to Listen to Hopes of Strategic Team and Define What's Possible in Current State of Funding/Staffing
- Any Contemplated Changes to Compensation Plan Design from an Administrative Standpoint Should be Part of Decision to Move Forward or Not
- Often the Development of Work Effort Measures can be Accomplished by Non-physician Clinic Staff (operations)

20

BKD

20

EVALUATING "COST" VERSUS "VALUE" IN COMPENSATION ARRANGEMENTS

21

What is a Cost v. Value Analysis?

- Three Parts to a Commercial Value Analysis
  1. Anticipated compensation per contract(s)
  2. Benchmarking of work effort as informed by relevant facts and circumstances under a standard of value
  3. Comparison of anticipated compensation to benchmarked range
- Item 1 is "Cost" as it shows up in financials
- Item 2 is "Value" as it represents expected work effort associated payment level (cost)

BY ADOPTING A "PRICING MODEL", ONE CAN DETERMINE VALUE, COMPARE IT TO COST, AND MAKE GOOD FINANCIAL DECISIONS

22

BKD

22

Considerations in Developing a Pricing Model

- Comprehensive & Componentized - all material physician work effort is valued on a standalone basis
  - Patient Care Work Effort – typically CMS' Work RVU scale
  - All Other Work Effort – time based approach (*e.g., rate x hours*)
- Highest & Best Use - Work that overlaps in time is valued at the highest value and secondary work is not also valued
- Realistic Cost to Employ Data Utilized – Pricing Values Need to Reconcile to Reasonable Levels of Total Compensation
- Coverage v. Productivity – For physicians whose work requirements are coverage-based (such as hospitalists), we consider hourly rates for clinical work effort instead of "re-priced" wRVUs

BKD

Once Priced, Physician Work Can Be Appropriate "Costed"

Employed physicians are routinely asked to contribute via:

- Clinical productivity (*assign cost to clinic*)
- Call compensation (*assign cost to hospital*)
- APP supervision (*assign cost to clinic*)
- Medical direction (*assign cost to hospital*)
- Clinical quality efforts (*assign to ACO/CIN*)
- Other time based services, such as teaching, research, administrative tasks, etc. *(assign to "consumer" of time)*

Internal Pricing Model

Regardless of what the contact calls for in terms of payment mechanisms, an internal pricing model can be used to assign a physician's cost into appropriate buckets.

Accomplish by establishing & adopting a standard pricing model

BKD

Policy: Internal Valuation Methodology Procedures

- The strongest internal FMV compliance approach is formal protocol for evaluating compensation terms, an “internal valuation methodology memo”
- Based on standardized treatment of common deal terms, a uniform evaluation of FMV can be applied
- For arrangements that don’t fit the internal pricing model, the methodology will describe an exceptions protocol to trigger additional approval and/or outside review
- An entity-specific methodology & accompanying Excel-model to rapidly process evaluations can be tailored to fit the risk profile of the hospital
- The same model can be used for provider services pricing of work effort, related cost allocations, and financial decision-making concerning the value of personally performed work effort.

BKD

25

Management’s FMV Risk Management Internal Controls Objectives (1/2)

10% MORE EFFORT THAN BEST PRACTICE FROM A FMV COMPLIANCE RISK MANAGEMENT PROCESS CAN GENERATE A CONSISTENT PRICING / COSTING MECHANISM TO GREATLY ENHANCE FINANICAL DECISION MAKING IN PHYSICIAN OPERATIONS

- Appropriate oversight and approvals (Operations)
- Adherence to contract terms and verification of the same (Finance)
- Processes for timely contract renewals (HR/legal)
- Compensation / fee setting processes and related management approvals (Finance)
- Verification and periodic testing of WRVU calculations and other productivity inputs to calculation models (Finance / Internal Audit)

BKD

26

Management's FMV Risk Management Internal Controls Objectives (2/2)

- Restrictions and close review of credit for "Designated Health Services and ancillary services credit in compensation arrangements (Compliance / Finance)
- Reconciliation and review of allocations of productivity credit regarding mid-level providers services (Operations)
- Use of internal valuation methodology memos to consistently establish and approve FMV (Compliance / Finance)

BKD

27

EFFECTIVE USE OF COMPENSATION LIMITERS

28

BKD

28

Cost Containment – Structural Spending Plans

- Regardless of the specific compensation plan design elements, all clinic-based/productivity-based providers can have their net loss amount "boxed in"
- There is a financial analysis that focuses on actual & target contribution margin above a base compensation threshold.
- Compensation plan productivity bonuses can be set to isolate a fixed loss level.
- This creates certainty with respect to annual investment & allows for more stable service line plan development
- Overall limits can also be applied as tied in with cash collections to enhance compliance from the standpoint of increased sustainability

BKD

29

Structural Loss Analysis – Part 1

Baseline:

Base Plus Bonus Model

	Total	Per Visit
Visits	4,000	n/a
Revenue	420,000	105.00
Practice Expense - Fixed	150,000	37.50
Practice Expense - Variable	170,000	42.50
Net Income before Physician Expenses	*100,000*	*25.00*
Physician Expense - Fixed	200,000	50.00
Physician Expense - Variable	-	-
Net Income/(Loss)	*(100,000)*	*(25.00)*
Physician Compensation per Unit	*$ 50*	

BKD

30

Structural Loss Analysis – Part 2

Flat Physician Comp/WRVU Bonus @ $60/visit

Practice Growth of 2,000 Visits

	Total	Per Visit	Marginal
Visits	6,000	n/a	(visit 6,001)
Revenue	600,000	100.00	95.00
Practice Expense - Fixed	150,000	25.00	-
Practice Expense - Variable	255,000	42.50	42.50
Net Income before Physician Expenses	*195,000*	*32.50*	*52.50*
Physician Expense - Fixed	200,000	33.33	-
Physician Expense - Variable	120,000	60.00	60.00
Net Income/(Loss)	*(125,000)*	*(31.25)*	*(7.50)*

Physician Compensation per Unit	*$ 53.33*

BKD

Structural Loss Analysis – Part 3

Increasing Physician Comp/WRVU Bonus Tiers

Base Plus Bonus Increasing Tiered Model - Practice Growth of 2,000 Visits

	Total	Per Visit	Marginal
Visits	6,000	n/a	(visit 6,001)
Revenue	600,000	100.00	95.00
Practice Expense - Fixed	150,000	25.00	-
Practice Expense - Variable	255,000	42.50	42.50
Net Income before Physician Expenses	*195,000*	*32.50*	*52.50*
Physician Expense - Fixed	200,000	33.33	-
Physician Expense - Variable	130,000	65.00	70.00
Net Income/(Loss)	*(135,000)*	*(33.75)*	*(17.50)*

Physician Compensation per Unit	*$ 55.00*

BKD

Structural Loss Analysis – Part 4

Decreasing Physician Comp/WRVU Bonus Tiers

Practice Growth of 2,000 Visits

	Total	Per Visit	Marginal
Visits	6,000	n/a	(visit 6,001)
Revenue	600,000	100.00	95.00
Practice Expense - Fixed	150,000	25.00	-
Practice Expense - Variable	255,000	42.50	42.50
Net Income before Physician Expenses	*195,000*	*32.50*	*52.50*
Physician Expense - Fixed	200,000	33.33	-
Physician Expense - Variable	119,000	59.50	52.00
Net Income/(Loss)	*(124,000)*	*(31.00)*	*0.50*
Physician Compensation per Unit	*53.17*		

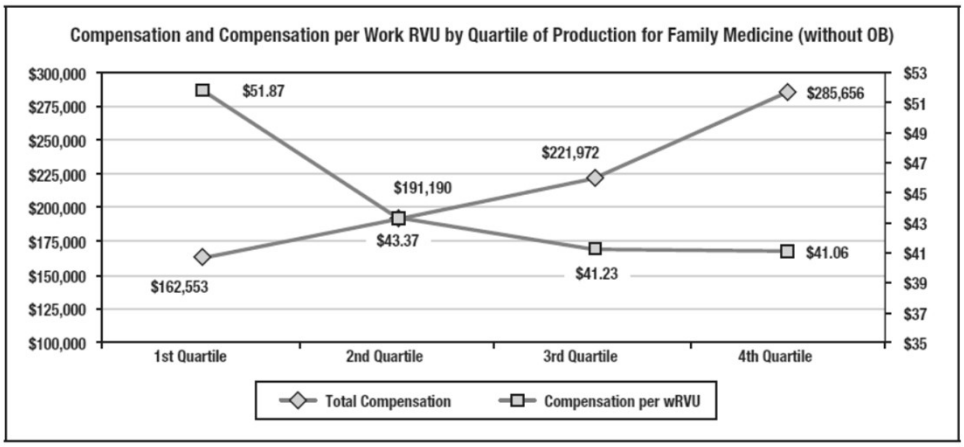
BKD

Structural Loss Analysis – Conclusion

- Effective physician compensation per unit is similar under all three growth scenarios
  - Constant Bonus Rate: $53.33
  - Increasing Tiers: $55.00
  - Decreasing Tiers: $53.17
- Alternatively, implementing compensation caps tied to collections (or both) can achieve a similar effect
- Philosophically, a declining productivity pay amount is a good tool to disincentivize physician burnout, a key driver of turnover

BKD

As Total Compensation Rises, Compensation per wRVU Falls



BKD

35

36

bkd.com/HC | @bkdHC

BKD

37