NATIONAL RURAL HEALTH RESOURCE CENTER

Delta Region Community Health Systems Development Hospital and Clinic Webinar Series - COVID Financial Recovery Part V: Physicians – Strategic Planning

Speakers:

- Randy Biernat, Partner, BKD
- Mark Blessing, Managing Director, BKD

This webinar does qualify for ACHE credits, if you are a member of the American College of Healthcare Executives and would like to receive the 1 hour of credit, please reach out to Program Coordinator, Synneva Hackman.

Randy Biernat

Mark Blessing

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $8,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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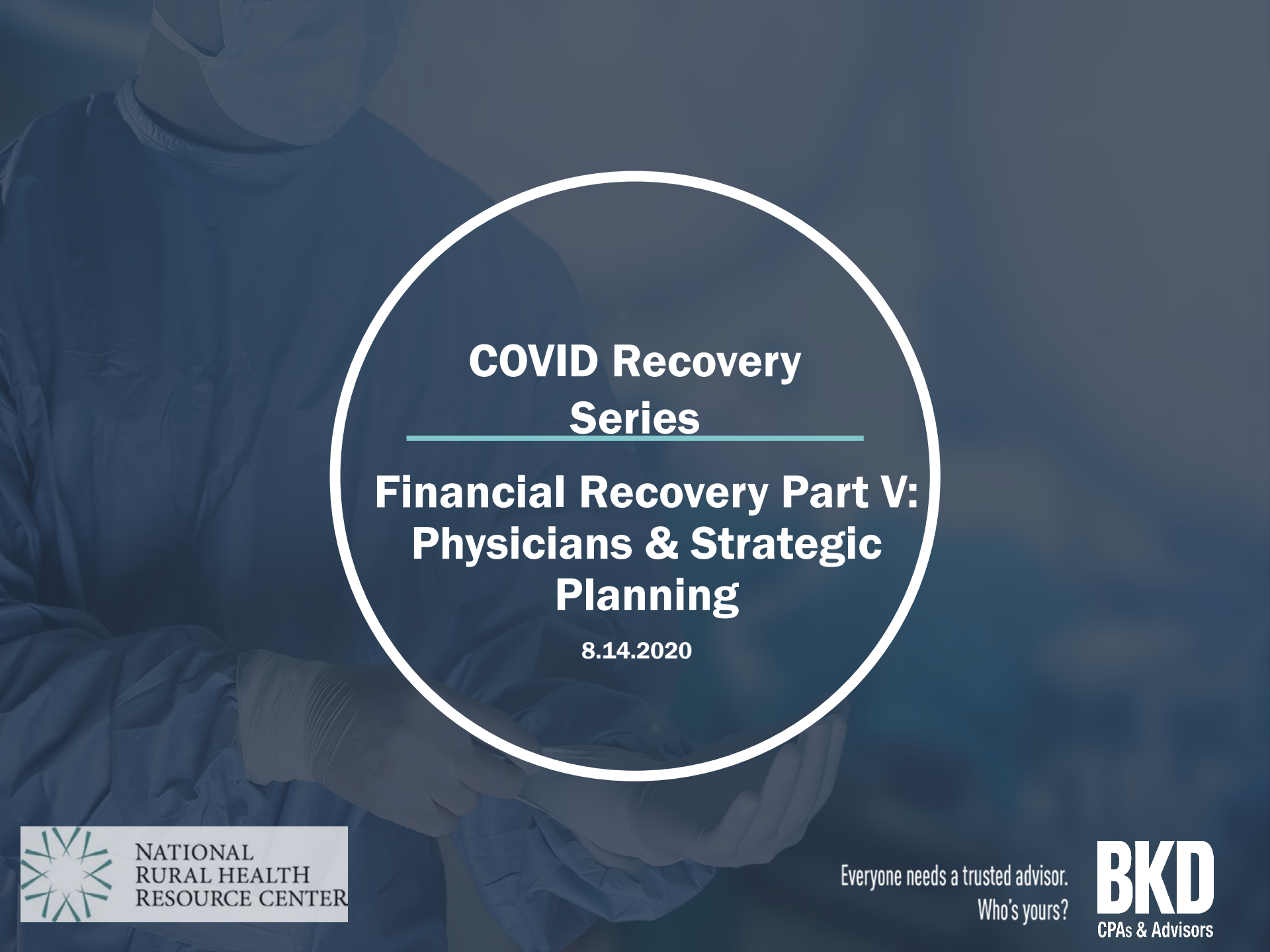

COVID Recovery Series

Financial Recovery Part V: Physicians & Strategic Planning

8.14.2020

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Agenda

1. Provider Compensation & COVID-19: Past, Present and Future
2. 2020 Outlook: Reimbursement, Regulatory and More

Speakers

1. Mark Blessing
2. Randy Biernat

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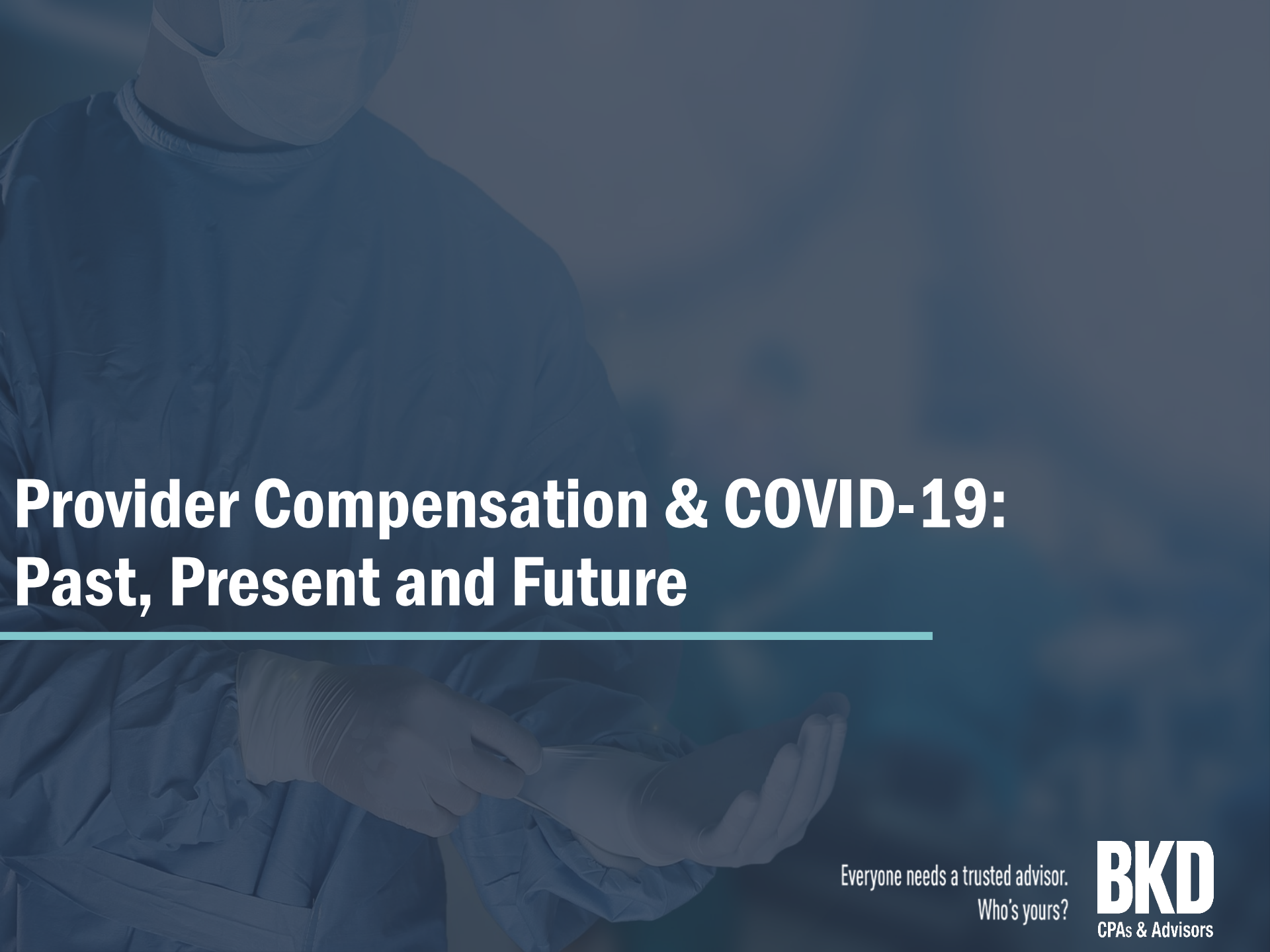

Provider Compensation & COVID-19: Past, Present and Future

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Provider Compensation in Rural Setting: Past

- Compensation levels required to recruit may not align with productivity possible in market
- Specialty care difficult to deliver efficiently in many rural markets given costs of specialist providers and technical operations needs versus possible market activity
- General trend in employment of providers versus independent practices has increased costs of rural hospitals
- Designations such as Provider-Based Program, Rural Health Clinic or Critical Access Hospital can provide significant reimbursement benefits for rural providers
  - Consideration of 340B Program benefits for Provider-Based designations

Provider Compensation in Rural Setting: Present

- COVID-19 effects
  - Varying handling of effect of idled time on provider compensation paid
  - Provider compensation may be key element of documentation supporting use of HHS Provider Relief funds, and specific supporting element of PPP Loan forgiveness support
  - Employee Retention Credit (part of the CARES Act) is potential payroll tax credit opportunity if idled providers were paid and entity did not have a PPP Loan
- Upcoming changes to E&M procedural work RVUs as part of 2021 Medicare Physician Fee Schedule could have significant effect on wRVU-based compensation plans
- Incentivization methodologies such as inclusion of practice expenses in compensation formula can be beneficial to control overall losses borne by hospital

Provider Compensation in Rural Setting: Future

- Potential value-based reimbursement change would cause significant effects on compensation plan incentives
  - Incentivize for efficient patient care management
  - Incentivize for quality outcomes
  - While productivity will remain important, singular focus on productivity tends to disincentive above factors
- Current trends are to contractually affiliate with as opposed to employ providers
  - Retains entrepreneurial spirit in providers
  - Controls losses borne by hospitals
  - Requires more complex recruitment effort and limits pool of suitable providers

2020 Outlook: Reimbursement, Regulatory and More

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2020 Outlook

- *Surprise billing & price transparency legislation will be disruptive*
- *Hospital CEO Searches Increasingly Seeking Physicians*
- *Flat reimbursement, but continued shifts to value based pay*
- *FTC and Congressional pressure on vertical integration*
- *More physician compensation arrangements moving away from volume based pay*
- *Private Equity Continues to Buy More Physician Practices*
- *Finalization of Fraud & Abuse law changes*
- *Pressure from non-traditional providers (like Amazon)*
- *Continued fatigue / non-sustainability over employed physician losses*
- *Better use of structured data for care management, coordination, and general physician performance measurement and monitoring*

Expansion of Telehealth Services

- Proposed rule includes an expansion of telehealth services, including home visits & care planning
- Proposed adding services temporarily through a category 3 assignment
  - Category 3 assignment is for services allowed through the end of the public health emergency
- Proposed expansion of eligible providers & allowance for supervision over audio/video communication

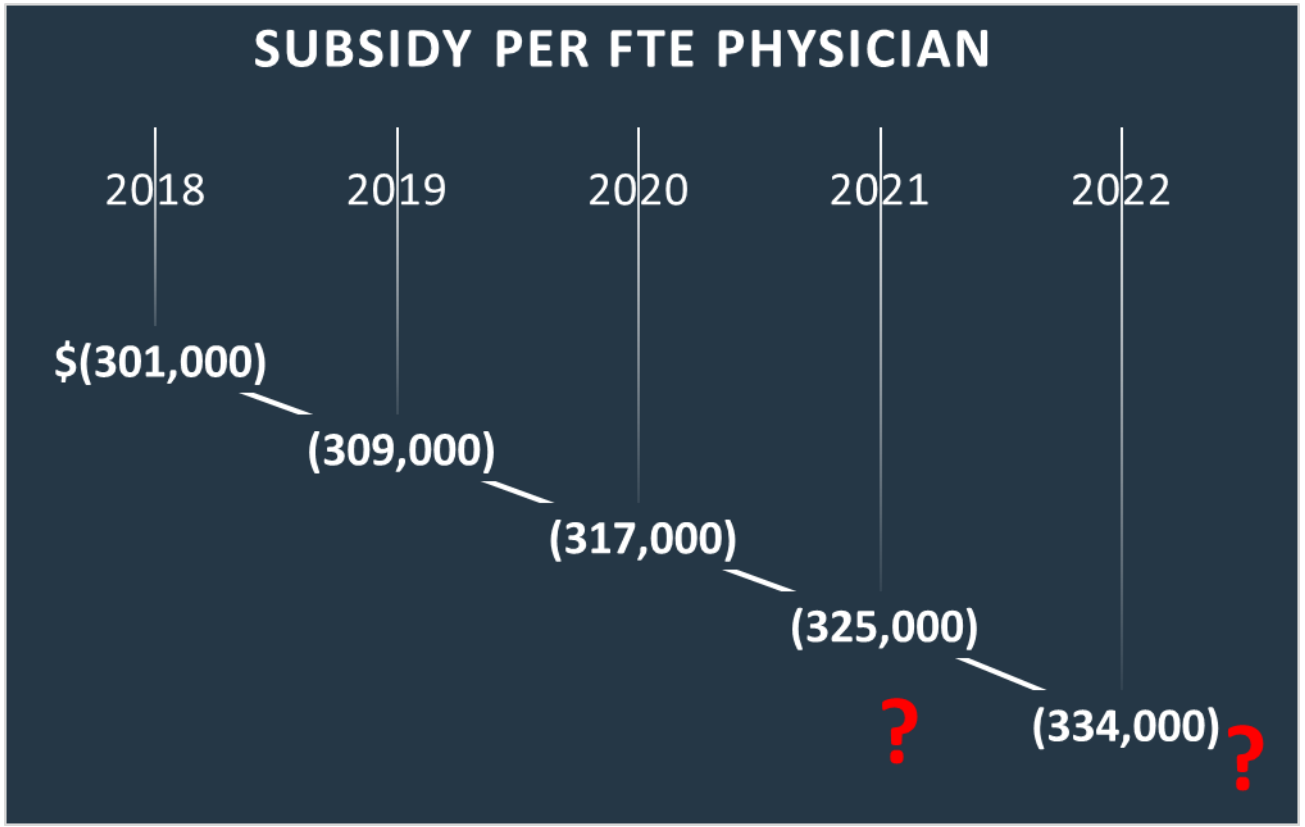
CMS Plan to Restructure RVU Values

E&M Code	CY 2020 wRVU Values	CY 2021 wRVU Values
99201	0.48	Removed
99202	0.93	0.93
99203	1.42	1.60
99204	2.43	2.60
99205	3.17	3.50
99211	0.18	0.18
99212	0.48	0.70
99213	0.97	1.30
99214	1.50	1.92
99215	2.11	2.80

- In addition to E&M codes changes, CMS proposed reevaluation of the following code sets
  - End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP) Services
  - Transitional Care Management (TCM) Services
  - Maternity Services
  - Cognitive Impairment Assessment & Care Planning
  - Initial Preventive Physical Examination (IPPE) & Initial & Subsequent Annual Wellness (AWV) Visits
  - Emergency Department Visits
  - Therapy Evaluations
  - Psychiatric Diagnostic Evaluations & Psychotherapy Services

What Does This Mean for Organizations?

An increase in reimbursement is not expected to offset increases in provider compensation. Organizations will see increase of subsidies on employed physician practices

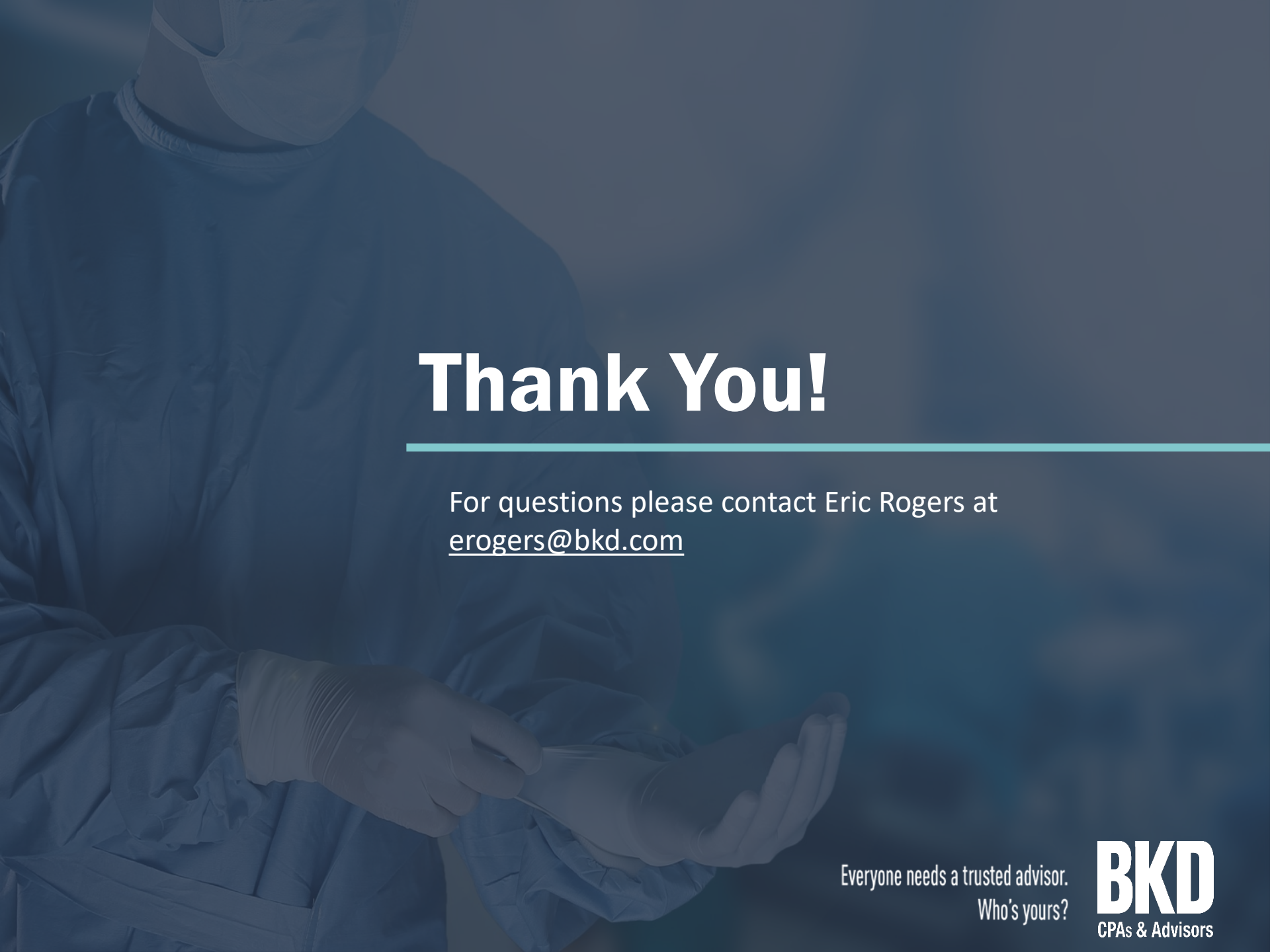


Forecast Financial Impact

- Develop a plan of action to appropriately analyze & respond to proposed changes
  1. Define objectives – define the goal of addressing physician compensation concerns;
  2. Gather key work effort & compensation arrangement information to evaluate current state, financial performance, & other key variables;
  3. Estimate changes to work effort under proposed payment & coding policies – complete basic projections of impact on reimbursement, provider compensation, & practice net income;
  4. Analyze “do-nothing” effect to create a baseline scenario; &
  5. Complete various scenario analyses to meet objectives defined in step 1 & evaluate direct contracting actions

Contracting Actions

- Direct contracting actions may be required to manage the impact
  - Patient Panel Pay – Make the move to patient panel pay for primary care in whole or in part. The current pay/panel/wRVUs could be used to re-base on a cost-neutral(ish) basis
  - Corridor Clauses – Update contracts to have a reciprocal “max” move up or down, to create a corridor effect by, say, 5% on units. A new contract would allow for re-basing in anticipation of wRVU changes
  - Unit One Bonus Plans – Consider “unit-one” wRVU arrangements that pay small productivity bonus amounts for all wRVUs produced. This still incentivizes productivity but creates a tighter band around likely outcome levels (similar in effect to #2). A new contract would allow for re-basing in anticipation of wRVU changes
  - Pooled Model Arrangements – A general trend in compensation design, pooled compensation models are being used promote team-based care. These are often service-line centered & could address the changes previously noted



Thank You!

For questions please contact Eric Rogers at erogers@bkd.com

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