CRITICAL ACCESS HOSPITAL

FINANCIAL AND OPERATIONAL VIRTUAL CONFERENCE

June 2024

HOUSEKEEPING

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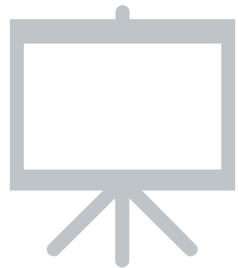
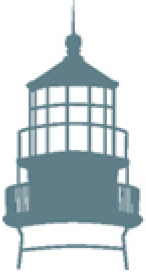


Slides and recordings will be made available to all registrants following the webinar

A short survey will follow each conference session. Your feedback is very important to us, and we appreciate your time in helping us improve.



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- **Operational Advisory**
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  - Cost Report Reviews and Analysis

STROUDWATER

BEST PRACTICES: REDESIGNING PROVIDER COMPENSATION

June 20, 2024

OBJECTIVES

Current Compensation Market

Compliance Requirements

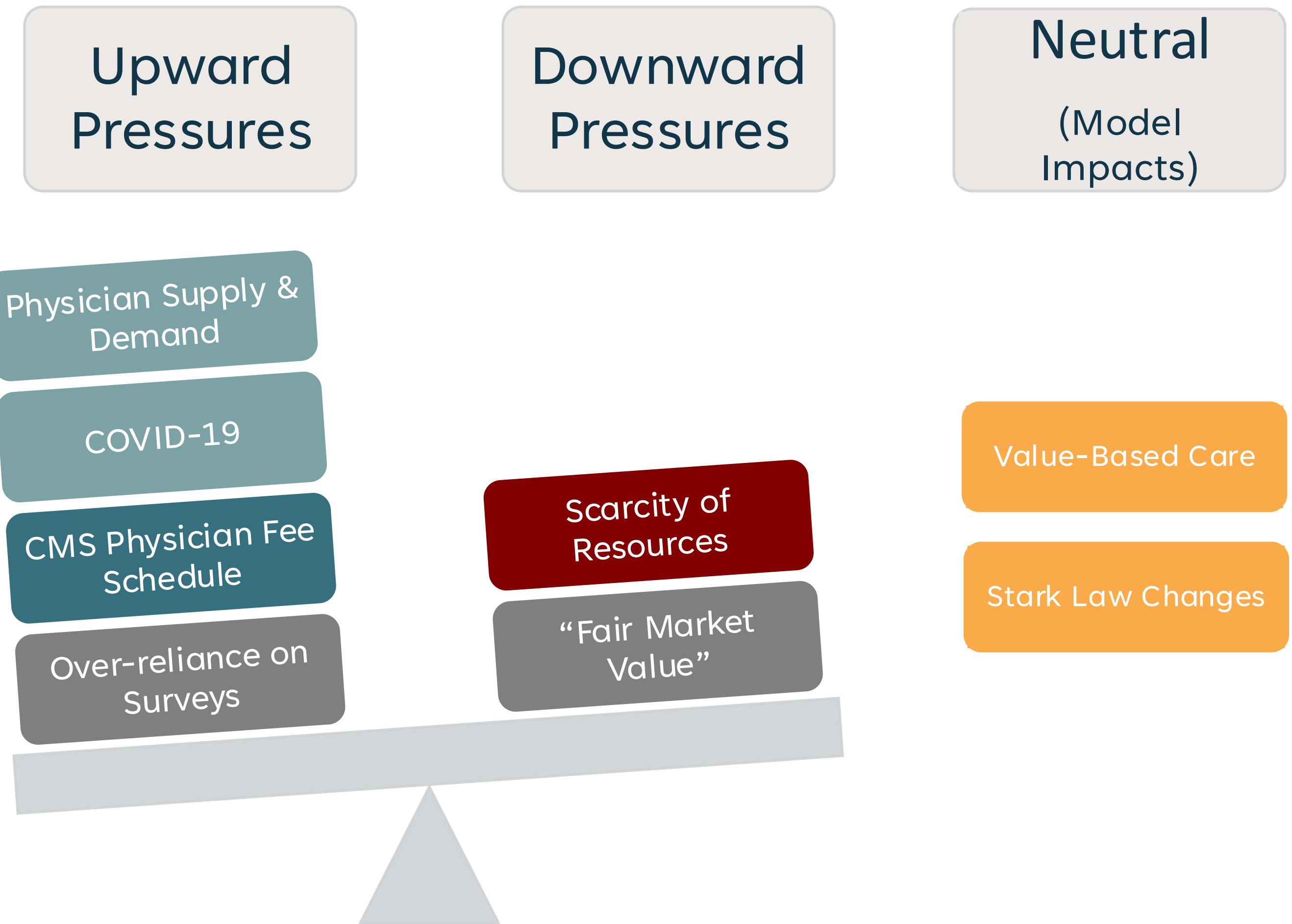
Compensation Engagement

Q&A

CURRENT COMPENSATION MARKET

FORCES INFLUENCING COMPENSATION

- Regulatory changes, COVID-19 impacts and the transition to value-based care intensify existing challenges with provider supply (shortages) and demand (increasing need), which directly influence compensation
- Factors to the right affect compensation within the industry. Rural hospitals are also affected by:
  - Difficulty recruiting
  - Lack of access to specialists
- Provider compensation must be attuned to present and evolving market forces that impact the healthcare system and organizational goals



PRE-COVID STATE OF PHYSICIAN SUPPLY & DEMAND

- Increasing demand for physicians continues to outpace growth in supply
- The Association for American Medical Colleges projected the following shortages by 2034, based on 2019 data assuming physician supply and demand were in equilibrium:
  - 37,800 to 124,000 total physicians
  - 17,800 to 48,000 in primary care
  - 21,000 to 77,000 in specialty care
- COVID-19 has raised awareness of disparities in health and access to care by minorities, people living in rural communities, and people without health insurance
  - If these populations had healthcare patterns similar to those of populations with fewer barriers, the national shortage ranges from **102,400 to 180,400**
- COVID-19 has had consequences for the physician workforce, including:
  - Training (e.g., interruption of education)
  - Regulation (e.g., changes in licensure and reimbursement)
  - Practice (e.g., telehealth, appointment cancellations)
  - Workforce exits

Pre-COVID-19 Physician Shortage Range

Full-Time-Equivalent Physicians
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
2019
2022
2025
2028
2031
2034
Year
124,000
37,800
19,800
2034 Range

2021 & 2022 PHYSICIAN FEE SCHEDULE

- Changes are made annually to the Medicare Physician Fee Schedule ("PFS") to address revised CPT codes and corresponding work RVUs ("wRVUs"); quarterly changes also apply, but are generally less significant
- On December 2nd, 2020, CMS published the final rule for 2021
  - Most significantly, CMS overhauled the office and outpatient evaluation and management ("E&M") codes 99201-99205 (new patients) and 99211 – 99215 (established patients)[1]
  - Changes were intended to address the ongoing documentation burden on physicians and the undervaluation of time and effort involved in these services
  - Most compensation models are based on wRVUs and, therefore, without intervention, compensation would increase significantly for certain specialties
- On November 2nd, 2021, CMS published the final rule for the 2022 PFS which included a conversion factor of $34.61, a decrease from the 2021 conversion factor of $34.89, but an increase from the initial 2022 conversion factor of $33.59 announced in the final rule
  - No material change in wRVUs based on 2021 PFS applied

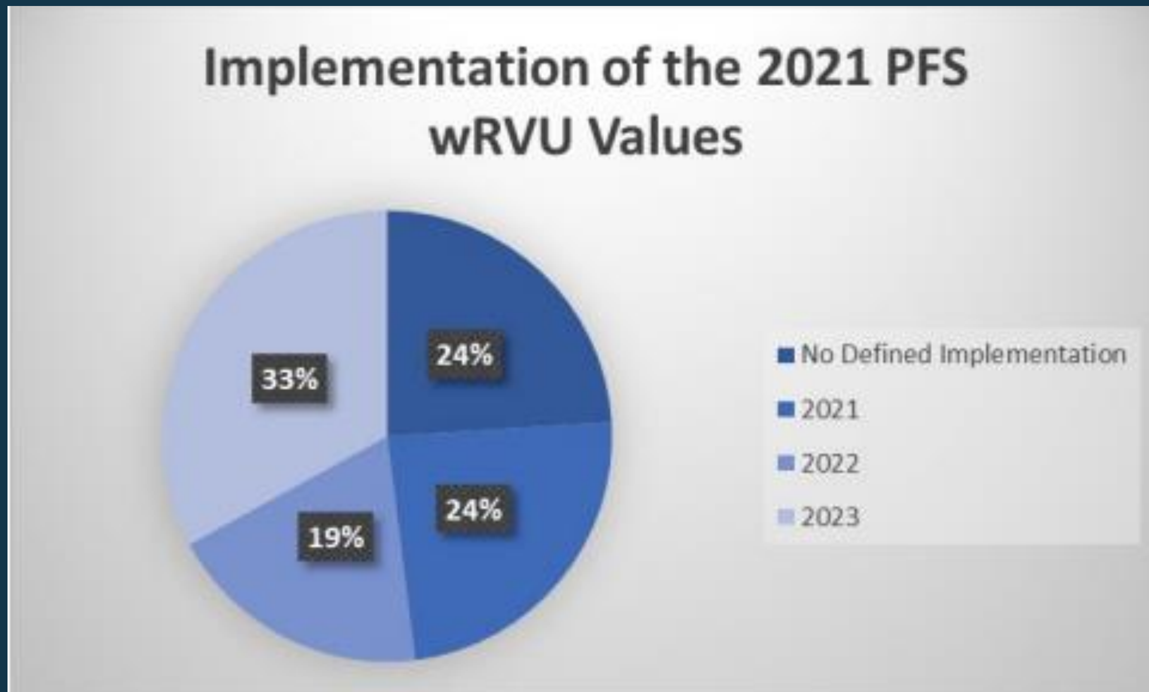
- **The impact of the PFS changes: Potentially higher provider compensation with lower reimbursement**

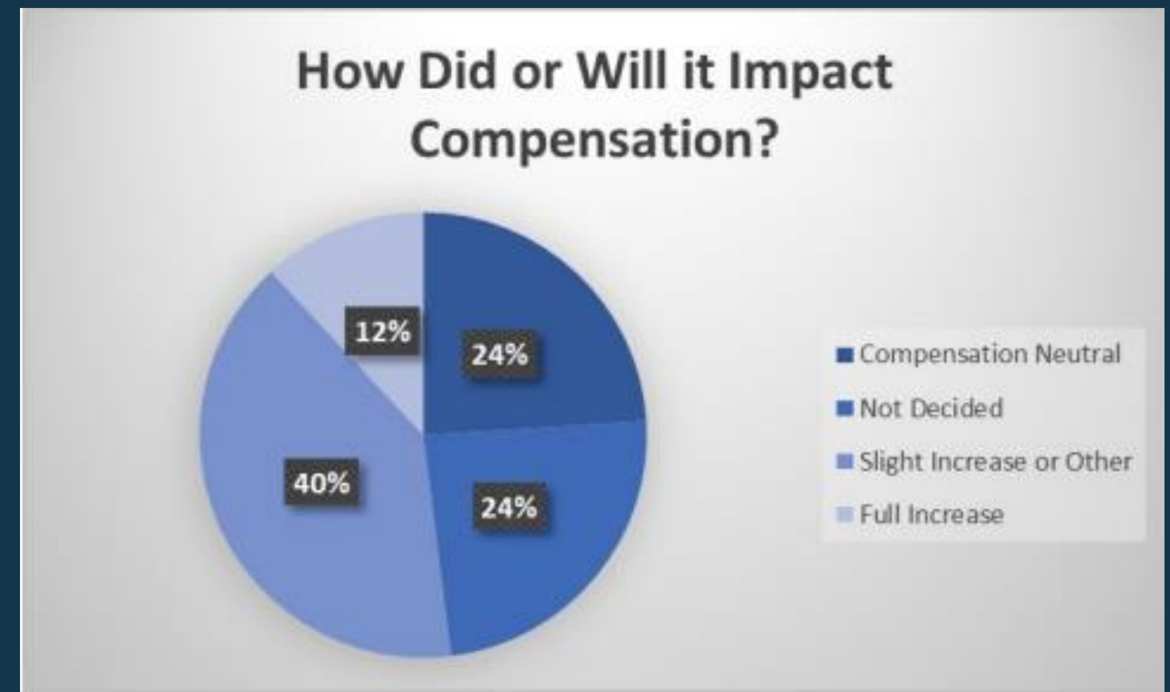
Specialty	2021 PFS: % Change in Total wRVUs[2]
Urgent Care	24.4%
Family Medicine (w/o OB)	19.3%
Hematology/Oncology	17.4%
Internal Medicine: General	17.4%
Pediatrics: General	13.5%
Cardiology: Noninvasive	8.4%
Orthopedic Surgery: General	6.3%
OB/GYN: General	3.9%
Gastroenterology	3.8%
Surgery: General	3.0%

1. Note: 99201 was eliminated (historically used for nurse visits)
2. Source: Gallagher/Integrated Healthcare Strategies. Based on MGMA procedural profile

2021 PFS CHANGE – NO ONE IMPLEMENTED UNIFORMLY

- Over a third of MGMA respondents had not gone live on the 2021 PFS at the time of the 2022 survey
- Only 12% allowed for providers to access a full increase in compensation resulting from changes in wRVU values





Source: American Association of Provider Compensation Professionals – “Physician Fee Schedule wRVUs and Billing Rules – This Changes Everything You Know About Provider Data”

2023 & 2024 PHYSICIAN FEE SCHEDULE

- The final rule for the 2023 PFS includes a conversion factor of $33.89, a decrease from the 2022 conversion factor of $34.61
  - The 2023 PFS includes changes to E&M CPT code wRVU values in inpatient settings and other facilities
  - The table to the left projects the impact of the 2023 CMS Final Rule on reported wRVUs
- The CMS CY2024 final rule for the physician fee schedule cuts the conversion factor by 3.4%, to $32.74 in CY 2024, as compared to $33.89 in CY 2023.
  - This reflects the expiration of the 2.5% statutory payment increase for CY 2023; a 1.25% statutory payment increase for 2024; a 0.00% conversion factor update under the Medicare Access and Children's Health Insurance Program Reauthorization Act; and a budget-neutrality adjustment.

Specialty	wRVU % Change: Initial	wRVU % Change: Full Adoption
Urgent Care	7.4%	10.8%
Sports Medicine	6.1%	8.5%
Dermatology	5.4%	7.6%
Endocrinology/Metabolism	5.8%	7.6%
Oncology-Only	5.2%	7.6%
Rheumatology	4.8%	7.0%
Allergy/Immunology	4.9%	6.7%
Internal Medicine	4.6%	6.6%
Family Practice without OB	4.6%	6.5%
Internal Medicine-Pediatrics	3.7%	5.9%

https://www.ecgmc.com/insights/blog/1505/what-the-proposed-2024-mpfs-means-for-physician-compensation
https://www.aha.org/news/headline/2023-11-02-cms-issues-cy-2024-physician-fee-schedule-final-rule

LIMITATIONS TO SURVEY DATA

Specialty	Group Count	Count
NP: Family Medicine (without OB)	92	341
Family Medicine (without OB)	76	264
Internal Medicine: General	32	83
Certified Registered Nurse Anesthetist	14	83
Surgery: General	38	80
Emergency Medicine	19	78
Hospitalist: Internal Medicine	20	76
Pediatrics: General	30	71
Family Medicine: Ambulatory Only (No Inpatient Work)	5	66
Obstetrics/Gynecology: General	29	66
PA: Family Medicine (without OB)	33	64
Physical Therapist	10	63
Orthopedic Surgery: General	26	56
NP (Primary Care)	23	56
Family Medicine (with OB)	16	47
Urgent Care	15	43
NP: Psychiatry	17	32
Urology	20	30
Otorhinolaryngology	15	29
Licensed Clinical Social Worker	8	27

Source: MGMA 2024 Provider Compensation and Productivity Survey (Based on 2023 Data)

- Survey data typically publishes total *cash* compensation for professional services
- What is in cash compensation?
  - W-2 wages
  - K-1 compensation
  - Medical director stipends
  - Research income
  - Call compensation
  - APP supervision stipends
- Not many rural respondents (servicing populations of less than 49,999)
  - General Surgery, OB/GYN, and Orthopedics are the only surgical specialties represented with more than 50 total providers
  - Primary care* data represents 1,165 providers
  - Women's Health** data represents 93 providers

*Primary care includes family medicine w/ and w/o OB, urgent care, pediatrics, dietitian/nutritionist, and internal medicine for both physicians and APPs.
** Women's Health includes OB/GYN, nurse midwives and NP: OB/GYN/Women's Health

SCARCITY HITTING RURAL

There have been 178 Rural Hospital closures or conversions since 2010 and 217 since 2005, these numbers include 26 Rural Emergency Hospital Conversions since 2023.

Medicare Payment Type
- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Rural Referral Center
- IHS

Current Status
- REH
- Complete Closure
- Convert to Other

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

© 2024 Mapbox © OpenStreetMap

Merative; as of May 13, 2024

COMPLIANCE REQUIREMENTS

RELEVANCE OF PROVIDER CONTRACTS

Provider remuneration expense is significant & increasing

Provider remuneration is highly regulated

Pace of change is significant

Many organizations find their provider alignment & compensation is misaligned with organizational strategy and industry trends

PRIMARY LAWS & STATUTES

Stark Law	Prohibits physicians from referring patients to receive "designated health services“ (“DHS”) payable by Medicare or Medicaid from entities with which the physician (or an immediate family member) has a financial relationship, unless an exception applies (such as Fair Market Value)
	Strict liability statute – this is where the technical violations happen!
Anti-Kickback Statute (“AKS”)	The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal healthcare programs (e.g., drugs, supplies, or healthcare services for Medicare or Medicaid patients)
False Claims Act (“FCA”)	Triple the damages caused for anyone who commits Medicare fraud
	Any violation of Stark or AKS are considered on their face false or fraudulent and violations of the FCA
Private Inurement	Applicable to not-for-profit organizations only
	Compensation that exceeds a typically fair salary for comparable positions
	Consequence is revocation of not-for-profit status

“DOJ Announces Record-Breaking Year for False Claims Act Settlements and Judgments.” – Reporting on $1.8 billion of the $2.6 total settlements in 2023

Jones Day, February 2024

TECHNICAL VIOLATIONS

- In 2023, recoveries were $2.6 billion
- Most cases were initiated by whistleblowers filing “qui tam” lawsuits; whistleblowers receive 15% - 30% of the recoveries associated with these cases (over $340 million in 2023)
- ROI: $4.30 is recovered from every $1.00 spent

FOR IMMEDIATE RELEASE Thursday, July 7, 2022

West Virginia Hospital to Pay $1.5 Million to Settle Allegations Concerning Impermissible Financial Relationships with Referring Physicians

DOJ Announces $3.8 Million Settlement to Resolve Allegations of False Claims Act and Anti-Kickback Statute Violations

By Nathaniel Arden & Guest Contributor on February 11, 2022

Prime Healthcare, its founder and doctor pay $37.5M to settle whistleblower case alleging kickbacks, Stark violations and fraud

BECKER'S HOSPITAL REVIEW

Tennessee hospital to pay $4.1M to resolve false claims allegations

February 2020

Texas-Based Heart Hospital Agrees To $48 Million Settlement For Alleged Violations Of Anti-Kickback Statutes

by Peter Briccetti — January 7, 2021 in Corporate, False Claims-Qui Tam, News, SEC

Reading Time: 3min read

July 15, 2021

Akron Ohio Health System Agrees to Pay Over $21 Million to Settle False Claims Act Violations for Improper Payments to Referring Physicians (Part IV of V)

Fort Myers clinic to pay $1.6 million to settle kickback allegations

RECENT VIOLATION – PROVIDERS LIABLE TOO

- March 2023 – 3 Michigan hospitals settled for over $69 million
  - Problematic compensation paid between 2006-2016
  - Violations included:
    - Medical director agreements between hospital and individual referring physicians not in compliance with Stark Law exception or AKS safe harbor
    - Physician employment agreement between 2006 and 2009 did not satisfy the Stark Law employment exception
    - Office space rental arrangement included forgiveness of physician's rent payments
    - Physician-owned investment entity that purchased large medical equipment to lease to the Hospital wasn't through non-arm's-length negotiations
  - Hospitals paid $69 million; 2 physicians had to pay $750K

FMV PROVIDER COMPENSATION

- Hospital considerations when determining FMV for provider services:

Specialty/subspecialty

Duties & responsibilities

Community need

(e.g., deficits, wait times, closed specialties, high disease incidence, outmigration, seasonality)

Community benefit

(e.g., new specialty or service)

Time it takes to recruit

Training & experience

Compensation methodology & amount

(including cash and in-kind compensation)

Benchmark comparison

FMV opinions must be documented with the physician's contract, especially if compensation is ≥70th percentile of benchmark and/or compensation to productivity variance is >10%

CASE STUDY: MIDWEST HOSPITAL COMPENSATION ENGAGEMENT

Compensation is the remuneration awarded to an employee in exchange for their services or individual contributions to your business. The contributions can be their time, knowledge, skills, abilities and *commitment* to your company or a project.

ENGAGEMENT BACKGROUND

- Midwest Hospital is a 25-bed CAH in a rural community, with the next PPS hospital over 45 minutes away
- New CEO joined the hospital as a first-time CEO, but with a background as a director of outpatient services
- CEO was concerned about inconsistent pay practices across providers
  - Hospital was losing money and had approved a negative operating budget for the first time
  - No set strategy
  - No transparency for providers on how to earn increases in compensation
  - No fair market valuations in place

There are two buttons I never like to hit: that's panic and snooze.

-Ted Lasso

ENGAGEMENT OVERVIEW

- Midwest Hospital wanted to adopt a new compensation strategy and model that would achieve the following:
  - Aligns with Hospital overarching strategy;
  - Addresses specialty-specific considerations to employ CRNA providers,
  - Competitively and fairly compensates providers for their work while balancing organizational needs;
  - Incorporates productivity incentives that reward high performers;
  - Considers the organization’s total remuneration, including compensation and benefits;
  - Addresses provider expectations and demands;
  - **Aligns with industry best practices and compliance requirements**; and
  - Enhances the consistency and understanding of provider employment contracts.

PROCESS

1. Data Collection
2. Initial Data Review & Analysis
3. Leadership Kickoff (9/14)
4. Provider Compensation Committee developed
5. Provider Compensation Educational Session (10/5)
6. Stakeholder Interviews with Stroudwater
7. Data Review, Analysis, Strategy Concept Outline
8. "Straw Man" Strategy/Model Development
9. Co-Creation of Compensation Strategy
10. Implementation (including Compliance)

PROVIDER INTERVIEWS AND COMP COMMITTEE

Suggestions and Feedback
1. Benefit Package (ie. health insurance, tuition payment) a) "Health insurance is pricier [for the organization] than it should be." b) "We all have terminal degrees." –Tuition payment is not an attractive benefit 2. Competition Compensation Comparison a) "Where is our comp compared to the clinic across the street?" 3. Productivity Incentives a) Concern about validity of data, inconsistent b) Used to seeing this in larger/previous organizations c) Denial/Coding management- "We used to get emails about this but don't anymore, worried we are missing things", "I don't get any feedback on my notes here." d) Prior Authorization management- "I'm concerned we are getting denials [based on this] and are not being made aware of it." e) Ensure the threshold aligns with rural

WHERE DO WE GO FROM HERE?

Specialty	Goals	Current Model	Best Practice
Family Medicine	1. Compliant (FMV) 2. Competitive (recruitment) 3. Growth (diversify services) 4. Financially sustainable 5. Operational Efficiency 6. Community Partners & Care coordination 7. CHNA Integration 8. Loyalty/retention/engagement (good citizenship) 9. Tenure/Education/Years of experience	1. Base salary & benefits 2. No incentives 3. Add-on's (if applicable) • Loan repayment • Medical Directorships • Housing • Sign-on bonus • Retention bonus • Relocation	1. Base Salary & benefits 2. Productivity Incentives 3. Quality Incentives
Behavioral Health			1. Base Salary & benefits 2. Productivity Incentives 3. Quality Incentives
Emergency Medicine			1. Base Salary & benefits 2. Quality Incentives 3. Excess shifts
Hospitalists			
Wound Care			

ENGAGEMENT RESULTS

- Committee determined to set compensation tying to MGMA data
  - Base Salary adjusted by up to 10% for specific criteria important to Midwest Hospital
    - Rural experience
    - Tenure at organization
    - Working in multiple departments
  - Productivity Incentives for clinic based providers
  - Extra compensation for taking extra-shifts
- 1 year guarantee of current compensation before moving over to compensation plan
  - Board approved contingent on undergoing operational improvement initaitives
- Redrafted all contracts and developed compensation plans by specialty
- Met with each provider individually to show side-by-side comparisons with scenario modeling
- Organization has been able to successfully recruit additional providers under new comp plan

Q&A

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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