Value Based Payments, Generational Influences and Other Income Distribution Issues

Learning Objectives

• Identify “Value Based Elements” that may be a key to the future success of private practice.
• Identify ways to begin incorporating “Value” into your Income Distribution Formula in preparation for when Value will matter more.
• This will not be a deep dive discussion of each value-based model but rather how do we use compensation to initiate value based behavior.
• Discuss other key income distribution formula challenges related to generational influences, overhead, ancillaries, slowing down and call.
Introduction

• For the Otolaryngology physician and practice, Value should be embraced, not feared.
• Value is ultimately how the otolaryngologist physician and practice manage the cycle of care or the care process for a patient with an intense focus on the outcome achieved for the cost of that outcome.
• Value vs. Volume is a misnomer. Volume is always important relative to still needing patient volume. The goal with referencing “Value” is tying more of the total payment to “Care Management” versus the “Volume of Care” Delivered.

Introduction

• Health Care is the only business in the US that is constructed around the “Suppliers” versus the “Consumer.” Do we have “Patient Centered Care” or “Supplier Centered Care”?
• Consider the influence of “AHA,” Pharmaceutical PACs, Device Company Lobbyists, which ultimately have driven medical specialty societies to hire their own lobbyist.

Introduction

• At the end of the day physicians are the only health care supplier that can design and drive “Patient Centered Care” and because of this physicians should be the biggest winner in the drive to “Value.”
Introduction

• Mission, Vision, Values and Culture
• Governance
• Compensation

• How do we drive desired behavior?

Introduction

• Desired behavior is the intersection of these three key areas and each area must support and reflect the other.
• Compensation
• Governance
• Mission, Vision, Values and Culture

We can certainly argue which is most important
Introduction

• Value needs to be a key element of our culture.
• While governance is important, compensation unfortunately or sadly is the ultimate tool for driving behavior.

Introduction

• The challenge today is the new generation of physicians view a group practice as a place to buy services but drive solo-practice models with detailed cost accounting for production (all levels) and overhead.
• There is little built into their thinking that cheers or rewards the group for the success of each physician. Stated differently, my partner’s success is irrelevant because I succeed based on “ME.”

Introduction

• In spite of this you still must begin to build a culture around “Value.” Note the reference to “begin.”
• Most references to “Value” models today still has a fee for service (discounted) at the core with Value returned on the back end.
• ACOs, Hospital CINs and all of the Medicare bundle payment initiatives are but a few examples of this.
Questions as a Leader That We Must Ask

- Does our methodology promote the behavior we desire and the culture we want to create (i.e., Value Driven)?
- Does our methodology incorporate quality metrics and begin addressing the transition from volume driven care to value driven care?
- What changes are needed when we get to where value based care dominates how we are paid? In today’s environment are we willing to incorporate consequences for non compliance with governance decisions of the group?

Value Based Elements

- Early stage items
- Pay for Reporting (P4R)
- Pay for Performance (P4P)

Value Based Elements

- Outcomes Management - Early stage items
- Hospital Value Based Purchasing
- Hospital Readmission Reduction Program
- Hospital Acquired Conditions Reduction Program
### Value Based Elements

- Physician Quality Reporting Program - PQRS
- EHR incentive payment program - Meaningful Use I, II & III
- Physician Value Based Payment Modifiers
- MACRA and Merit Based Incentive Payment System (MIPS) – Quality; Resource Use = Efficiency; Advancing Care Information = Meaningful Use; Clinical Practice Improvement Activities

### Value Based Elements

- Physician focused - Reduced readmissions
- Physician focused - Reduced infections
- Physician focused - Change in quality of life
- Physician focused - Return to work, school, return to pre-injury functionality, etc.

### Value Based Elements

- Alternative Payment Models
- Accountable Care Organizations – Medicare – MSSP, Pioneer and Next Generation
- Accountable Care Organizations – Hospital driven PHO of the 1990s
- Episode Based Models – CMS/CMMI Bundled Payment initiatives (note CMS does not currently consider these value-based payment models for MACRA)
- Population health management/global budgets
Quality Measures Information

- AAO-HNS Externa
  - Acute Otitis Externa Measure
    - Acute Otitis Externa (AOE): Topical Therapy (NQF 0653/PQRS #91)
    - Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use (NQF 0654/PQRS #93)
  - Adult Sinusitis Measures
    - Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use) (PQRS #331)
    - Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) (PQRS #332)

Quality Measures Information

- Adult Sinusitis Measures (Cont'd)
  - Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse) (PQRS #333)
  - Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse) (PQRS #334)
- Otitis Media with Effusion Measures

Individual Quality Measures

- Acute Otitis Externa (AOE) Measures
- Sinusitis Measures
- Asthma Measures
- Perioperative Measures
- Preventive Care Measures
- Falls Measures
- Miscellaneous Measures
Quality Measures Groups

- Asthma Measures Group
- Sleep Apnea Measures Group
- Sinusitis Measures Group
- Acute Otitis Externa Measures Group
- Multiple Chronic Conditions (New)

Patient Satisfaction Measures

- General Quality of Life
  - Veterans RAND 12 (VR-12)
  - SF – 12
  - SF – 35

Value Based Elements

- Some elements have already had economic consequences and presumably positive impacts on physician compensation (PQRS, Meaningful Use).
- Some will have future negative economic consequences (MIPS) tied directly to the physician no matter whether reported by physician level or group level.
Potential Medicare Payment at Risk

Payment Adjustments

a) Groups of 10+ Eps (including Pas, NPs, CNS, CRNAs)

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<th>Average Quality</th>
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<td>High Cost</td>
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b) Groups of 2-9 EPs and Solo Physicians

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c) Groups of Pas, NPs, CNSs, or CRNAs without Physicians

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**Value Based Elements**

• How do we build the culture and tools for all else?
• The answer today will not be the answer 2 years from now, but we need to get started.
• This will not be a complex accountants continuing employment act discussion or set of solutions.
• We must crawl, walk, then run. Today we are at the crawling stage.

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**Value Based Elements**

• Commercial Bundled Payments
  – These are going to increase dramatically over the next few years.
  – Standard FFS allocation to providers (MDs, ASC, Ancillaries, etc.)
  – Contract payments to outside providers – Skilled Nursing, Home Care/Therapy, etc.
  – Amount remaining for distribution?

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**Value Based Elements**

• Commercial Bundled Payments
  – Amount remaining for distribution two options:

  **Option 1** – Equal allocation based on the premise this is similar to an ancillary income source (as physician was paid FFS amount)
  Primary negative to this is lack of accountability over care plan compliance.
  – Allocation occurs after proper withhold/reserves for adverse outcomes and accounted for quarterly with final distribution tied to year end
Value Based Elements

• Commercial Bundled Payments
  – Amount remaining for distribution two options:

  **Option 2 – Multi-faceted allocation approach**
  – 10% allocated to offset overhead for administration cost
  – 25% allocated equally among the owner physicians
  – 65% allocated to the providers performing bundled payment services as follows:
    a. 25% of 65% pro-rata patient satisfaction score ranking
    b. 25% of the 65% based on percent (%) compliance with care protocols/pathways agreed upon
    c. 25% of the 65% based on inverse order of infection or re-admission percent
    d. 25% of the 65% based on number of patients

Value Based Elements

• Need for care plan design and administration
• Need for patient satisfaction forms completed and Patient Reported Outcome Forms (PROs) Completed
• Need for Technology/EHR Compliance and really a technology/data driven culture (note Gen X and Millennials are assets here)

Value Based Elements

• Carve out a share of ancillary income and place in a Value Based Bucket
• Extract $36,000 from each physician and place in a Value Based Bucket ($3,000 per month per MD)
• Return pool to physicians based on:
  – Administration fee for work on care plan design for top volume/spend services ($350 per hour)
  – Achieving targeted number of completed PROs
  – Achieving targeted number of patient satisfaction surveys completed
  – Rank order % compliance with EHR utilization and documentation compliance
  – Rank order % compliance with designated outside care vendors (managing cost of care for patients)
**Value Based Payments**

- If $3,000 per MD per Month is not enough to move the needle then move the dollar value higher.
- The next stage after a few years of data gathering will be the harder stage and that will be rewarding for results and outcomes achieved.
- Goal today is start doing something.

**Value Based Payments**

- MACRA / MIPS
- Penalty versus reward
- Determine today how you will allocate the penalty.
- Items in physician control can be rewarded/penalized.
- Items outside of control need shared.

**Value Based Payments**

- General Go Forward Concept
- Consider short-term “shadow” period where concepts are actually calculated but no impact on compensation for initial shadow/six-month period.
- When shadowing begins communicate at the end of shadow period the particular element being shadowed will now be “live.”
Value Based Payments

• One Last HAC – Harry Audacious Concept

Value Based Payments

• Right Care
• Right Provider
• Right Facility
• Right Cost
• Right Outcome
• If Right Care by Right Provider is truly what patient centered care is then why not equal compensation (in total or a high percent of total compensation) so the focus is right care by right provider?

Value Based Payments

• Any equal allocation (100%, 50%, etc.) will require metrics to be met to qualify for equal but this eliminates the production mentality (volume of services and payer mix gymnastics) and looks to have all win in the model.
Value Based Payments

• Equality Based (same compensation per MD)
  – Primary Advantages
    • Generally ensures patients are routed to the physician with best training to perform the case (subspecialty focused) since there is no gain for a physician with a different skill set to perform the case.
    • If one thinks there are over utilization issues this generally solves it.

• Equality Based (same compensation per MD)
  – Primary Disadvantages
    • “High producers” have little long-term financial incentive so may choose to work less
    • “Low producers” may be allowed to ride on the financial coattails of the more productive physicians (no incentive to increase productivity and potentially no penalty for decreasing productivity)
    • Can drive higher overhead or more overhead dollars spent since all pay equally for overhead

• Equality Based (same compensation per MD)
  – Key Criteria for Success
    • Must hire physicians who buy into the sub-specialty model and the good of the group.
    • Since most of the current retirements are general otolaryngology physicians/surgeons we shall soon cycle to all sub-specialists.
    • Need criteria to qualify for the equal share to ensure the systems is not gamed (which shouldn’t be if the right physicians are hired but invariably someone always figures out how to game the system).
    • In the world of health care reform and value based care this might be the ideal model, but not likely able to be implemented if you are in a production driven model today, but worth dreaming.
Value Based Payments – Qualifications for Equal Compensation

- Productivity Metrics for FTE Determination
  - Gross charges
  - wRVUs
  - RVUs
  - New Patient Visits
  - New and Established Patient Visits
  - ER Call Days Worked
  - Clinics Staffed

All above related to physicians professional services only, ancillaries excluded.

Recommended FTE Approaches – Value Based Payments – Qualifications for Equal Compensation

Using the metrics above, a physician would be either:
- 1.0 FTE (90%, or above, of mean production)
- .90 FTE (between 80% and 89% of mean production)
- .80 FTE (between 70% and 79% of mean production)
- .70 FTE (between 60% and 69% of mean production)
- .60 FTE (between 50% and 59% of mean production)
- .50 FTE (between 40% and 49% of mean production)
- .40 FTE (between 30% and 39% of mean production)
- .30 FTE (between 20% and 29% of mean production)
- .20 FTE (between 10% and 19% of mean production)
- .10 FTE (less than 10% of mean production)

This status determination is applied to determine the Number of full shares allocable. If 10 owners but one is a .60 FTE, then there are 9.6 shares for allocation for allocation of ancillary net income.
**Other Significant Income Distribution Topics**

- Generational Issues
- Overhead Allocation
- Ancillary Net Income Allocation
- Physician Extenders
- Slow Down
- Call

**Other Significant Income Distribution Topics**

- Changing Income Distribution Formulas can be career altering
- Change should first be viewed from the starting point – the current formula
- The end point is unlikely the first modification but likely a number of transition years away
Other Significant Income Distribution Topics

• There is a tendency to think “I” will be negatively impacted by change. Some formulas impact culture and accountability without necessarily causing a big compensation swing.
• There is a tendency to focus on those negatively impacted by change. What about those positively impacted by change who may have a claim they have been wronged all of these years with the current plan?

Questions as a Leader That We Must Ask

• Are we willing to focus on the rationale behind what we want our formula to be and not perform a look back calculation?
• Old formula, old behavior drivers, new formula, new behavior drivers.

The Basic Compensation Formula

• + Collections/Charges/RVUs/Combination
• – Refunds
• = Net Collections/Revenue
• – Fixed Overhead (not everyone has)
• – Variable Overhead (not everyone has)
• + Ancillary Net Income (not everyone has)
• – Physician Administrative Pay (not everyone has)
• – Physician Direct Expenses
• = Amount Available for Physician Compensation
• – Salary
• = Additional Compensation/Bonus Payable
Generational influences have raised the topic on overhead allocation methods. Starting Point is defining Overhead and where it belongs in terms of direct and indirect allocations before determining what is allocated to the physicians professional practice side.

**Income Distribution Methodology: Overhead**

- Owner Physician Direct Cost Accounted Expenses
- Owner Physician Direct/Personal Expenses
- Employed Physician Direct/Personal Expenses
- Ancillaries Expenses, Direct and Indirect
- Physician Assistant/Nurse Practitioner Expenses, Direct and Indirect
- All Remaining Overhead for Allocation and Determination as to Type of Overhead

**Income Distribution Methodology: Overhead**

- Owner Physician Direct Cost Accounted Expenses
  - Space Used
  - Direct Staff/Assigned Staff used and their wages, taxes, benefits, etc.
  - Supplies Directly costed/accounted
  - Equipment/Furniture expense or depreciation costed/accounted
  - Marketing expense costed/accounted
  - Scribes
### Income Distribution
**Methodology: Overhead**

- **Physician Direct Expenses:**
  - Physician Wages, taxes, benefits, etc.
  - Nurse/PA Wages, taxes, benefits, etc.
  - Insurance - Health, Disability, Life
  - Insurance - Malpractice
  - Retirement Plan Contributions
  - Dues, Subscriptions, Meals, Entertainment
  - CME and all related Travel Cost
  - Uniforms and Lab Coats
  - Transcription
  - I-phone, I-Pad, Laptop, Pager, etc.
  - Vehicle Depreciation, Vehicle Lease and other Vehicle Related Expenses

- **CT/MRI Techs & all related expenses**
- **CT/MRI depreciation/lease payment**
- **CT/MRI maintenance**
- **CT/MRI space rent**

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<tr>
<th>Ancillary Expenses (Cont’d)</th>
<th>6% - 8% of Revenue</th>
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- **Indirect Expenses to the Ancillary:**
  - Contracting, billing, collecting, etc.
  - Management including legal, accounting, HR, etc.
  - Total Indirect Cost Allocation – 10% - 15% of Revenue
**Income Distribution Methodology: Overhead**

- **Ancillary Expenses (Cont’d)**
  - Indirect Expenses to the Ancillary:
    - Indirect expense allocations to Ancillaries are reductions of the general overhead category (i.e., overhead that remains for allocation to the physician’s professional practice revenue).

- **Physician Assistant / Nurse Practitioner**
  - **Direct Expenses:**
    - Wages, Taxes, Benefits, etc.
    - Insurance - Health, Disability, Life
    - Retirement Plan Contributions
    - Dues, Subscriptions, Meals, Entertainment
    - CME and all related travel cost
    - I-phone, I-Pad, Laptop, Pager, etc.

- **Physician Assistant / Nurse Practitioner**
  - **Indirect Expenses:**
    - Should some fixed overhead be allocated against extender receipts? PAs, FTE status determined relative to an Orthopaedic Physician (i.e., 15% thus a .15 FTE)
    - Should some variable overhead be allocated against extender receipts?
    - Seeing movement in this direction (the free ride is nearing an end) since they do consume practice resources.
Income Distribution
Methodology: Overhead

• Net Income or Loss allocated directly to the Physician for whom the PA/NP works?
• Net Income or Loss treated as an ancillary income department and allocated to the owners in the same manner as other ancillaries?

Income Distribution
Methodology: Overhead

• Employed Physician Direct Expenses:
  – Physician Wages, Taxes, Benefits, etc.
  – Insurance - Health, Disability, Life
  – Insurance - Malpractice
  – Retirement Plan Contributions
  – Dues, Subscriptions, Meals, Entertainment
  – CME and all related Travel Cost
  – Uniforms and Lab Coats
  – Transcription
  – I-phone, I-Pad, Laptop, Pager, etc.
  – Vehicle depreciation, Vehicle Lease and other Vehicle related Expenses

Income Distribution
Methodology: Overhead

• Employed Physician Indirect Expenses:
  – Should some fixed overhead be allocated against Employed Physician receipts? FTE status determined relative to an Owner Physician (i.e., 50% - a .50 FTE for a fixed overhead allocation)
  – Should variable overhead be allocated against Employed Physician receipts?
  – Somerset generally believes Employed Non Owner physicians should be in the same formula as the Owner Physicians excluding ancillaries.
Income Distribution Methodology: Overhead

• Employed Physician Indirect Expenses:
  – Net Income or Loss treated as an ancillary income department and allocated to the owners in the same manner as other ancillaries.

Income Distribution Methodology: Overhead

• All Overhead after Physician Direct Cost Accounted Expense,
  – Physician Direct/Personal Expenses,
  – Ancillary Direct Expenses,
  – Ancillary Indirect Expenses,
  – Physician Assistant/Nurse Practitioner Direct Expenses,
  – PA/NP Indirect Expenses and
  – Employed Physicians Direct and Indirect Expenses
Represents the Remaining Practice Overhead to be Allocated.

Income Distribution Methodology: Overhead

• Remaining Overhead is Usually categorized as Fixed (equally allocated) or Variable (consumption allocated) or a combination of Fixed and Variable.
• A significant battle occurring on the “Fixed” versus “Variable” concept.
**Income Distribution Methodology: Overhead**

* The essence of the “Fixed” Overhead debate:
  - Year over year overhead does not change so doesn’t that mean it is fixed?
  - The resources are here to be used, if you choose not to use them that is your issue because you should pay for them anyway.
  - When overhead is variable, when my fellow physician slows down I automatically am shifted more overhead to pay when I did nothing differently.

**Income Distribution Methodology: Overhead**

* The essence of the “Variable” Overhead debate:
  - The busy physician consumes more of the practice resources so they should pay for these.
  - Shouldn’t we all be happy paying the same overhead rate (i.e., percent)?
  - If I leave because I can’t survive under all fixed overhead, won’t the fixed overhead proponents ultimately lose when they have to pay the overhead I used to pay?

**Income Distribution Methodology: Overhead**

* The reality of the essence of the “Fixed” versus “Variable” debate:
  - The busier physician wants 100% profit on his production above the fixed overhead acting as if there is no overhead being consumed by patients seen above this level.
  - The slower physician wants to slow down as they choose and not be forced to a minimum work level to cover overhead.
Income Distribution Methodology: Overhead

* In reality overhead methodologies that tend to be at one end or the other of the spectrum (all variable overhead or all fixed and equally allocated) can work; however, success is often tied to physicians with very similar practice styles and productivity.

Income Distribution Methodology: Overhead

* Overhead methodologies that tend to be at one end of the spectrum or the other (all variable overhead or all fixed and equally allocated) can also be challenging for a broad based practice if the goal is to accommodate a full spectrum of sub-specialist and physicians at different ages.

Income Distribution Methodology: Overhead

* Groups generally choose 1 of 3 methods for identifying fixed/variable expenses:
  – Call all expenses Fixed
    • Allocate expenses equally
  – Call all expenses Variable
    • Allocate based on revenues or some other consumption metric
  – Use a combination of Fixed and Variable Expenses
**Income Distribution Methodology: Professional Practice Overhead**

- 100% Fixed (Equal) – Line Item Identification (Not Production/Consumption driven)
  - Rent
  - C Suite management salary and benefits
  - Marketing
  - Legal and accounting
  - Depreciation
  - All Technology related costs (PMS, EHR, Outcomes tools, etc.)

**Income Distribution Methodology: Professional Practice Overhead**

- 100% Variable - Line Item Identification (Production/Consumption driven)
  - Billing and Collections
  - Check-in and Check-out
  - Patient Scheduling
  - Medical Supplies
  - Office Supplies
  - Medical Records - Manual
  - Transcription

**Income Distribution Methodology: Overhead**

- Some % of both Fixed and Variable

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*There is a push towards a higher fixed overhead allocation (moving from 50F/50V to 60F/40V) with younger physicians wanting even more fixed overhead.*
### Expense Allocation Methodologies

- See a push for more expenses called Fixed & Equally allocated due to increase in technology in practices
- See a Minor movement to more line item or department identification and unique metrics for allocating each department

**Example:**
- Appointment Scheduling – Appointments Scheduled
- Billing – # Claims Processed or Cash Collections
- Pre-certifications – Surgeries or CTs Pre-certified
- Medical Records – Established and New Patient Visits

### Income Distribution Methodology: Ancillaries

- Very Hot Topic!
- Many forget there are legal issues that impact the allocation methodology chosen:
  - Stark Regulations
  - Anti-Kickback/Fraud and Abuse

### Income Distribution Methodology: Ancillary Services

- Ancillary services often times make up a substantial portion of a practices profits that may equal or exceed income generated by the physicians' professional services
  - CT/MR/UC PET
  - Speech Therapy
  - DME
  - Injections
  - Laboratory Services
- Stark = distribution of profits cannot be related to the volume or value of referrals
- Productivity allocation must not take into account the physicians' own referrals of Medicare or Medicaid patients for designated health services (DHS)
### Income Distribution Methodologies: Ancillaries

- **Net Income Allocation Methodologies**
  - Equal
    - Safe for those who fear Stark & Anti-Kickback
    - Team building element
    - Equal risk = equal reward
    - A rising tide lifts all boats
  
  Equal is dominant method in the industry

### Income Distribution Methodology: Ancillary Services

- Ancillary Collections
- Ancillary Direct Expenses
  - Rent
  - Supplies
  - Equipment depreciation
  - Equipment maintenance
  - Wages and benefits
- Ancillary Indirect Expenses (approximately 10% - 15% of collections)
  - Billing and collections
  - Payer contracting
  - Check-in and check-out
  - Legal and accounting
  - Human resources
  - Marketing
  - C Suite management salary and benefits

**Indirect expense allocations to ancillaries are reductions of the general overhead categories of fixed & variable expenses.**

### Income Distribution Methodology: Ancillary Services

- Ancillary Net Income Allocations
  - Equality Models
    - 100% Equal (dominant methodology)
      - Safe for those who fear Stark & Anti-Kickback
      - Team building element
      - Equal risk = Equal reward
    - Equal subject to some qualification metrics
      - What is a 1.0 FTE physician?
  - Production Models
    - 100% Productivity (Stark compliant)
    - Physician's professional productivity, office visits (new or established), Total RVUs or wRVUs
    - % of investment in the practice
  - A combination of Equal and Productivity
Income Distribution
Methodologies: Ancillaries

• Net Income Allocation Methodologies – Use of a Stark Approved Productivity Methodology
  – Based upon physicians professional productivity percentage, patient visits, RVUs, or some other productivity measure that is not tied directly to the volume or value of DHS referrals

• Have seen a number of bifurcated approaches (which we do not like):
  – Medicare and Medicaid equal per Owner physician.
  – Commercial allocated based on direct referrals (for states with no matching Stark or Anti-kickback provisions).
  – Issues over how overhead should be allocated between the two buckets.
  – Issues over even $1 of Medicare or Medicaid ending up in the commercial bucket.
  – Issues over Medicare and Medicaid providers feeding most of their ancillaries into the shared bucket with little for the production bucket.
  – What is the rallying cry for cheering on your partners to be successful? There is little in it for you if they succeed and there clearly is “no rising tied lifts all boats concept.”
Income Distribution Methodologies: Ancillaries

- For those utilizing some elements of Equal Allocation (all or a percent of the ancillaries) trend toward identifying "what is a 1.0 FTE Physician" that qualifies a Physician for participating fully in the equal amount?
  - What is driving this trend?
  - Pros and Cons of this trend.

Income Distribution Methodology: Ancillary Services – FTE Equivalency

- Should we have metrics to qualify for equally shared elements of the compensation plan (i.e., ancillary net income, employed physician net income, any top line equal revenue allocations, etc.)?
  - Low producers
  - Retiring physicians (slow-down)
  - Those who choose to lower their productivity for life-style purposes
- Allow data (metrics) to determine a 1.0 FTE rather than emotions and physician personal opinions

Income Distribution Methodologies: Ancillaries

- Productivity Metrics for FTE Determination
  - Gross charges
  - Net Charges
  - wRVUs
  - RVUs
  - Collections
  - New Patient Visits
  - New and Established Patient Visits
  - Surgeries
  - ER Call Days Worked
- All above related to physicians professional services only, ancillaries excluded.
Recommended FTE Approaches – Ancillary Services Net Income (Including Employed Physicians and Extenders)

Using the metrics above, a physician would be either:

• 1.0 FTE (90%, or above, of mean production)
• .90 FTE (between 80% and 89% of mean production)
• .80 FTE (between 70% and 79% of mean production)
• .70 FTE (between 60% and 69% of mean production)
• .60 FTE (between 50% and 59% of mean production)
• .50 FTE (between 40% and 49% of mean production)
• .40 FTE (between 40% and 54% of mean production)
• .20 FTE (between 25% and 39% of mean production)
• .00 FTE (less than 25% of mean production)

This status determination is applied to determine the number of full shares allocable. If 10 owners but one is a .60 FTE, then there are 9.6 shares for allocation for allocation of ancillary net income.

Somerset FTE Approach – Ancillary Services Net Income - Sample

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To total: 12345678910

Revenues:

- New & Established Patient Visits
  - 45,435 5,642 4,890 4,205 4,492 5,973 4,755 3,029 4,523 2,539 5,387
  - % of Total N&E Patient Visits: 100% 12.42% 10.76% 9.25% 9.89% 13.15% 10.47% 6.67% 9.95% 5.59% 11.86%
- Share of Rev for N&E Pts Measure: 6,000,000

- New Patient Visits
  - 8,486 1,301 610 779 808 1,163 819 670 1,091 312 933
  - % of New Patient Visits: 100% 15.33% 7.19% 9.18% 9.52% 13.70% 9.65% 7.90% 12.86% 3.68% 10.99%
- Share of Rev for New Pts Measure: 6,000,000

- Total RVU's
  - 160,949 18,908 19,792 21,309 14,971 19,378 18,106 13,453 13,295 8,767
  - % of Total RVU's: 100.00% 11.75% 12.30% 13.24% 9.30% 12.04% 11.25% 8.36% 8.26% 5.45% 8.06%
- Share of Rev for Total RVUs Measure: 6,000,000

- Charges
  - 19,308,805 2,132,975 2,452,283 2,514,637 1,749,399 2,359,266 2,371,195 1,567,163 1,542,008 1,149,515
  - % of Total Charges: 100.0% 11.0% 12.7% 13.0% 9.1% 12.2% 12.3% 8.1% 8.0% 6.0% 7.6%
- Share of Rev for Chrgs Measure: 6,000,000

- Net Collections
  - 9,273,464 1,129,351 1,043,534 1,128,551 895,640 1,114,697 1,085,281 659,556 858,397 514,099 844,359
  - % of Net Collections: 100% 12.18% 11.25% 12.17% 9.66% 12.02% 11.70% 7.11% 9.26% 5.54% 9.11%
- Share of Rev for Coll. Measure: 6,000,000

- Total Adjusted Revenue
  - 30,000,000
- FTE Status: 9.20 1.00 1.00 1.00 1.00 1.00 1.00 0.80 1.00 0.40 1.00
- Share based upon FTE status: 100% 10.87% 10.87% 10.87% 10.87% 10.87% 10.87% 8.70% 10.87% 4.35% 10.87%

FTE Status - Tiers

- Adjusted Rev: 30,000,000
- Average (10): 3,000,000
- below 25% - 0 FTE - 0.00
- 25% - 39% - .20 FTE - 750,000
- 40% - 54% - .40 FTE - 1,200,000
- 55% - 69% - .60 FTE - 1,650,000
- 70% - 84% - .80 FTE - 2,100,000
- 85% or above - 1.0 FTE - 2,550,000

*BASED ON A ROLLING 12 MONTH AVERAGE

FTE Calculations - 5 Measures
Income Distribution Methodology: Ancillary Services – FTE Equivalency

- Hot Topic:
  - Should we allow a physician to be more than a 1.0?
  - If we do are we really saying we have a productivity model?
- Possible consideration to be given to this
  - We have rarely done this
    - Place a cap up to a 1.2 FTE in the calculation

Income Distribution Methodology

- Other Topics if we have time
- Extenders
- Physician Slow Down
- Call

Income Distribution Methodology: Extenders (PAs)

- Direct Economics Model – Option 1
  - PA Collections
    - Directly assigned to the physician the PA works for
  - PA Wages and Benefits
    - Direct expense to the physician the PA works for
  - PA Overhead Allocation
    - The PA would not incur fixed overhead because they are assumed one and the same as the physician & the physician is charged his/her pro-rata share of fixed overhead
    - Since the PA’s collections are included with the physicians collections, the variable overhead allocation % would be applied to the net collections (MD + PA)
Income Distribution Methodology: Extenders (PAs)

• Direct Economics Model – Option 2
  – PA Collections
  – Directly assigned to the physician the PA works for
  – PA Wages and Benefits
  – Direct expense to the physician the PA works for
  – PA Overhead Allocation
    • The PA would incur fixed overhead since they utilize facilities, management & really all resources categorized as fixed overhead. Their fixed share calculated as a function of their status (based on collections) to the status of the average of orthopedic physician’s collections. May receive anywhere from .15 to .25 of a fixed overhead share.
    • Since the PA’s collections are included with the physicians collections the variable overhead allocation % would be applied to net collections (MD + PA). If PA is treated as their own column in income distribution model then they would be allocated variable overhead in the same fashion as the physicians.

Income Distribution Methodology: Extenders (PAs)

• Pooled Economics Model – Option 1
  – Separate profit/loss center
  – Same methodology of owner physicians with the following exceptions:
    • Fixed overhead is allocated at a reduced share (i.e., .15 FTE share rather than a 1.0 FTE share)
    • Do not receive a share of the ancillary net income allocation
  – The net income(loss) of the profit/loss center would be allocated pro-rata physician owners (equal allocation)

Income Distribution Methodology: Extenders (PAs)

• Pooled Economics Model – Option 2
  – Separate profit/loss center
  – Same methodology of owner physicians with the following exceptions:
    • Fixed overhead is allocated at a reduced share (i.e., .15 FTE share rather than a 1.0 FTE share)
    • Do not receive a share of the ancillary net income allocation
    • Any net loss determined on an individual PA basis would be allocated back to the sponsoring physician as a direct expense/loss. Sponsoring physician would be allowed to recover loss from that PA’s profits on a go-forward basis.
  – The net income of the profit center (after PA losses extracted) would be allocated pro-rata physician owners (equal allocation)
PHYSICIAN SLOW-DOWN PLAN

Physician Slow-down

* Identify organization’s goals and objectives with respect to the plan.
  - The Qualified Slow-down is not intended to allow a physician in a slow-down phase to work half the time they previously worked, for a full-time orthopedic surgeon.
  - Any vote for a Qualified Slow-down request shall require a super majority affirmative vote of the remaining Members.

Physician Slow-down

* Qualifications to enter into a “Qualified Slow-down”:
  - A minimum of 240 months of services and achievement of 60 years of age.
  - Twenty-four (24) months’ notice of intent to enter into a Qualified Slow-down up to age 60.
  - Eighteen (18) months’ notice of intent to enter into a Qualified Slow-down between ages 60 and 62.
  - Twelve (12) months’ notice of intent to enter into a Qualified Slow-down between ages 62 and 65.
  - Six (6) months’ notice of intent to enter into a Qualified Slow-down after age 65.
Physician Slow-down

• Qualifications to enter into a Qualified Slow-down:
  – Notice can only be given on July 1st or December 31st.
  – If more than one physician submits notice on the same day, the request of the physician with the most tenure will be considered first.
  – No more than two physicians can participate in a Qualified Slow-down during any calendar 12-month period.

Physician Slow-down

• Qualified Slow-down Physician Practice Economics
  – Assume a three-year limit
  – The Physician will receive credit for their converted production for services rendered by the physician in accordance with the revenue allocation methodology in accordance with the group's distribution methodology.

Physician Slow-down

• Qualified Slow-down Physician Practice Economics
  – Physician will receive a 1.0, .80, .60, .40, or .20 FTE allocation of the fixed overhead allocation with the determination of their practice status.
  – In order to continue to receive the benefit of the reduced fixed overhead allocation, a physician in a slow-down cannot have their production exceed 80%, 60%, 40%, or 20% of the measure(s) chosen by the group to determine FTE status. See prior slide for recommended metrics.
Physician Slow-down

• Qualified Slow-down Physician Practice Economics
  – The purpose of selecting an FTE status threshold is to prevent a physician from taking advantage of the reduced overhead by maintaining a full-time practice.
  • The company will be responsible for monitoring the slow-down physician and ensuring there is an appropriate allocation of overhead. The monitoring process shall begin at the end of the first (6) months of the slow-down.

Physician Slow-down

• Qualified Slow-down Physician Practice Economics
  – The definition of fixed & variable overhead expense shall be as they would be defined in the income distribution plan.

  – A Physician will be allocated their direct expenses in accordance with the current compensation formula then in effect.

Physician Slow-down

• Qualified Slow-down Physician Practice Economics
  – A physician will receive a 1.0, .80, .60, .40, or .20 FTE share of practice ancillary services net income in accordance with their FTE status

  – The ancillary net income allocation shall never exceed that of the physician’s FTE status determined.
**Physician Slow-down**

- Qualified Slow-down Physician Practice Economics
  - If there are ancillary services owned outside the group practice entity or other ancillary entities (medical office building ownership or ASC entity) that are controlled by the group or owned in identical fashion as the ownership of the medical practice, then the physician will be required to sell their interest in these entities to match the FTE status within the group.

**Call Schedule Issues**

- What is Impact to Current Physician?
- What is Impact to the Group?
- What is Impact on Recruitment?
- Will Call go to a Competing Group and thus Impact our Referral Patterns?

**Call Issues To Consider**

- Ensuring minimum number of physicians providing Call coverage in order to manage the burden and facilitate the ongoing recruitment process (i.e., Call coverage ratio)
- Determining the number of years in which a physician can continue to work with the group once they have elected off of Call
Call Issues To Consider

• Determining whether any age for coming off Call (as may be documented in the groups legal documents) is the appropriate age or whether some combination of age and years of service should be developed (i.e., 20 yrs. of service & age 55 = 75 points) for Call exemption eligibility

Call Issues To Consider

• Determining Whether Physicians on their Own Shall Be Free to Sell & Buy Call
• Should there be Sub-specialty Call?

Call Issues To Consider

• Our Minimum Coverage Ratio shall be 1 in 5. If the Ratio drops below this, physicians off Call shall fill in to allow maintenance of this ratio.
• After 3 years Off Call (if less than age 65) employment will terminate unless otherwise negotiated.
**Call Issues To Consider**

- Should Call Coverage Ratio established by group be impacted by physicians electing off ED Call, all physicians electing off ED Call shall be responsible for providing coverage to maintain the Ratio (i.e., they shall all share group coverage)

**CALL POOL ECONOMICS**

**Call Pool Economics**

- $$ Dollars per physician as the funding of Call pool funded by all physician up until age ??
- An equal share of ancillary income from all sources, plus
- All monies received from hospitals for providing Call coverage
Call Pool Economics

• Or, set the Call Value (i.e., $1,200 per night) and back into where you will get the money

Compensation Call Pool

• Proposed Call Distribution Plan
  – The total Call Pool will represent a value per Call day/night. Each physician taking Call will have distributed from the Call Pool the applicable dollar value per point for each point earned from taking Call.
  • A Weekday night (Mon., Tues., Wed., Thur.) = 1 point
  • Weekend (Fri., Sat., Sun.) = 1.5 points
  • Holiday Call = 2 points

Compensation Call Pool

• Proposed Call Distribution Plan (Cont’d)
  – By way of example:
    • A total of 10 holidays = 20 holiday points (10 days x 2 points per day)
    • 156 weekend nights (Thurs. Fri & Sat) = 234 points (156 x 1.5) & 199 regular Call days = 199 points (199 x 1) for a total = 453 points
    • At an average $1,200 per day x 365 days = Pool of $438,000 $438,000 ÷ 453 points = $966.88
Compensation Call Pool

- Proposed Call Distribution Plan (Cont’d)
  - Holiday = $966.88 x 2 = $1,933.76
  - Regular Days = $966.88 x 1 = $966.88
  - Weekends = $966.88 x 1.5 = $1,450.30
  Where holiday & weekend Call overlap, holiday value is utilized. All points & values are determined at beginning of the Call year.

Calculation Period

- Quarterly calculation
- Based upon YTD financial activity
- Reconciles to net income on the financial statements (not cash in bank balance)
- Negative/positive amounts due to/from at year end are carried forward into the following year (if not paid out before year end in the form of a bonus or not paid back by the physician if in the red)

QUESTIONS?
Contact Information

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