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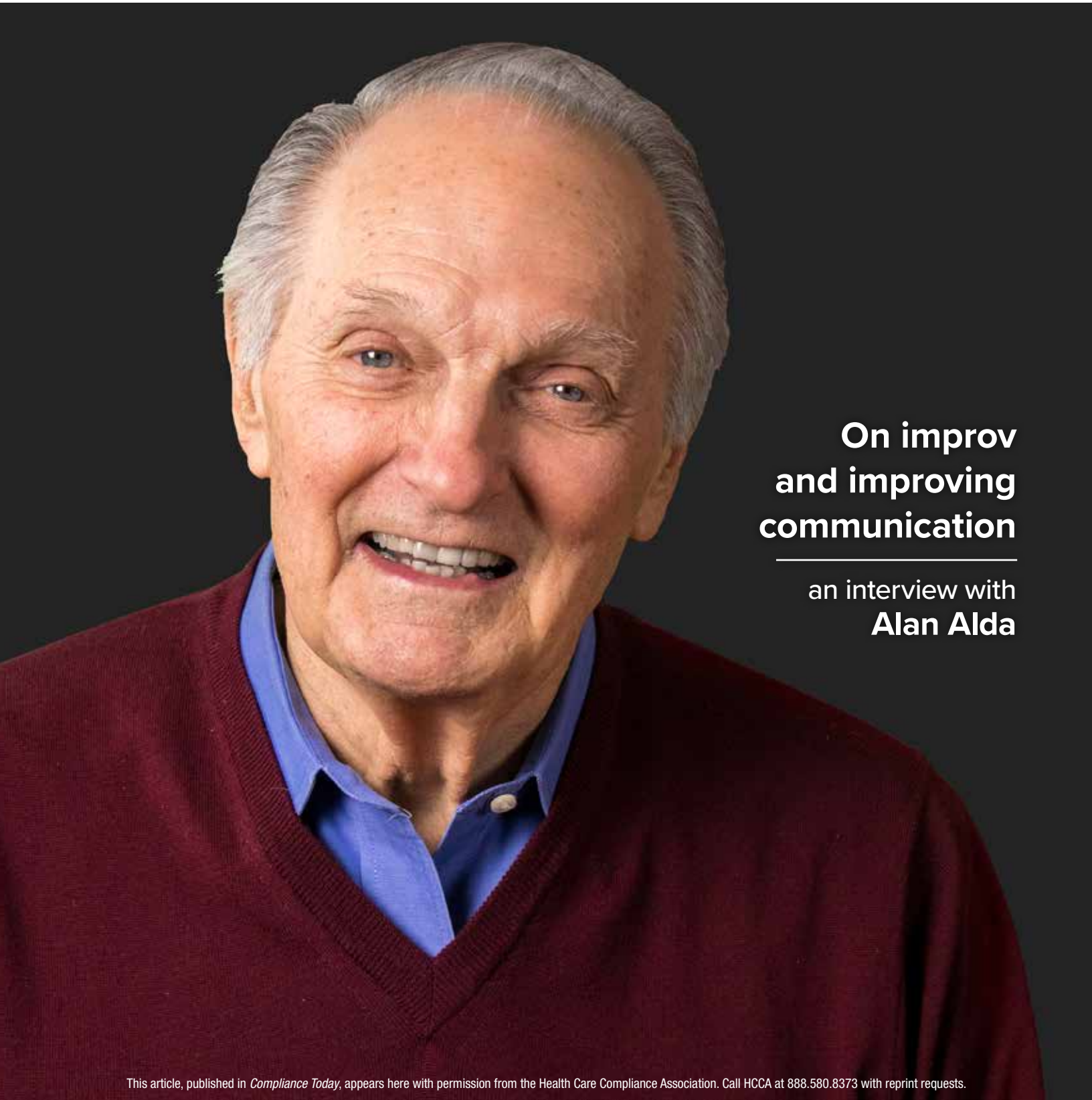

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by Bartt B. Warner, CVA and Thomas A. Warrington, Jr., CVA

Stacked physician compensation: Keys to compliance

» Compensation paid to physicians is under constant scrutiny as the number of healthcare settlements continues to rise both in number and in settlement awards.

» Compensation paid to a physician must be commercially reasonable, consistent with fair market value (FMV), and not in violation of other laws and regulations designed to prevent fraud and abuse.

» Stacked compensation refers to taking the individual components of a physician compensation arrangement and adding them up to derive total compensation.

» If each individual component is consistent with FMV, that does not automatically mean the total stacked compensation is as well.

» By thinking through each component of a physician's agreement and asking the appropriate questions, hospitals and health systems can reduce the risk of enforcement actions for their physician arrangements.

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Compensation paid to physicians is under constant scrutiny as the number of healthcare settlements continues to rise both in number and in settlement awards. There has also been a shift by *qui tam* relators and the government to include both physicians and medical practices in enforcement action cases. Recent settlements have demonstrated the severe financial implications of improper financial relationships as shown in the Table 1 on page 36.

Staying within the law

But what does all this mean? The answer is that any compensation paid to a physician must meet several requirements. It must be commercially reasonable. In the preamble to the Stark Phase II interim final rule, CMS defined *commercially reasonable* as:

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> [A]n arrangement will be considered commercially reasonable in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential designated health services referrals.[3]

Physician compensation must also be consistent with fair market value (FMV).

Table 1: 2015 & 2016 Notable Healthcare Settlement Summary

2015 & 2016 Notable Healthcare Settlement Summary			
Year	**System**	**Settlement Reason**	**Amount**
2015	Citizens Medical Center[1]	Civil FCA allegations that it engaged in improper financial relationships with referring physicians.	$21.8 Million
2015	North Broward Hospital District[1]	Civil FCA allegations that it engaged in improper financial relationships with referring physicians.	$69.5 Million
2015	Columbus Regional Healthcare System[1]	Civil FCA allegations that they submitted claims to federal health care programs that violated the Stark Law and that misrepresented the level of services they provided.	$35 Million
2015	Tuomey Healthcare System[1]	Civil FCA judgment entered against it for illegally billing the Medicare program for services referred by physicians with whom the hospital had improper financial relationships.	$72.4 Million
2015	Tuomey Healthcare System[2]	Former Tuomey Healthcare System CEO (Ralph Cox) - illegal referrals	$1 Million
2015	Memorial Health, Inc., Memorial Health University Medical Center, Inc., Provident Health Services, Inc., and Memorial Health University Physicians[2]	Civil FCA allegations that they engaged in improper financial relationships with referring physicians that violated the Stark Law.	$9.9 Million
2016	Tenet Healthcare Corp. (Tenet)[2]	Allegations of illegal kickbacks paid to clinic owners in exchange for referring patients for labor and delivery to Tenet hospitals.	$514 Million
2016	Lexington Medical Center[2]	Hospital overpaid physicians and rewarded them based on their referral of patients to the facility.	$17 Million

According to the International Glossary of Business Valuation Terms, *fair market value* is defined as:

> The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms-length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.[4]

Compensation paid to physicians must not be in violation of the Stark Law. According to the Office of Inspector General, "The Stark Law (42 USC § 1395nn) prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies."[5]

The Anti-Kickback Statute (AKS) also figures into physician compensation. According to the Office of Inspector General, "The Anti-Kickback Statute (42 USC § 1320a-7b(b)) prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business."[6]

And finally, physician compensation must not trigger the False Claims Act,[7] and other regulations designed to prevent fraud and abuse. According to the Office of Inspector General, "The False Claims Act (31 U.S.C. §§ 3729–3733) prohibits the submission of false or fraudulent claims to the Government."

Thus, it is crucial to understand the entire compensation package being paid to a physician in addition to the individual components.

Stacked compensation

As the number of employed physicians increases and hospitals and health systems look for alignment strategies based on quality, the issue of "stacked" compensation is becoming more prevalent. Stacked compensation refers to taking the individual components of a physician compensation arrangement and adding them up to derive total compensation. For example, it is not uncommon for physicians to be paid for call coverage, clinical services, medical director/physician executive

services, quality, advance practice clinician oversight, and/or academic teaching and proctoring, among others. However, even if each individual component is consistent with FMV, does that automatically mean the total stacked compensation is as well? This is a crucial issue that must be considered by legal counsel and the compliance team when looking at complex compensation arrangements.

Keys to compliance

When looking at stacked compensation, one should focus on the following items to ensure compliance and understand if the arrangement is consistent with FMV:

1. Are each of the individual components consistent with FMV and how was this determined?
   - Internal process by the hospital or health system. This method does not guarantee consistency with FMV, however, internal processes may be appropriate for low-risk arrangements.
   - Independent third-party valuation. The government has shown preference for this method.[8]
2. Is the arrangement and each component commercially reasonable?
   - Arrangement must make business sense absent consideration for referrals. This is the "why" of the arrangement.
3. Does the compensation arrangement comply with the healthcare laws and regulations?
4. Have you confirmed that the arrangement is not based on the volume or value of the physician's referrals?
5. Are the benefits and paid time off (PTO) package reasonable and consistent with industry norms?
6. One-time payments and bonuses such as signing, commencement, retention, relocation and various other bonuses are becoming more and more prevalent. Have these payments been considered when analyzing the total compensation paid to the physician?
7. Has the compensation package been tested using reasonability tests? In addition, have sensitivity models been performed/analyzed at various levels of productivity for physicians receiving productivity-based compensation?
8. How does the compensation compare to what other physicians in the same specialty receive in the market?
9. Are the overall hours reasonable and can the hours be worked without adversely affecting performance and/or other components?
10. Are each of the services separate and distinct, and are items paid on an hourly basis being tracked/documented?

According to Joseph N. Wolfe, Esq., the first three bullet points are crucial to defensibility in court. In addition, "Because these tenets of defensibility are found in most exceptions, physician compensation policies and procedures should take special care to document compliance with these three tenets, regardless of the exception that is ultimately relied upon."[9]

Real world example

To fully understand this concept, let us look at real example of a pediatric surgeon employed by a large health system (see Table 2 on page 38):

At first glance, one may intuitively assume this physician is overpaid due to the high annual base guarantee. However, it is imperative to benchmark all metrics when analyzing the physician compensation to understand if the components are reasonably aligned. What Table 2 does not show is that this physician currently produces above the 90th percentile of market surveys for both work relative value

Table 2: Example of compensation for a highly productive pediatric physician

Example: Highly Productive Pediatric Surgeon			
Compensation Component	**Notes**	**Compensation**	**Estimated Annual Hours**
Annual Base Guarantee	Base Guarantee or $75 per WRVU	$800,000	2,000
Quality Incentive	Outcome based metrics	$50,000	n/a
Medical Director	$175 per hour up to 240 hours per year	$42,000	240
Call Coverage Compensation (1:5 Rotation)	Required to provide five (5) days per month uncompensated. Paid $1,000 per 24 hour shift after day five (5). Physician provides two (2) additional days per month.	$24,000	576
Total		**$916,000**	**2,816**

WRVU = Work relative value units (a method for calculating the volume of work or effort expended)

units (WRVU) and professional collections. As a result, the compensation is *potentially* consistent with FMV. However, in situations such as these, FMV assessments are always recommended to ensure compliance. In addition, the hours listed above may warrant additional review to ensure the physician can reasonably work the hours and to confirm the physician is not receiving multiple streams of income during the same hour of service.

Practical takeaways

1. Create a documented compliance program and ensure triggers are in place to determine when/if a valuation/FMV assessment is needed.
2. Analyze total hours worked and ask if it is reasonable for the physician to be paid for that amount of hours. Also, can the physician reasonably perform this amount of workload without negatively impacting other areas of the physician's practice?
3. Review each compensation component in the agreement to ensure the physician is not receiving multiple streams of income during the same hours worked. For example, a minimum amount of hours are required for physicians receiving base salaries. In essence, this time has already been paid for.
4. A highly productive physician will likely warrant a compensation-per-WRVU rate at or below the median percentile. (Note: An inverse relationship exists between compensation and compensation per WRVU—higher producing/earning physicians will indicate a lower compensation per WRVU.) Ensure benchmarking analyses are performed and review to see if compensation and productivity are reasonably aligned.
5. Review and document any instances of physician practice losses. It is important to detail why the losses are occurring. For example, when hospitals purchase physician practices, it is not uncommon for general overhead to be allocated to the physician practice profit and loss statement, which creates a loss on paper. In addition, many health systems will strip out the ancillary services post-transaction and move these services to the hospital. The loss of this technical revenue stream may result in physician practice losses. Another factor, which can create physician losses, is many health systems will negotiate stronger payer contracts for the hospital, while accepting lower rates for outpatient physician services. Each of these are the result of decisions the

hospital/health system makes as the owner of the physician practice, but may result in losses being implied at the physician practice level. Documentation is crucial for compliance.

6. Perform routine audits to understand if the services are still needed, hours are being effectively tracked, and compensation is being paid in accordance with the agreement. For example, a new hospital service-line medical director may be required to provide a certain number of hours per week or month while getting the program started. However, once the program is up and running, the time requirements may not be as burdensome and may need to be reduced. In addition, if the physician can earn compensation through quality incentives, those metrics should continually be reviewed to ensure they are appropriately structured to achieve the desired quality outcomes.
7. Document non-referral business rationale supporting compensation arrangements.

Conclusion

The government has made it clear that healthcare organizations face large potential penalties for violations of healthcare laws and regulations. Therefore, it is imperative to ensure all physician compensation arrangements are consistent with FMV, both individually and in aggregate. By thinking through each component of a physician's agreement and asking the appropriate questions, hospitals and health systems can reduce the risk of enforcement actions for their physician arrangements.

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