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A Perfect Storm

Navigating Physician Compliance and FMV in the wake of 2020-2021

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Disclosure Slide

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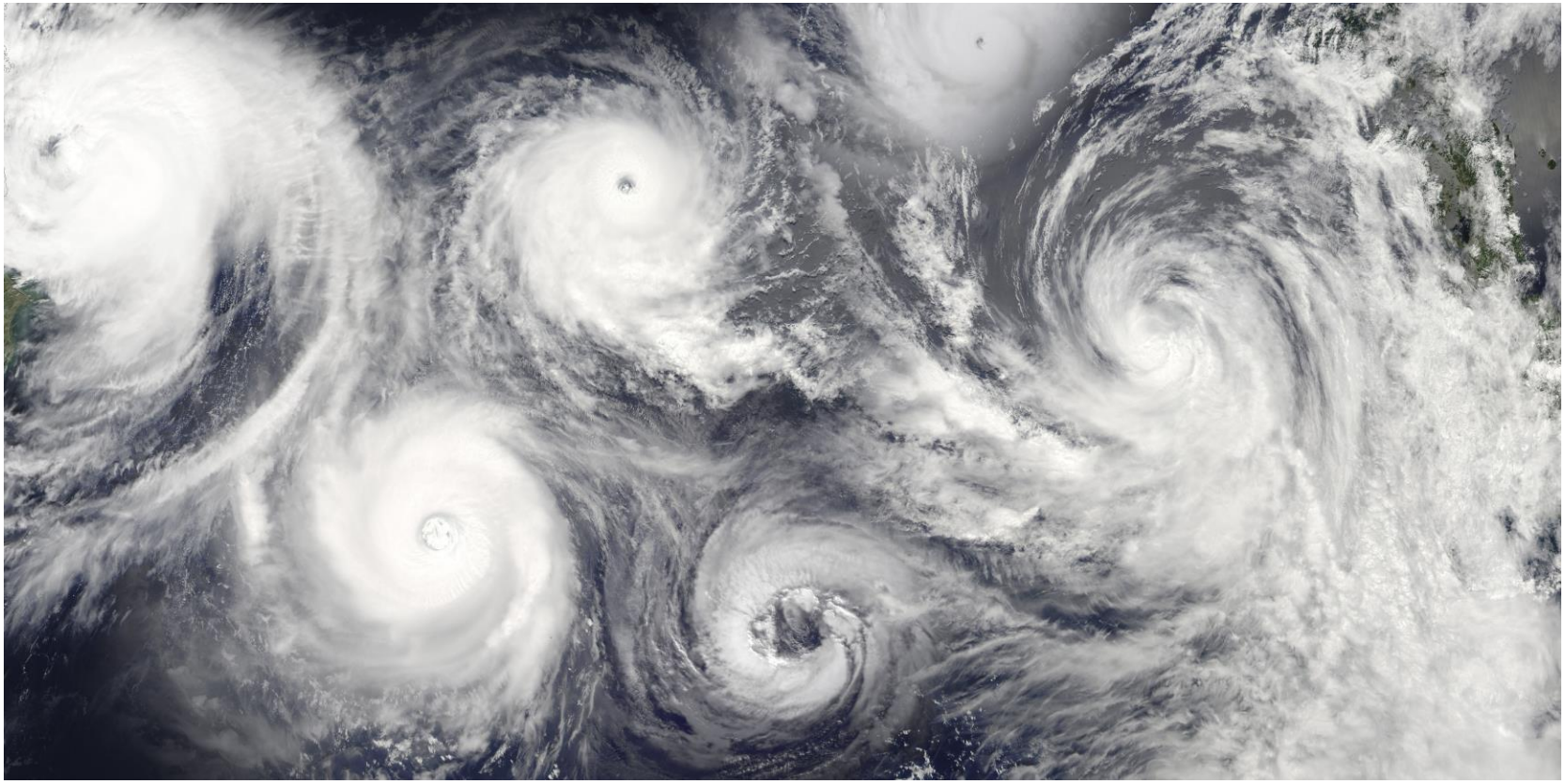
As a healthcare valuation expert with over 20 years of professional experience, he is frequently called upon as a trusted advisor to health system executives, physicians, health lawyers, compliance officers and investors.

PRESENTATION OVERVIEW

- Forces that Created a Perfect Storm:
  - COVID-19
  - Stark and AKS updates
  - 2021 Medicare Physician Fee Schedule
- Navigating Compliance – the Health System Perspective
- Navigating Compliance – the Valuator Perspective
- Hypothetical Scenarios
- Q&A

A Perfect Storm



Forces that Created a Perfect Storm

The Healthcare sector is subject to constant (and often material) changes stemming from legislation, health policy, innovation, demographic shifts, disease prevalence and other factors.

During 2020 and 2021 three major forces came to bear on the healthcare industry simultaneously:

- The COVID-19 Pandemic
- The 2021 Stark and AKS Final Rules
- The 2021 Medicare Physician Fee Schedule

COVID - 19

The COVID-19 Pandemic disrupted life and business as we know it. The impacts were pervasive and significant.

- Nearly 1 million deaths in US
- Impacts to economy, business and recreation
- Quarantines and masking
- Politicization of vaccination / treatment regimens
- Vax mandates and workforce expulsion
- PPE and Staff shortages
- Provider Burnout
- Shut down of elective surgery
- Patient fear and deferral of care
- Accelerated shift to Telemedicine

STARK AND AKS MODERNIZATION

- Updated definitions of FMV and CR
- Separation of V/V Standard – new objective test
- New Value-based Exceptions
- CMS Commentary

Stark Law - New Definitions

Fair Market Value means**:**

1) **General**: The value in an arm's length transaction, consistent with the *general market value* of the subject transaction.

2) **Rental of equipment**: The value in an arms length transaction of rental property for general commercial purposes (not taking into account its intended use), consistent with the *general market value* of the subject transaction.

3) **Rental of office space**: The value in an arms length transaction of rental property for general commercial purposes (not taking into account its intended use), without adjustment to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lesser where the lessor is a potential source of referrals to the lessee, and consistent with the *general market value* of the subject transaction.

Stark Law - New Definitions

General Market Value means:

1) **Assets**. The price that an asset would bring on the date of acquisition of the asset as a result of bona fide bargaining between a well-informed buyer and seller that are not otherwise in a position to generate business for each other.

2) **Compensation**. The compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well informed parties that are not otherwise in a position to generate business for each other.

3) **Rental of equipment or office space.** The price that rental property would bring at the time the parties enter into the rental arrangement as the result of bona fide bargaining between a well-informed lessor and lessee that are not otherwise in a position to generate business for each other.

Stark Law - Commercially Reasonable

- CMS defined "commercially reasonable" as "that the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty."
  - CMS codified a favorable response to recent court decisions that a "commercially reasonable" arrangement does not need to be profitable.
  - Examples: Certain hospital call coverages are necessary to keep the hospital open but payment for coverage may exceed the patient fees generated; behavioral health may not generate enough revenue to cover expenses but is a valued service to community

"Volume or Value of Referrals" and "Other Business Generated" Standards

- Many exceptions to the Stark Law require that compensation not take into account the volume or value of referrals (V/V) or other business generated (OBG) between the parties.
- **New "Objective Test":** Compensation from an entity furnishing DHS to a physician takes into account the V/V or OBG by the physician only if:
  - the formula used to calculate the compensation includes the physician's referrals to the entity or OBG as a variable; and
  - resulted in an *increase or decrease* in the compensation that positively correlates with the number or value of the physician's referrals to, or the OBG for the entity.

Stark Law – New Value-Based Exceptions

- The 3 new exceptions for value-based arrangements do not include typical Stark Law requirements that compensation be:
  - Fair market value.
  - Not based on the volume or value of referrals or other business generated.
  - Commercially reasonable (however the "no risk" value-based exception requires the arrangement to be commercially reasonable)
- If a value-based exception is satisfied and an employed physician takes on meaningful downside risk, the physician's compensation may no longer be subject to FMV.

2021 Medicare Physician Fee Schedule

- The 2021 MPFS final rule updates policies affecting the calculation of payment rates and includes misvalued codes.
  - Revisions to calculation of RVUs and changes to conversion factor
- Adds services to the telehealth list including a third temporary category for services added under the declared Public Health Emergency, as well as certain other revisions to telehealth services.
- Addresses direct supervision as it relates to interactive technology, payment for teaching physicians, and provides clarification on medical record documentation.
- Additionally, the final rule includes several regulatory actions regarding professional scope of practice for certain non-physician practitioners.
- E/M wRVU changes part of an overall objective to shift value to Primary Care.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

2020 vs. 2021 E&M wRVU Comparison

CPT	2020	2021	Change	% Change
99201	0.48	Eliminated	N/A	N/A
99202	0.93	0.93	-	0.0%
99203	1.42	1.6	0.18	12.7%
99204	2.43	2.6	0.17	7.0%
99205	3.17	3.5	0.33	10.4%
99211	0.18	0.18	-	0.0%
99212	0.48	0.7	0.22	45.8%
99213	0.97	1.3	0.33	34.0%
99214	1.5	1.92	0.42	28.0%
99215	2.11	2.8	0.69	32.7%

Physician Fee Schedule Conversion Factor Comparison

				% Change over PY Final	
CF	2020	2021	2022	'20 to '21	'21 to '22
Initial/proposed		$32.41	$33.60	-10.2%	-3.7%
Final	$36.09	$34.89	$34.61	-3.3%	-0.8%
% Inc. over Initial		7.7%	3.0%		

Overview of Impact by Specialty

		Work RVU Adjustment	Collections/Compensation Adjustment				
Self Identified Primary Specialty (NPI)	Sample Size	Mean wRVU Change 2020-2021	Mean Total RVU Change 2019-2021	2020 CF	2022 CF	Mean CF Change 2019-2022	100% Estimated Collections Impact
Radiology - Diagnostic Radiology	25,128	-0.70%	-0.50%	$36.09	$34.89	-3.32%	-3.80%
Hospitalist	10,188	0.70%	1.30%	$36.09	$34.89	-3.32%	-2.06%
Ophthalmology	15,001	3.70%	0.80%	$36.09	$34.89	-3.32%	-2.54%
Internal Medicine - Gastroenterology	12,297	6.80%	6.60%	$36.09	$34.89	-3.32%	3.07%
Surgery	14,699	7.80%	7.50%	$36.09	$34.89	-3.32%	3.94%
Internal Medicine - Cardiovascular Disease	16,126	9.70%	8.50%	$36.09	$34.89	-3.32%	4.90%
Internal Medicine	68,003	15.70%	13.20%	$36.09	$34.89	-3.32%	9.45%
Urology	7,936	15.80%	16.60%	$36.09	$34.89	-3.32%	12.73%
Obstetrics & Gynecology - Gynecologic Oncology	971	18.40%	17.40%	$36.09	$34.89	-3.32%	13.51%
Family Medicine	72,028	22.60%	18.30%	$36.09	$34.89	-3.32%	14.38%

A Health System Perspective

Uncertainty Among Health Systems and Providers

- Health care systems are grappling with all of the following factors, and all of the combined changes are causing confusion and uncertainty amongst providers:
  - Impact of Stark Law COVID Blanket Waivers
  - Impact of MPFS changes
  - Impact of new FMV and CR definitions
  - Staffing shortages/redeployment/locums
  - Rumors of compensation rates changing rapidly
  - Survey uncertainty for 2022 and 2023
  - Understanding and implementing value based exceptions/safe harbors

IMPACT OF COVID BLANKET WAIVERS

- Stark Law COVID Blanket Waivers exempting several types of remuneration and referrals
- Counseling clients that these can only be used for "COVID-19 Purposes"
- Other Stark exceptions should still be relied upon first when possible
- Ensuring these temporary arrangements end when federal PHE ends
- Potential impact to benchmark data

Impact of MPFS Changes

- Significant financial and administrative challenges for hospitals/health systems that employ physicians
- Confusion among providers about what changes mean for their own compensation
- Potential significant loss to hospitals, especially if physicians are paid mainly on productivity basis
- Impact of changes to fair market value and commercial reasonableness of physician compensation

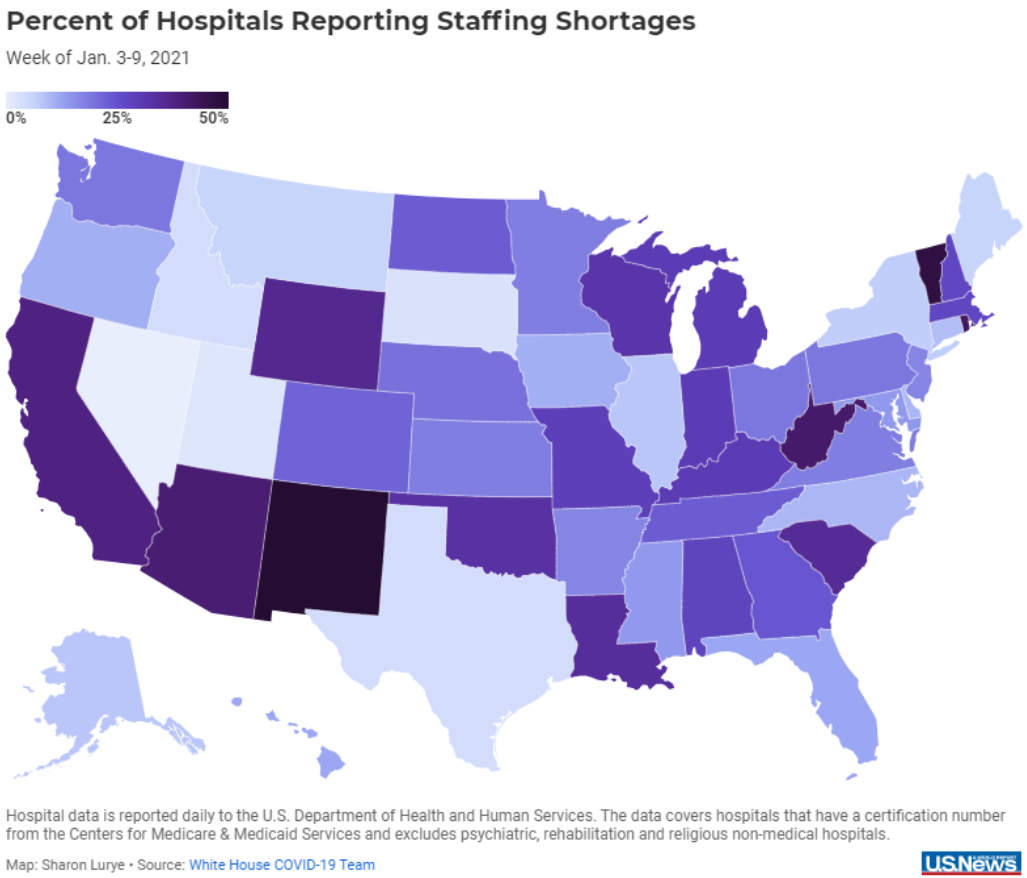
IMPACT OF FMV/CR DEFINITIONS

- Clarified the definition of general market value for "compensation" specifically
- Guidance on compensation formulas that take into account V/V
- CMS: "the determination of commercial reasonableness is not one of valuation"
  - Fair market value ≠ commercially reasonable
- Reassurance in the fact that an arrangement can operate at a financial loss and still be commercially reasonable.
  - CMS' examples: "community need, timely access to healthcare services, fulfillment of licensure or regulatory obligations ... provision of charity care, and the improvement of quality and health outcomes"
  - Need for documentation that a losing arrangement meets one of these factors

Staffing Shortages, Redeployment, Use of Locums

Healthcare systems grappling with:

- How to pay redeployed providers throughout system
- Incentivizing providers to pick up unfilled shifts
- Pay for locums as last resort



Rumors of Chaning Compensation Rates

- Physicians hearing from their colleagues in other health systems
- Recruits that have declined for higher-paying offers nearby
- Unreliable benchmark data to back this up

Survey Uncertainty

- Healthcare systems should not be relying on survey data alone; need to look at additional factors
- Providers and healthcare executives wanting to use 2020/2021 benchmark data for upcoming years, but may be unreliable due to all the factors we've discussed:
  - COVID
  - Stark waivers
  - MPFS changes
  - Etc

IMPLEMENTING VALUE BASED EXCEPTIONS

- Attractive to healthcare systems and physicians due to:
  - Push to value based care; move away from volume
  - Higher quality of care
  - Sharing of cost savings
  - Removal of fair market value standard
  - Move away from productivity based model in light of wRVU/benchmark uncertainty
- Many steps to implementation:
  - Establish a VBE with an overseeing accountable body/person
  - Identify target patient population and identify value-based purpose for that population
  - Physician contracting, compliance policies
  - Alignment of patient/providers/system goals

A Valuator's Perspective

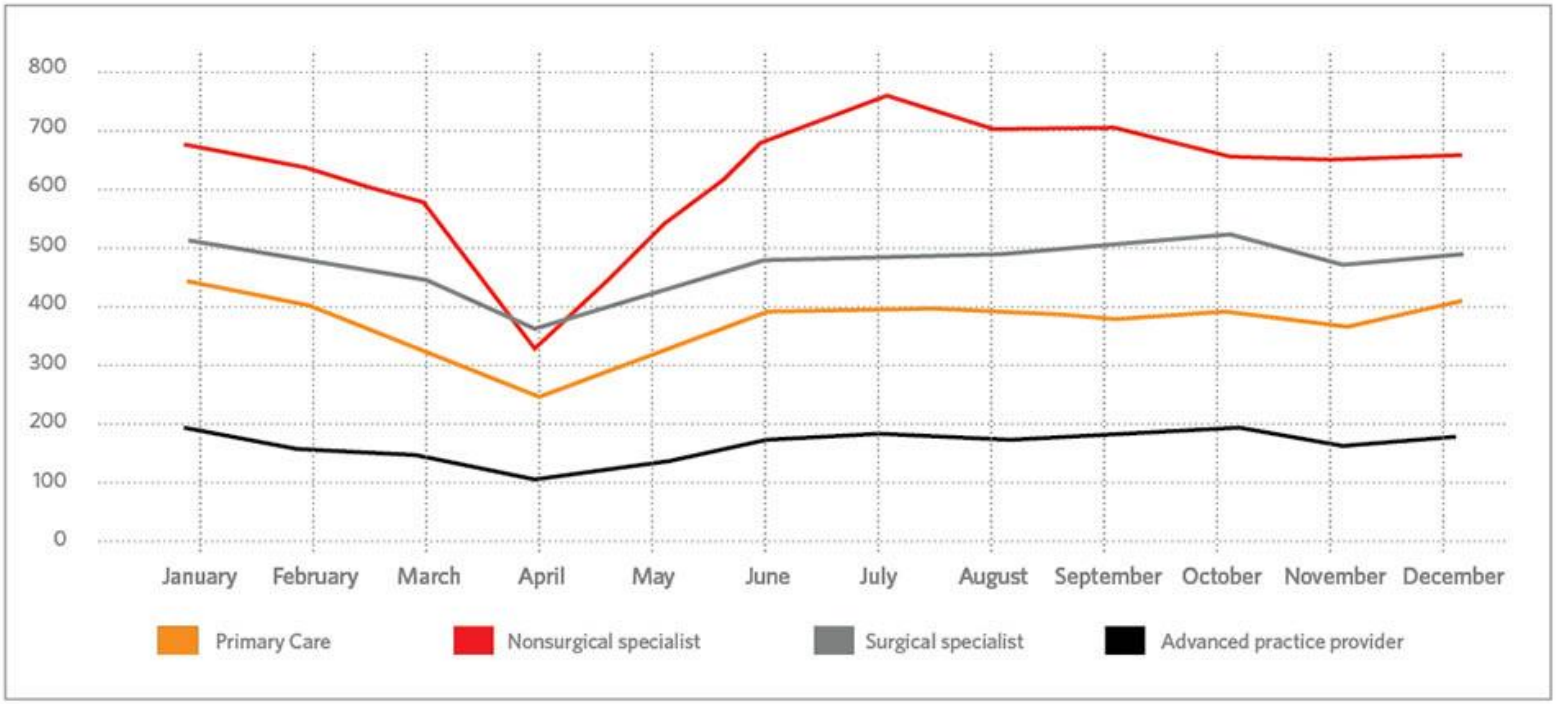
How will the Determination of FMV be impacted?

From a valuator perspective, this perfect storm has created a number of challenges in the determination of FMV, including, but not limited to:

- Disruptions to historical productivity and collection patterns
- Population shifts
- Adjusting for the impact of MPFS changes
- Use of Survey data for 2022 and 2023
- Impact of new FMV definitions
- Impact of new CR definition
- Impact of CMS commentary

DISRUPTIONS TO PRODUCTIVITY

FIGURE 1. 2020 MONTHLY WORK RVUs, FULL-TIME, ACTIVELY EMPLOYED



Source: *Quantifying COVID-19: Measuring the Pandemic's Impact on Medical Practices*

- As portrayed in the graph above, in April 2020, there was a significant drop in wRVUs in April 2020 (MGMA)

Disruptions to Productivity

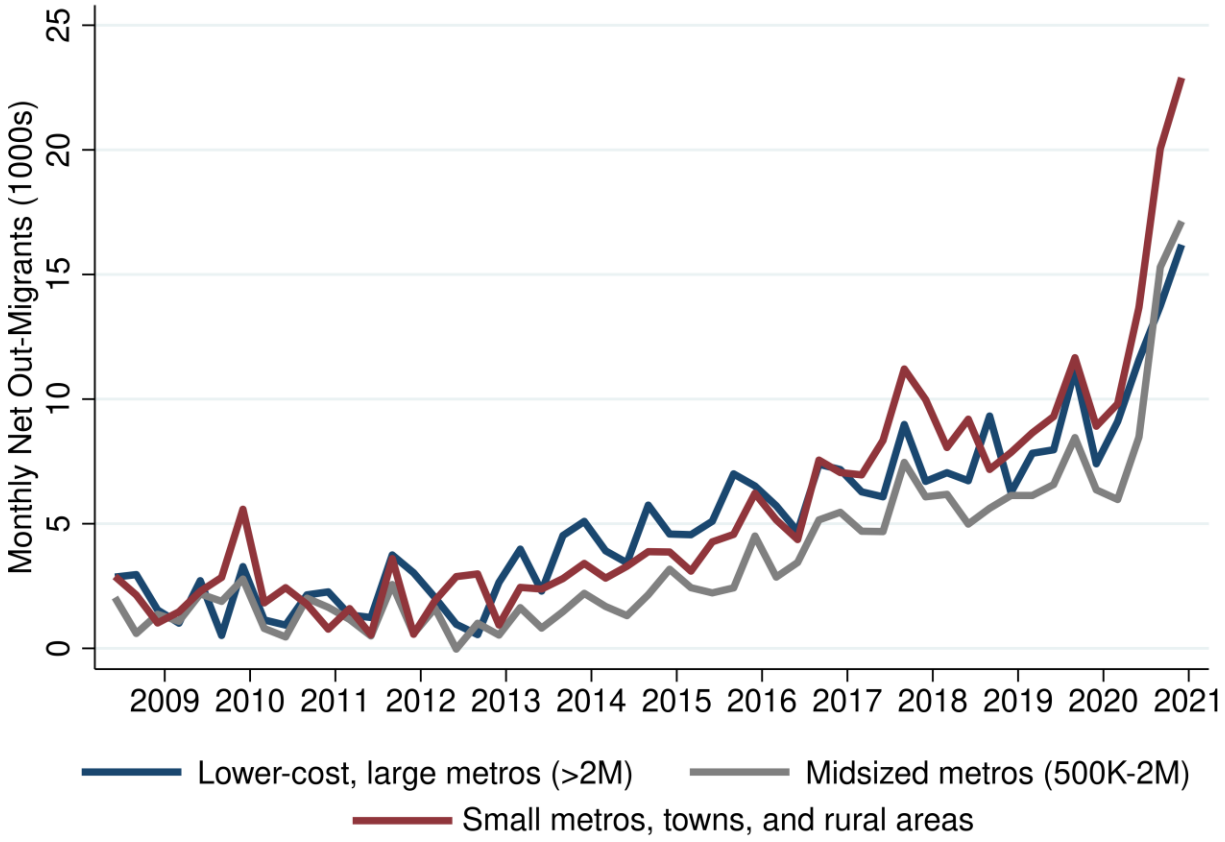
- Physician burnout, shortage of staff, reduced elective surgeries and reduced patient turnout (MGMA)
- wRVUs per 1.00 FTE decreased by 8.4% from 2019 to 2020 (FierceHealthcare)

Impact on Collections

In addition to the FFS collections disruptions caused by productivity, there were also several other factors that impacted revenue:

- Shift to telemedicine and (temporary) rate parity
- Non-recurring stimulus money / CARES Act
  - PPP (forgivable loan)
  - HHS Stimulus (grants)
  - Medicare Advance Payments (loan)
  - EIDL loans
  - Employer tax credits and deferrals
- Sicker patients – those that waited to be seen during height of pandemic are now coming to hospitals with higher acuity, longer stays
- Higher expenses – staff, pharmaceuticals, PPE, etc. all increasingly more expensive

Population Shifts: Domestic Migration



Population Shifts: Healthcare

- Estimated physician shortage of between 54,100 and 139,000 physicians by 2033
- Demand for APRNs and PAs and is projected to double in the next 15 years
- Key driver for APRNs and PAs is the population aged 65 and over which is expected to grow up to 45.1% by 2033
- With shift in population, urban rural provider imbalances may be exacerbated

IMPACT OF 2021 MPFS

- Calculation of wRVUs for 2021 forward are no longer comparable with prior periods
- The conversion factor changes make benchmarking collections to prior periods difficult
- On a combined basis, these forces make comparative analytics on a $/wRVU basis difficult if not impossible
- Compensation models structured on a wRVU basis MUST be adjusted to account for these changes.
- The impact to each medical specialty varies, with the highest benefit accruing to E&M focused specialties, and the largest detriment to non-E&M focused specialties

COMP SURVEYS USING 2020 DATA: MGMA

- The drivers for compensation change were physicians taking voluntary reductions, bonuses being cut, and reductions in funding for continuing medical education (MGMA)

USE OF SURVEY DATA FOR 2022 AND 2023

- Survey data gathered from 2020 and 2021 tainted
- Impact of COVID pandemic
  - varied by specialty, inpatient vs. outpatient, elective vs. non-elective, availability of PPE and staff, etc.
- Impact changes in MPFS
  - Expected overall increase in wRVUs varies by specialty
  - Conversion factor decline depends on payor mix and how commercial payors respond
- General Expectations
  - Compensation remains fairly steady as many employed physician organizations attempted to mitigate downside funding internally and/or through PPA/SBA Loans
  - Total wRVUs decline in 2020 for majority

Be especially cautious when relying on compensation per wRVU benchmarks during this period

Impact of New FMV Definitions

- FMV is to be "consistent with the general market value *of the subject transaction*"
- "General market value" redefined with separate succinct definitions for Assets, Compensation, and Leases
- Separation of the Volume or Value Standard from the FMV Definition
  - Brightline test for V/V standard
- CMS declined to provide rebuttable presumptions or safe harbors for compensation that would be considered FMV (e.g., 75th Percentile)

CMS Commentary on Establishing FMV

Reliance on Survey Data:

- "We continue to believe that the general market value of a transaction is based solely on consideration of the economics of the subject transaction"
- "We continue to believe that the fair market value of a transaction—and particularly, compensation for physician services—may not always align with published valuation data compilations, such as salary surveys"

No Brightline Test for percentile compensation:

- Assumption compensation below 75th percentile is FMV
- compensation exceeding the 90th percentile may be appropriate
- compensation at the 50th percentile may not be appropriate

Impact of CMS Commentary

- Clear guidance that compensation survey data is not the only data that should be considered in setting FMV
  - This is helpful given that for the next few years the compensation data is going to have anomalies that may render their data problematic
  - Reiterates the importance of considering the qualitative elements of the arrangement

Impact of New CR Definition

- "the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty."
  - **Impact** – Provides clarification that CR is separate and distinct from FMV, and that it should consider a multitude of factors *specific* to the parties.

- "[a]n arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties."
  - **Impact** – Provides flexibility to healthcare organizations to invest in services such as behavioral health that are important for the community and health system as a whole, but that may not generate profit.

Hypothetical Scenarios

HYPOTHETICAL #1: EMPLOYED PHYSICIANS

Employed Physician Networks faced with dilemma on how to adjust for 2021 MPFS overhaul

- Especially for outpatient Primary Care and Specialty providers on production-based models

Key Issues

- Physician understanding and contracting
  - Primary Care expecting big comp bumps
  - Specialty physicians (especially those whose services are bundled) don't want to see a drop in comp
- Difficulty projecting (i.e. not as simple as just converting prior production to new wRVU values
  - CPT 99201 eliminated
  - 2020 coding guidelines changes
  - 2020 production disruptions due to Covid
- External Pressures
  - Physician demand high, risk losing to other employment opportunities
- Internal Pressures
  - Financial – (i.e. bottom line)
  - Regulatory/Compliance

HYPOTHETICAL #1: EMPLOYED PHYSICIANS

Key Considerations

1. Physician acceptance/buy-in, retention, and recruitment
2. Financial forecasting and feasibility
3. Payor mix / commercial payors actions
4. Winners and Losers
   - Shifting value to Primary Care
   - Balancing cuts to specialties
5. FMV and Commercial Reasonableness

Discussion Note:

While declining MPFS conversion factors will impact nearly all physicians, hospital-based and surgical specialties w/ E&Ms bundled into surgical codes are largely insulated from the change in wRVUs. As such, the following discussion and examples primarily relate to E&M heavy primary care and specialty-based providers.

HYPOTHETICAL #1: EMPLOYED PHYSICIANS

Potential Options

1. Do nothing (i.e. keep using 2020 wRVU Values and comp rates)
2. Convert to nonproduction-based comp models
3. Keep using 2020 wRVUs, but modify comp rates
4. Move to 2021 wRVU values, but keep conversion factors
5. Move to 2021 wRVU values and adjust conversion factors

HYPOTHETICAL #1: EMPLOYED PHYSICIANS

Option #2 – Convert everyone to non-production-based comp models

Short-term:

- Eliminates the 2021 MPFS wRVU problem
- Eliminates uncertainty regarding physician's comp
- Impossible to model impact of production incentives
- Opportunity to create/implement more robust quality-based compensation models
- Huge undertaking to change all providers' comp model

Long-term:

- Not currently feasible or advisable
- FMV/CR compliance

HYPOTHETICAL #1: EMPLOYED PHYSICIANS

Option #3 or #4 – Modify either wRVUs or Conversion Factor

3. Keep using 2020 wRVU Values and Conversion Factors
   Short-term:
   - Reduces uncertainty
   - Easy to comprehend
   - Less paper work
   - Allows time to develop and implement long-term solution

   Long-term:
   - Will not reflect market conditions
   - Potential physician retention issues

4. Move to 2021 wRVU values, but keep conversion factors
   Short-term:
   - Most physicians will see a big bump in comp
   - Potential financial losses for health system overall

   Long-term:
   - Not feasible, will lead to financial losses and FMV/CR issues

Hypothetical #1: Employed Physicians

Option #5 – Move to 2021 wRVU values and adjust conversion factors

Short-term:

- Hardest to implement
- Requires much more modeling
- Uncertainty around setting FMV/CR rates
- Difficulty getting physician buy in/acceptance

Long-term:

- Recognizes CMS goal of shifting value to primary care
- Still some uncertainty around FMV/CR, but should become more in line with market in future

Hypothetical #2: Inpatient Psychiatry

- COVID-19 has exacerbated mental health deficiencies in our healthcare system and the burden of mental health providers.
- A hospital needs to maintain psychiatric coverage for its inpatient psych unit and its existing provider is 70 and wants to retire.
- Locums coverage is very limited, will impact continuity of service and is very expensive.
- Survey data lags current market realities, with 90th percentile psychiatrist comp noted as approximately $425,000, NP/PA at $160,000.
- Only available provider is asking for compensation amount well in excess of 90th
- How do you analyze FMV and CR for the transaction?

Questions?