# Health Law Webinar

## Physician Compensation in Hospital Systems and Clinics

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# Agenda

- Practical thoughts about compensation models.
- Brief overview of the relevant laws.
- Stark's limits on a compensation both in clinics and hospital systems.
- Analysis of how a focus on salary surveys in health systems is misguided.
- Why "systems lose money on physicians" is both untrue and a really foolish thing to say.

# Practical Considerations

- What is the goal of a comp. system?
- If someone can leave and make more, there is inherent instability.
- What tangibles/intangibles matter?
  - Production/RVUs/revenue?(they are different!!)
  - Good citizen?
  - Reputation?
  - Quality?
  - Patient Satisfaction?

# Practical Considerations

- What does your system incentivize?
  - Is reimbursement in sync with physician comp? Note the recent RVU adjustment.
  - Macro: production vs. salary vs. capitation.
  - How can you encourage sharing? Practice development?
  - Is “gainsharing” legal for employed physicians?
  - Are certain types of patients favored?
  - Can people control their incentives? (On time start bonus.)

# Is Your System Fair?

- Do small changes in behavior yield large impacts? (Beware of cliffs!)


# Hazardous Cliff!

The ground may break off without warning and you could be seriously injured or killed.


Stay back from the edge.

# Is Your System Fair?

- Do small changes in behavior yield large impacts? (Beware of cliffs!)
- Is it transparent?
- Are expectations set out in advance?
- What work goes uncompensated?
- Does supervising merit compensation?
- How do you credit for administrative time?
- Is paying everyone the same “fair?”
- How do you allocate overhead?

# Overhead Projections

- This is really important both in both independent clinics and systems. Systems often fail to understand the implications of this decision. (See the final slide).
- How should you split space? Staff? Equipment? Fish and Flooring?
- Choose equal/variable/direct.

# Carrot vs. Stick

- In a privately owned physician group, consider two memos.
- “Every physician who attends the shareholder meeting will receive $500.
- “Every shareholder who fails to attend the meeting will be fined $200.”
- Which memo includes a bigger fine/penalty for non-attendance?

# Physician Comp Is Atypical

- What professions have identical per-unit fees and pay?
  - What do law firms pay for?
  - Clients/revenue.
  - Hours.
  - Revenue.
  - Seniority/experience.
  - Realization.

# Physician Comp Is Atypical

- Are tiered compensation models good?
- In many integrated systems, the lowest producer gets the highest comp/RVU. That makes NO sense.
- This practice has interesting Fair Market Value (FMV) implications.

# Medicare Antikickback Statute

- It is illegal to offer, solicit, make or receive any payment intended to influence referrals under a federal health care program.
- The government applies the “one purpose” test. If one purpose of the payment is to influence referrals, the payment is illegal.
- Only applies to payments from OUTSIDE of the corporation.

# 56 F.R. 35952 (July 29, 1991)

Comment: Many commenters requested the OIG to clarify that payments between corporations which have common ownership are not subject to the statute. Commenters cited as examples intracorporate discounts and payments between two wholly-owned subsidiaries. Some commenters argued that referral arrangements between two related corporations do not constitute "referrals" within the meaning of the statute, and suggested that the OIG define the word "referral" to exclude such activity.

Response: We agree that much of the activity described in these comments is either not covered by the statute or deserves safe harbor protection. **We believe that the statute is not implicated when payments are transferred within a single entity, for example, from one division to another. Thus, no explicit safe harbor protection is needed for such payments.**

# Antikickback Statute

- Intent is everything. The question: Is the payment intended to curry favor? Keep asking “why?”
- There is potential risk when your corporation has different entities. Logically, the existence of an additional entity shouldn’t matter.
- The government can argue excess comp isn’t “bona fide.”

# Antikickback Advice Caveat

- Epidemic of bad antikickback advice.
- “You must meet a safe harbor…”
- “We didn’t find an advisory opinion, suggesting this is illegal…”
- Self-disclosure makes no sense unless you are admitting improper intent.


STARKS
Bar & Grill
3125
Dodd Rd
NO PARKING

# Stark

- If an entity provides Designated Health Services (DHS), any financial relationship with a physician (or physician's immediate family member) who referred patients for DHS must meet an exception.
- Financial relationships can be ownership or compensation. Stark covers two types of compensation, direct or indirect.

# Stark

- Applies only* to Designated Health Services (DHS) for Medicare (and probably Medicaid), but all hospital services are DHS. (See next slide for others).
- Intent doesn’t matter; you must meet every part of an exception.
- Not criminal; but the penalty is up to $15,000/claim.

*Some exceptions apply, see store for details…

# “Designated Health Services”

- Clinical laboratory.
- Physical therapy.
- Occupational therapy.
- Radiology services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrition.
- Prosthetics and orthotics.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

# Stark is Sneaky

- It is much harder to do a Stark analysis.
- The exceptions have weird traps.
- Is “takes into account” different from “varies with?” Is “based on” different from “varies with?”

# Stark Quirks

- Remember that compensation to a family member is compensation to the physician. Beware of kids/spouses, parents/grandkids.
- “Referral” includes making a plan of care.
- The “entity” includes both
  - The entity billing for the service AND the entity providing the service.
    - This prohibits “under arrangements” relationships if the physician who orders the service is providing it “under arrangements.”

# December 2020 Stark Changes

- New flexibility, BUT, new restrictions for compensation formulas as of 1/1/22:
  - All DHS revenue for the group/subgroup must be aggregated.
  - Subgroups must have at least five physicians.
  - The same allocation methodology must be used for all DHS.
  - This now applies to non-Medicare DHS revenue.
- Stark does NOT require equal division of DHS.

# Productivity Bonuses In Group Practice*

- Can credit for services personally performed or incident to if not directly related to volume on the value of referrals (may directly relate for incident to).
- Deemed not to relate to the volume or value if:
  - Personally performed by the physician,
  - Not DHS and not considered DHS if payable by Medicare, or
  - Revenues from DHS are less than 5% of total revenue and each physician's compensation.

* You need to be sure you are a group practice!!!!

# Options for DHS Under the Compensation Formula

- Productivity (RVUs, visits etc.).
- Choose an allocation and stick with it.
- Equal division.
- Seniority.
- Any combo of above, provided it is used consistently for all DHS within the group/subgroup of 5.
- Anything else unrelated to creating the plan of care.
- Don’t forget state law!

# Special Stark Savior

- If less than 5% of all revenue of the group, and less than 5% of each physician's comp is from DHS, you may not need to worry about the comp formula.

# Credit for Supervisees OK!

"To the extent that a productivity bonus (or portion of a productivity bonus) paid by a group practice to a physician in the group is solely based on services performed by a member of the physician's care team that are not designated health services, the productivity bonus (or portion of the productivity bonus) would not violate § 411.352."

85 FR 77566

# Takes into Account Volume/Value/Other Business

"Compensation to a physician or immediate family member takes into account…if the formula used to calculate the physician's (or immediate family member's) compensation includes the physician's referrals to the entity as a variable, resulting in an increase or decrease in the physician's (or immediate family member's) compensation that positively correlates with…"

§ 411.354(d)(4)

# Correlation

“For purposes of applying this paragraph, a positive correlation between two variables exists when one variable decreases as the other variable decreases or one variable increases as the other variable increases.”

§ 411.354(d)(5)

# Key Clarification From 2019: 84 Fed. Reg 55766, 55795

"However, for clarity, we reaffirm the position we took in the Phase II regulation. With respect to employed physicians, a productivity bonus will not take into account the volume or value of the physician's referrals solely because corresponding hospital services (that is, designated health services) are billed each time the employed physician personally performs a service. We are also clarifying that our guidance extends to compensation arrangements that do not rely on the exception for bona fide employment relationships at § 411.357(c), and under which a physician is paid using a unit-based compensation formula

# Key Clarification From 2019: 84 Fed. Reg 55766, 55795

for his or her personally performed services, provided that the compensation meets the conditions in the special rule at § 411.354(d)(2) That is, under a personal service arrangement, an entity may compensate a physician for his or her personally performed services using a unit-based compensation formula—even when the entity bills for designated health services that correspond to such personally performed services—and the compensation will not take into account the volume or value of the physician's referrals if the compensation meets the conditions of the special rule at § 411.354(d)(2) (see 69 FR 16067)."

# Set in Advance

- Deemed to be set in advance if set out in writing before the furnishing of items/service/space & formula is set in sufficient detail it can be objectively verified.
- May be modified at any time if:
  - All requirements of an exception are met on the effective date.
  - The modified compensation formula is determined before the furnishing of the item/service and written in sufficient detail to permit objective verification.*

*The preamble notes there is no signature requirement.

85 FR 77594

# Set in Advance

"The surest and most straightforward way for a party to establish that the compensation under an arrangement is set in advance is to satisfy the deeming provision at § 411.354(d)(1)(i). Under [it], the parties document the compensation in writing prior to the furnishing of items, services, office space, or equipment in sufficient detail so that it can be verified are deemed to satisfy the set in advance requirement. However, we are reiterating in this final rule that the compensation (or other formula determining the compensation) does not need to be documented in writing and it does not need to be deemed to be set in advance under [this provision] in order to satisfy the set in advance requirement during the first 90 days of the arrangement."

85 FR 77595-96

# New Flexibility?

"Given the writing requirement in the new rule at § 411.354(d)(1)(ii) on modifying compensation during the course of an arrangement, we are qualifying this statement in the final rule. As finalized in this rule, compensation may be set in advance even if it is not set out in writing before the furnishing of items or services as long as the compensation is not modified at any time during the period the parties seek to show the compensation was set in advance. For example, assume the parties to an arrangement agree on the rate of compensation before the furnishing of items or services, but do not reduce the compensation rate to writing at that point.

# New Flexibility?

Assume further that the first payment under the arrangement is documented and that, under § 411.354(e)(4), during the 90-day period after the items or services are initially furnished, the parties compile sufficient documentation of the arrangement to satisfy the writing requirement of an applicable exception. Finally, assume that the written documentation compiled during the 90-day period provides for a rate of compensation that is consistent with the documented amount of the first payment, that is the rate of compensation was not modified during the 90-day period. Under these specific circumstances, we would consider the compensation to be set in advance…To the extent that our preamble discussion in the CY 2016 PFS final rule suggested that the rate of compensation must always be set out in writing before the furnishing of items or services in order to meet the second advance requirement of an applicable exception, we are retracting that statement." - Page 77592

# In Office Ancillary Exception

- The strongest exception: protects ownership and compensation. A silver bullet for clinics and systems.
- Allow physicians to be compensated for DHS “incident to” the physician. Health systems may want to use it!
- Has many conditions.

# “Group Practice”

- Single legal entity.
- At least 2 physicians who are group “members”.
- Each physician member provides full range of care through the group.
- Substantially all (75%) of the patient care services provided by physician members are billed in the name of the group.
- Group members must personally conduct 75% of all physician-patient encounters for the group.

# “Group Practice”

- Distribution of income and expenses determined in advance.
- Unified business, centralized decision-making.
- No compensation based on volume or value of DHS referrals (sharing overall profits or profits from a “component” of the group consisting of at least 5 physicians is o.k.).

# Concerns for Group Practices

- Do you bill as a group? If box 33 lists a physician, rather than the group name, you are NOT billing under the name of a group.
- Increasing use of professional service agreements may cause group to fail to bill in its name 75% of the services provided by the group.
- Large group practices may lack unified business and centralized decision-making.
- Compensation formulas that allocate profits from components of the group that fall below 5 physicians.

# Location, Location, Location

- Group practices can furnish services in a “centralized location.” Other physicians must be in the “same building.”
- “Centralized location” can be offsite as long as there is supervision. If anyone else bills for any DHS in the space, it is NOT a centralized location.
- The “same building” tests can be problematic unless you see patients 35 hours a week at the location/30 with a physician present.

# Location, Location, Location

- The other “same building” tests only allow you to provide DHS to patients you see primarily at that location. Medicare/caid patients from other locations can’t get DHS.
- The bottom line: DHS can be across the street, (or across town) but only if you bill for all the services there.

# Advanced Imaging Notice

- Give written notice to all MR/CT/PET pts. (E-mail is ok).
- At time of referral (i.e. NOT registration).
- Must indicate patient can go elsewhere.
- Address/phone for at least 5 “suppliers” within 25 miles. (If fewer than five, list them. If none, no notice necessary).
- Can say more; may wish to warn about insurance coverage.

# Non-Profit/Tax Exemption Issues

- “Private inurement/private benefit” occurs when a person gets an undeserved benefit from a tax exempt organization.
- Intermediate sanctions allow the IRS to recoup the money, plus penalties, from the recipient.

# Compensation or Dividend?

- Some cases have argued that the if a non-shareholder (physician/NP/PA) leaves money on the table, it must be treated as a dividend, not compensation.
- Even bigger focus on ancillaries.
- Words matter. Beware of “profit.”

# Fee Splitting

- May prohibit a physician from sharing revenues with non-physicians, and/or physicians outside of the group except on the basis of work performed.
- May be in ethical rules.
- Unusual interpretations can prohibit percentage management contracts. (See Florida).
- Notice to patients?

# Questions

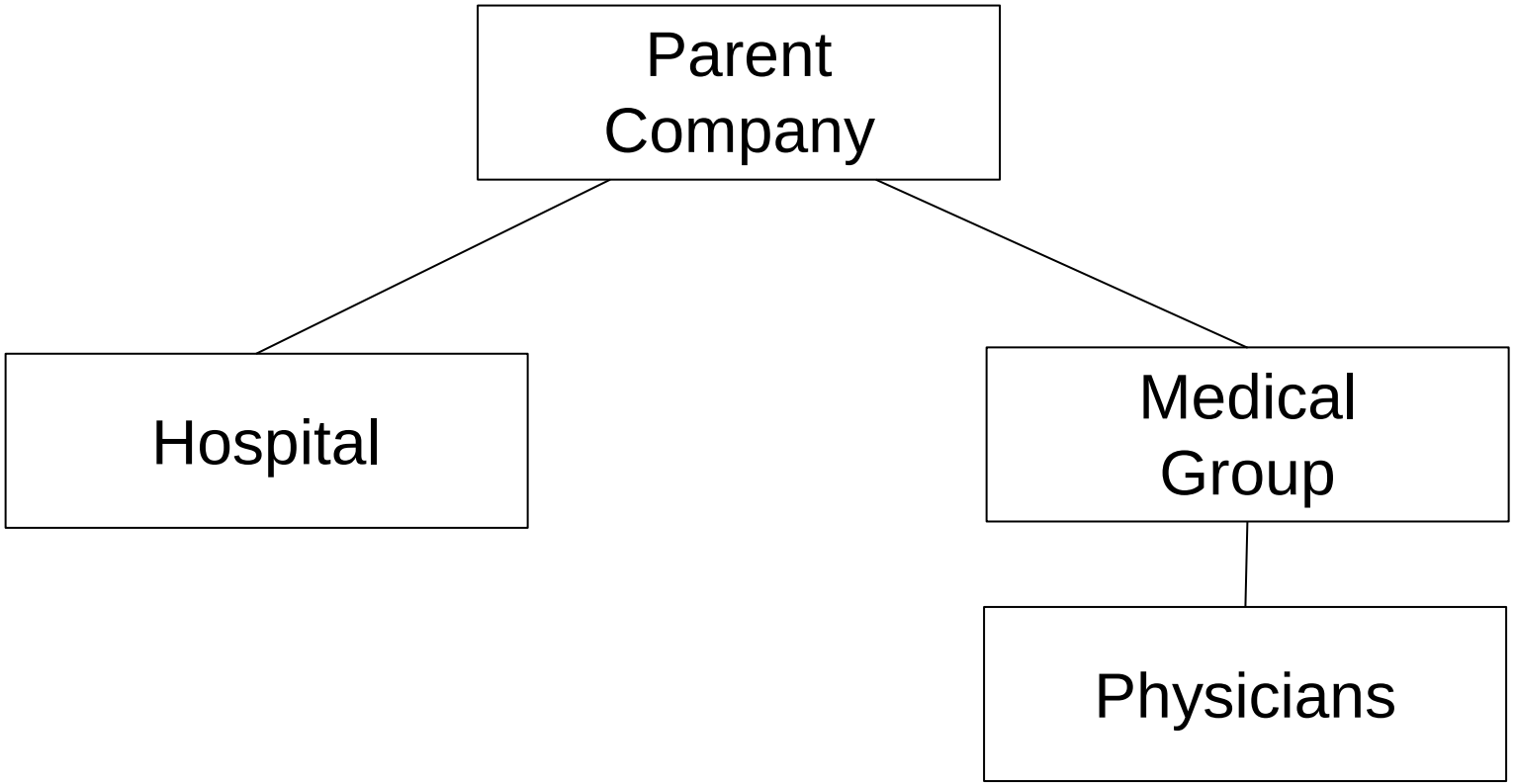
- Can you credit a physician for supervising chemo?
- Can you credit a physician for supervising PT?
- Can an ortho group run ASC profits through its comp formula?
- Can a hospital system pay a group of physicians at FMV and let them divvy it up?
- Can you bonus a physician for a group's profitability?

# Hospitals and Employed Physicians

- Don’t need to worry about antikickback.
- Stark is huge.
- Direct or indirect compensation?

# Stark: Direct or Indirect?

- Is the entity that provides the DHS the same as the one paying the physician, or is there an “intervening entity?”
  - 42 C.F.R. § 411.354(c)(1)(i).



# Stark: Direct or Indirect?

- Is the entity that provides the DHS the same as the one paying the physician, or is there an "intervening entity?"
  - 42 C.F.R. § 411.354(c)(1)(i).
- Hospital in one entity, medical group is separate? Indirect compensation if hospital subsidizes Drs.
- If the medical group provides lab, x-ray etc. may still have direct.

# Possible Stark Exceptions

- Stark treats direct and indirect comp. differently.
- Comp. from a medical group to the physician is direct and should meet the employment exception.
- Comp. (subsidies and other payments) from other medical system entities must meet the indirect compensation exception, if it is indirect comp.

# Employment Exception

- “Identifiable” services.
- Consistent with FMV and not determined in a manner that takes into account directly or indirectly the volume or value of any referrals.
- Commercially reasonable even if no referrals.
- Productivity bonus for personally-performed services okay. (Can’t credit for incident to DHS. You can credit for OTHER incident to).
- Need not be written!

# Indirect Comp: Plain English

- Does the payment “take into account” the volume or value of referrals?
- Mathematical question, but also a metaphysical one.

# Indirect Compensation Requires:

(i) Between the referring physician (or a member of his or her immediate family) and the entity furnishing DHS there exists an unbroken chain of any number (but not fewer than one) of persons or entities that have financial relationships…between them (that is, each link in the chain has either an ownership or investment interest or a compensation arrangement with the preceding link);

**(ii) The referring physician (or immediate family member) receives aggregate compensation from the person or entity in the chain with which the physician (or immediate family member) has a direct financial relationship that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS…; and**

(iii) **The entity furnishing DHS has actual knowledge** of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) receives aggregate compensation that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS.

– 42 C.F.R. § 411.354(c)(2).

# Stark: Burden of Proof

- The government will have the burden of proving that the compensation meets the definition of indirect compensation.
- “Once the government has established the proof of each element of a violation under the Act, the burden shifts to the defendant to establish that the conduct was protected by an exception.” *U.S. ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88, 95 (3d Cir. 2009).

# Things to Note

- Government must prove all three.
- “Referral” very specific: “a request by a physician for, or ordering of, DHS.” 42 CFR § 411.351
- Only referrals/business (i.e. in/outpatient services) from physicians to hospitals matter. Professional services irrelevant.
- “Fair market value” does not appear.

# Indirect Compensation: *Tuomey* Instruction

"An indirect compensation arrangement means that the referring physician receives aggregate compensation from the entity in the chain with which the physician has a direct financial relationship that varies with, or otherwise takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing services."

# Indirect Compensation Exception

- Consistent with FMV and not determined in a manner that takes into account directly or indirectly the volume or value of any referrals.*
- Commercially reasonable even if no referrals are made to the hospital.
- In writing, signed by the parties, specifying the services covered by the arrangement.
  - Except bona fide employment relationship (must be for identifiable services & commercially reasonable if no referrals, but needn't be written).
- Does not violate AKS.

* huh??

# Indirect Comp Exception

**(1) (i)** The compensation received by the referring physician (or immediate family member) described in § 411.354(c)(2)(ii) is fair market value for services and items actually provided and not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician for the entity furnishing DHS.

**(ii)** Compensation for the rental of office space or equipment may not be determined using a formula based on—

**(A)** A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the office space or to the services performed on or business generated through the use of the equipment; or

# Indirect Comp Exception

**(B)** Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee

**(2)** The compensation arrangement described in § 411.354(c)(2)(ii) is set out in writing, signed by the parties, and specifies the services covered by the arrangement, except in the case of a bona fide employment relationship between an employer and an employee, in which case the arrangement need not be set out in writing, but must be for identifiable services and be commercially reasonable even if no referrals are made to the employer.

**(3)** The compensation arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

42 CFR § 411.357(p)

# “Takes into account”

“Accordingly, the question, which should properly be put to a jury, is whether the contracts, on their face, took into account the value or volume of anticipated referrals. As the Stark Regulations and the agency commentary indicate, compensation arrangements that take into account anticipated referrals do not meet the fair market value standard. Thus, it is for the jury to determine whether the contracts violated the fair market value standard by taking into account anticipated referrals in computing the physicians’ compensation.” *Tuomey I*, 675 F.3d 394, 409 (4th Cir. 2009), underlining added.

# How Is Compensation Sliced?

- 42 CFR § 411.354(c)(2)(ii) states that indirect compensation arrangements examine "**aggregate** compensation from the person or entity in the chain with which the physician (or immediate family member) has a direct financial relationship."
- Compensation is considered in its entirety (aggregate).
- There is no temporal demarcation.

# Death of Common Sense (and Math)?

- Survey says?
  - Is 50th percentile a ceiling? What about 75th? 90th?
- Conventional wisdom in this area is awful. True analysis seems rare.
- FMV is supposed to ignore presence of referrals. Is that even possible?

# Surveying the Environment

- Meghan Wong at MGMA has explained "the data are not intended to be used as an academic data set for extrapolating to the U.S. population of physicians," and are not a "one-to-one representation of the universe of medical practices that are in the country.”*
- High and low responses are thrown out.

*Thanks to Tim Smith, Ankura Consulting, and Forthcoming BVR/AHLA Guide to Valuing Physician Compensation and Healthcare Service Arrangements

# Surveying the Environment

- Do people understand “total compensation?”
- Is there an inverse relationship between productivity and per RVU compensation?
- Do groups comply with the “professional data only, no technical fees” request?

# Analyze This

- 90th Percentile Interv. Card. CF in 2012:
  - AMGA: $102.06 MGMA: $86.47
- 90th Percentile RVU IC.:
  - 2009 16,758
  - 2010 18,316
  - 2011 16,136
  - 2012 15,208 (20% swing from 2010!)

# “We Lose Money on Every Physician.”

- If true, is this a problem?
- Is it true?
  - How is overhead calculated and allocated?
  - How is revenue allocated?
- What about ancillaries?

# Presenter

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