Physician Compensation Amid Covid-19: A Position Paper

By Pinnacle Healthcare Consulting

Hospitals and physicians have spent years refining and negotiating compensation models that align strategies and compensate fairly for work performed. Then, along comes a pandemic that throws all that hard work into a quagmire within days. This document will attempt to address several concerns that our clients are facing at these uncertain times.

Provider Arrangement Overview

Provider employment and other types of agreements range from straight guarantees to sophisticated documents requiring broad services and allowing for multiple incentives. Covid-19 will likely prevent providers from achieving certain production or quality thresholds, performing certain services, and attaining currently structured incentives.

Pinnacle's Position: From a high-level standpoint, the pandemic has thrown into contrast the standard operations of the healthcare industry to those which occur during unforeseen circumstances. Safeguards and new protocols are being created across all areas of society and the healthcare industry is no exception. In fact, given the medical nature of the Covid-19 emergency, clinical and operational changes are evolving daily. Updates and temporary modifications to current healthcare regulations have been issued and are expected to continue in order to afford patient access to necessary physician services while keeping overarching safeguards in place. Hospitals and health systems should continue to work with their counsel to stay abreast of regulatory updates and to revise their provider arrangements, as appropriate, to provide necessary services in a compliant manner during the changing environment.

Physician Staffing and Scope of Practice

Emergency rooms and intensive care units are being overwhelmed while elective procedures have been cancelled and patients are being told to stay away from hospitals / physician offices for all but life-threatening conditions. This has created a new reality for providers as they work to treat acutely ill patients and contain the spread of the virus.

Healthcare organizations are working quickly to re-deploy resources for maximum impact in serving their communities during the pandemic. Individual providers with excess capacity may be requested to perform services outside of their typical scope of practice including but not limited to managing patients in the ICU / on the inpatient floor or performing telehealth visits. In New York, one example of this has been reported as orthopedic surgeons performing services more aligned with hospitalists, emergency medicine physicians, and Intensivists.

In addition to the operational and logistical challenges created by this scenario, many organizations have identified possible regulatory issues associated with paying providers for services which may or may not be billable and may be different from their usual activities. Regulatory bodies have provided relief for providers in many forms as a response to the current state of emergency and blanket waivers for Stark Law were issued by the Centers for Medicare and Medicaid Services ("CMS") on March 30, 2020; however, payments to providers supporting on Covid-19 should still be reasonable and based on an objective methodology.

Pinnacle's Position: Pinnacle supports an analysis of blending physician specialties to help clients determine FMV payments for providers that support on Covid-19 response initiatives and perform services that may be outside of their typical scope of practice. They are not intended to replace payments under existing contractual arrangements, and clients can either apply the rates in the attachments or defer to existing contractual structures to the extent that those arrangements allow for payments for additional shifts.

Work RVU Production

Governors across the country are restricting elective procedures to free up hospital space to emergent Covid-19 cases and prevent the spread of the virus within waiting rooms. Further, patients are cancelling non-emergent physician visits, such as annual well visits, in an attempt to social distance. Each elective procedure and office visit cancelled results in less work relative value units ("RVUs") performed by the provider and ultimately, less compensation. Arrangements that reconcile value of service to collection will likely require additional analysis to support this transition (emergency medicine, radiology, anesthesia, etc.).

Pinnacle's Position: Medical providers and physicians are on the front lines of the societal level emergency presented by Covid-19. The emergence and proliferation of the virus should not ultimately penalize providers from a compensation standpoint. In the event a material decrease in work RVU production occurs in the aftermath of elective procedures and/or office visit cancellations, a potential approach would be to assess production based on a review of periods prior to the Covid-19 outbreak to support agreement terms. Further, as regulations continue to evolve during the crisis, hospitals will receive additional direction therein and should document information and data accordingly. Developing consistent and operationally explainable models will be critical with this transition period. Additionally, researching forecasts from the financial sector serve as notable sources for referential data to support and document short term adjustments or modifications (i.e. JP Morgan on March 25, 2020 published the following – *"We spoke with a number of non-profit CFOs representing hundreds of hospitals from around the country (both in areas beginning to see material growth of COVID-19 patients and areas that have not), ranging from single hospitals to large systems. We are hearing numbers like this from the trailing 1-2 weeks:* ***total revenues down 40-60%,*** *ER visits down 25-30%, inpatient surgical volumes down 30-50%, outpatient surgical volumes and procedures down 50%+, ASC procedures down 70%+."* *(source – https://markets.jpmorgan.com/research/email/-2kpqn02/pQkXdmsMoWg6SlyWWueoWA/GPS-3313255-0)*

Thresholds

When providers are paid a guaranteed level of compensation per year, employment agreements generally include some level of productivity that is expected (e.g., $200,000 guaranteed compensation and 4,000 work RVUs expected). As noted above, the number of work RVUs achieved by providers will be lower as a result of Covid-19.

Pinnacle's Position: Guaranteed compensation is established for the purpose of providing a provider with a certain level of security. Thresholds are developed to prevent a provider from earning compensation without providing commensurate services. If a provider is unable to achieve the thresholds as a result of cancelled or restricted appointments, then the guarantee would still remain consistent with fair market value, especially if the guarantees were based on historical levels of productivity or market data for entry level positions. Physician work and contribution may need to be documented in other areas such as worked shifts, telemedicine visits and/or availability, leadership/coordination activities, etc.

Addressing Staffing and Operational Challenges Though Telemedicine

As physician groups and hospitals are being forced to close their office-based practices for non-essential/emergent clinical services, the government has implemented new rules intended to break down many of the barriers to increase access and allow patients to receive necessary, but non-emergent services. On March 6, 2020, Congress submitted a house bill to remove the Rural and site limitations related to reimbursement for telehealth coverage. Telehealth services can now be provided regardless of where the enrollee is located geographically and type of site, which allows the home to be an eligible originating site. Furthermore, The Office of the Inspector General (OIG), waived the cost sharing requirements (coinsurance and deductibles). Private insurance companies have also waived these requirements.

Additionally, as of March 30, 2020, sweeping changes were made since mid-March to continue to allow providers in delivering care to patients. In summary, some of the substantial changes include:

- Waivers to state credentialing and licensing (allowing physicians to provide telehealth services across state lines;
- Expanded eligible providers to include FQHCs/RHCs (during the emergency period only);
- Added Medicare coverage of, and payment for, telephone evaluation and management (E/M) services (CPT 99441-99443). These services may be provided to new or established patients. With discretion provided to the physicians to select the level of office/outpatient E/M furnished via Medicare telehealth based on medical decision making (MDM) or time;
- Expands the list of services that can be provided via telehealth;
- Complete reimbursement parity for Medicare services (i.e., reimbursed at the same rate as in person visit (billing requirements for POS and -95 modifier required);

- Services via telehealth and remote patient monitoring and virtual check-in can be provided to new and established patients;
- CMS exercising enforcement discretion or waiving requirements for face-to-face / hands-on requirements for ESRD, dialysis, nursing home, and hospice patients;
- Frequency limitations on subsequent in-patient visit (once every three days), subsequent SNF visit (once every 30 days), and critical care consult (once a day) were removed;
- Exceptions during this period to Ryan Haight Act for telehealth that allows DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation; and,
- Broad Stark Law waivers hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians; health care providers can support each other financially to ensure continuity of health care operations; and others.

Pinnacle's Position: Clearly, the government is implementing sweeping changes to allow physicians and health care organizations flexibility in providing access and delivering care through different modalities. Some of these changes are directly related to the treatment of patients suffering with Covid-19, but others are directed at proving support to community physicians to maintain their general practice and treat patients. Organizations or groups that have already been utilizing telemedicine will have an advantage, but the groups that can mobilize and implement telemedicine into their practice will have the most success.

While these changes have been caveated to be limited to the "emergency period", it is unknown how long a state of emergency will be in place. Pinnacle would recommend that organizations and practices work to take advantage of these opportunities to implement telehealth into their practice given this uncertainly. Additionally, many in the industry believe these changes may remain after the state of emergency (e.g., reimbursement and maybe geographic and place of service requirements), which would finally allow for the broader advancement and utilization of telemedicine. This would be consistent with the slow, but progressing trend observed over the past five years. Obviously, many of these changes will be scaled back and revisited (e.g., State waivers on licensure and credentialing, broad Stark Waivers) so Pinnacle would advise clients to be proactive and thoughtful on how they are developing these initiatives – even if it is after emergent implementation.

Quality and Efficiency Bonuses

Covid-19 threatens to overwhelm the US healthcare system and leave providers without adequate manpower, hospital beds, medical supplies and other resources needed to address the number of severe cases anticipated. Providers under value-based reimbursement models face additional risk as resources spent treating patients and minimizing the spread of the virus throughout their communities may not be recouped through payment models in place. A number of these quality programs are based on metrics

that include readmissions of patients with comorbidities, wellness visits as a percent of assigned patients, and other metrics that will not be achieved as a result of Covid-19.

CMS addressed this issue on Sunday March 22nd by announcing relief for providers participating in Medicare Quality reporting programs. Provider programs including the Merit-Based Incentive Payment System ("MIPS") and Medicare Shared Savings Program Accountable Care Organizations ("ACOs") will see the reporting deadline extended one month from March 31, 2020 to April 30, 2020. Further, clinicians unable to submit MIPS data by April 30 will qualify for an exemption and receive a neutral payment adjustment for the 2021 payment year. Hospital programs such as the Ambulatory Surgical Center ("ASC") Quality Reporting Program, End-Stage Renal Disease ("ESRD") Quality Incentive Program, Hospital Inpatient / Outpatient Quality Reporting Programs and Hospital Value-Based Purchasing Program among others will also see relief. Submission of performance data for October 1, 2019 – December 31, 2019 is optional for participating organizations and will be excluded from performance calculations if not submitted.

Pinnacle's Position: This global pandemic threatens to wipe out any progress that the US healthcare system has made in the transition away from fee-for-service toward value-based purchasing if action is not taken. Quality metrics determined prior to the outbreak are no longer meaningful and targets must be re-assessed in the context of the events that have occurred in the past three months.

Pinnacle notes that CMS is currently taking a position to ease the burden on providers for reporting under quality-based programs. Pinnacle believes that CMS is providing a roadmap that should be followed by our clients. Providers can follow CMS' lead by delaying or eliminating the administrative burden on providers associated with quality measurement until the virus is contained. For providers with quality incentives included in their individual compensation arrangements, neutral scores should be assigned to ensure that individuals are not penalized for circumstances outside of their control. Alternatively, quality could be measured using citizenship as a scoring mechanism to reward providers that go above and beyond the call of duty during this crisis.

Administrative Compensation

Medical directors and other providers performing administrative services may find that significant additional hours are necessary to meet the planning demands for the pandemic. These duties may or may not be included in an administrative services agreement and might include:

- Working with supply chain to coordinate acquisition of PPE;
- Work with senior management to facilitate patient quarantine areas and navigate facility plan to manage case volume (both Covid-19 and other surgical and medical cases);
- Managing providers and other staff to accommodate patient demands and management of case flow, particularly for emergent services;

- Training and education for providers and other staff regarding operational and/or clinical protocol changes as a result of the pandemic;
- Further community outreach to facilitate education and/or safety protocols within their service area and market; and,
- Work with providers at other facilities to ensure safety measures are appropriately communicated/coordinated.

Pinnacle's Position: These arrangements commonly have hour restrictions which limit the amount of time a provider can spend on these services and earn compensation. However, fair market value rates for administrative services are often determined and set as an hourly rate for compensation (and/or an effective hourly rate can be easily cross walked based on required annual hour and annual compensation for administrative services). Should facilities have a defined and specific need for additional administrative time from their medical directors and/or physician executives, facilities should work with their counsel to determine if an agreement addendum and/or isolated transaction is appropriate. This includes the release or new determination of monthly caps on paid hours and/or discussion of stipend arrangements if appropriate.

Physician Call Coverage

Employed and independent providers are occasionally paid a per diem rate to provide coverage at hospital emergency rooms. For employed providers, both a compensation per work RVU and a per diem are analyzed cohesively to verify that when a procedure is done as part of an emergency room call the aggregate compensation (i.e., per diem plus compensation per work RVU) does not exceed fair market value. (OIG Advisory Opinion 12-15)

The burden on providers has exploded as patient demand needs have changed in the face of Covid-19. The burden for call coverage has long been based on the factors including:

- The number of physicians in the coverage rotation;
- The number of calls received by the on-call physician;
- The number of calls requiring a physician to spend significant time on the phone or present in person at the hospital;
- The severity of the cases resulting from a call / time spent in the hospital; and,
- The likelihood that the physician will receive remuneration from a patient / insurance company.

In addition to these factors, external factors resulting from Covid-19 are also occurring. These external dynamics include altered patient flow (i.e., less elective cases, increased operational requirements) and changes in physician supply (i.e., some locum tenens companies have pulled their providers from the field or changed their staffing plans).

Pinnacle's Position: The increase in the number of shifts and the number of procedures performed per shift will increase the burden on the physicians, which will ultimately increase the fair market value of the services provided. If the per diem and compensation per work RVU are set based on historical levels, the aggregate compensation based on a significant increase in procedure volume could result in aggregate compensation per work RVU above previously established guardrails. A review of this compensation based on a pro forma model of expected outcomes is advisable.

Key Takeaways

Given the nature of the Covid-19 issue, circumstances are evolving daily. This continuous change has resulted in regulatory changes even since the inception of this position paper, including Stark waivers associated with the pandemic (1135 waivers). Despite these challenges, numerous types of physician arrangements - such as those discussed herein - are manageable, particularly with thorough documentation. We encourage data and information tracking such that robust documentation can occur with regard to unique circumstances affecting provider arrangements. In these unprecedented times, maintenance of oversight and review measures which document the key facts associated with physician arrangements will be more critical than ever. Arrangements can certainly continue to reflect fair market value; however, as facts change, continuous review and documentation should also commensurately occur. These efforts will also assist in the transition back to a new go-forward environment once we get through this crisis. Be safe and please let us know if we can be of assistance.