203. The Myth(s) of Median to 75th: New Perspectives on Assessing, Managing and Monitoring Physician Compensation Arrangement Risk

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Topics For Today's Presentation

- Impact of USA ex rel. Bookwalter v. UPMC 938 F.3d 397 (3d Cir. September 17, 2019): Stark exceptions are "affirmative defenses"
  - burden of proof on the hospital "to prove that an exception applies"(at 405)
  - Compensation above fair market value "can suggest that the compensation is really for referrals."(at 411)
- Lessons from litigated cases about improving physician compensation arrangement risk assessment process
- Strategies and resources for identifying and managing outlier arrangements at an enterprise level
- Innovative, lower cost, and more effective risk management alternatives for determining and monitoring FMV and commercial reasonableness, including tips for mitigating risks inherent in relying on survey data

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Presentation Overview

- Laws Governing Physician Compensation Arrangements
- Typical Controls Health Care Organizations Use to Manage Physician Compensation Risks
- Myth(s) Of Median To 75th: Weaknesses And Failures Of Typical Approaches
- Strategies to Improve Effectiveness of Controls and Enhance Success of Risk Mitigation Efforts

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LAWS GOVERNING PHYSICIAN COMPENSATION ARRANGEMENTS

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Reasonable Compensation and Fair Market Value: "One Country, Two Systems"

- Nonprofit Health Systems must comply with two legal systems regarding employee compensation
  1. the world of IRS 990 (Part VI, Question 15)CEOs, other officers and key employees
  2. the Stark and Anti-Kickback Laws that pertain to physicians with a bona fide employment relationship

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Reasonable Compensation in the IRS 990 World

Question 15 *(2019 Instructions at IRS.gov)*

- Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?
  A. The Organization's CEO, Executive Director, or top management official?
  B. Other officers or key employees of the organization
- If yes, describe the process in Schedule O (see instructions)

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Reasonable Compensation in the IRS 990 World

- Answer "yes" "if, during the tax year, the organization (not a related organization or other third party) used a process for determining compensation…of the CEO, executive director, or other person who is the top management official, that **included all of the following elements:**
  - Review and approval by a governing body or compensation committee
  - Contemporaneous documentation and recordkeeping for deliberations and decisions regarding the compensation arrangement
  - No person with a conflict of interest regarding the compensation arrangement may be involved in the review

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"No person with a conflict of interest regarding the compensation arrangement may be involved in the review"

- The committee member or a family member is participating in or economically benefitting from the arrangement
- The member is in an employment arrangement subject to the direction or control of any person participating in or economically benefitting from the comp arrangement
- The member receives compensation…subject to the approval by any person participating in or economically benefitting from the compensation arrangement
- The member has a material financial interest affected by the compensation arrangement
- The member approves a transaction providing economic benefits to any person participating in the compensation arrangement, who in turn has approved or will approve a transaction providing economic benefits to the member

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Physicians as "key employees" or "five highest compensated employees"

- Answer "Yes" on line 15b if the process for determining compensation of one or more officers or **key employees** other than the top management official included all of the elements listed above.
- If the answer was "Yes" on line 15a or 15b, describe the process on Schedule O (Form 990 or 990-EZ), identify the offices or positions for which the process was used to establish compensation of the persons who served in those offices or positions, and enter the year in which this process was last undertaken for each such person.
- https://taxmap.irs.gov/taxmap2016/instr2/i990-020.htm

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Key Employees

- Employees who manage a discrete segment or activity of the organization that represents 10 percent or more of the organization's assets, income, activities or expenses, or whether they have authority to control or determine 10 percent or more of the organization's capital expenditures, operating budget or employee compensation

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Physicians as Five Highest Compensated Employees

Report on 990 at Section VII

- Five current highest compensated employees with reportable compensation of at least $100,000 from the organization and related organizations who are not officers, directors, trustees, or key employees of the organization

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Schedule O-

- Describe the process for determining compensation, in response to Lines 15a and b
- For officers, directors, and key employees
- No specific requirement for five highest compensated employees (yet)

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Stark: "Commercially reasonable"

- An 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…of similar scope and specialty, even if there were no potential DHS [designated health services] referrals
- Medicare Program: Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II) Interim Final Rule,'' Federal Register, Vol. 69, No. 59 (March 26, 2004), 16093

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STARK AND FALSE CLAIMS ACT: SYSTEMATICALLY IMPROPER COMPENSATION ARRANGEMENTS

- "To bolster even further its allegations that Wheeling Hospital **systematically** entered into improper compensation agreements, the Complaint describes with specificity a spreadsheet created by the hospital in 2012 that detailed the compensation terms for all of the hospital's employed physicians at that time."
- **UNITED STATES EX REL. LONGO v. WHEELING HOSPITAL, INC., Dist. Court, ND West Virginia 2019**

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DOJ RELEASE SEPTEMBER 9, 2020

- **West Virginia Hospital Agrees to Pay $50 Million to Settle Allegations Concerning Improper Compensation to Referring Physicians**
- ". . . the United States alleged that, from 2007 to 2020, under the direction and control of its prior management, R&V Associates, Ltd. and Ronald Violi, Wheeling Hospital **systematically** violated the Stark Law and Anti-Kickback Statute by knowingly and willfully paying improper compensation to referring physicians that was based on the volume or value of the physicians' referrals or was above fair market value"

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SAMPLE IRS 990-Wheeling Hospital (FYE 9/18)

- Part VII- 5 highest compensated employees
- D.B. (cardiology) $1.541 million
- G.M.(urologic oncology) $1.301 million
- J.P. (radiation oncology) $1.179 million
- C.S. (ob/gyn) $1.069 million
- V.M. (cardiothoracic surgeon) $868,000
  - Key employee CFO $333,364
  - Key employee CMO $531,061

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SAMPLE IRS 990: UPMC

- Bookwalter v. UPMC was about neurosurgery wRVUs
- UPMC Part VII- 5 highest compensated employees-No Neurosurgeons
  - Orthopedic surgeon -$2.273 million
  - Transplant surgeon-$2.130 million
  - Cardiothoracic surgeon-$2.092 million
  - Orthopedic surgeon-$1.596 million
  - Orthopedic surgeon-$1.576 million
    - Key employee(general counsel)$1.764 million
    - EVP and chief medical officer $1.821 million

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SCHEDULE J Questions Regarding Compensation

- Question 1a (other benefits)
  - First class or charter travel
  - Travel for companions
  - Tax indemnification and gross-up payments
  - Health or social club dues
  - Follow written policy regarding payment or reimbursement? yes
  - Question 3-techniques to establish comp for executive director
  - Part II-base comp/bonus and incentive comp
  - Free text: “rebuttable presumption of reasonableness procedures” under IRS regs-53.498-6(c)

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Allegations in DOJ Wheeling Hospital Case

"Systemic" Problems with Physician Compensation

- Hospital sought to and did gain market share, primarily as a result of referrals from highly compensated physicians
- Strategically targeted physicians with high patient volumes through employment and other agreements to maintain/gain referrals
- Excessive compensation to physicians that were considered most profitable to hospital, and also to physicians not generating referrals (e.g., diagnostic radiologists, radiation oncologists)
- When hospital learned of potential overpayments, it found ways to justify payments in order to avoid the risk of losing referrals

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Allegations in DOJ Wheeling Hospital Case
(continued)

- Matching private practice income in employment not appropriate
- Exceptions to standard review processes made for some highly paid physicians
- Selective disregard for losses in specialties that generated referrals
- CEO allowed improper arrangements established before his tenure to continue
- Internal communications on physician compensation in practices generating losses referred to protection of hospital margin

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TYPICAL CONTROLS HEALTH CARE ORGANIZATIONS USE TO MANAGE PHYSICIAN COMPENSATION RISK

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Primary Focus of Risk Management Controls: Fair Market Value (FMV)

- FMV generally evaluated through a physician-by-physician comparison to survey data
  - Pay at or below median deemed to be low risk
  - Pay between 50th and 75th percentile generally considered acceptable risk, or even presumptively FMV
- Frequent reliance on third party opinions, especially when compensation exceeds 75th or 90th percentile
- Strong preference for FMV reports to be fast, cheap, and "yes"

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Common Approaches to Assessing FMV

- Selection of approach varies case by case
- Valuation methods and data used to support FMV vary physician to physician depending on the compensation structure proposed:
  - The compensation and WRVU relationship is the only thing that matters for FMV
  - The compensation and WRVU relationship is not relevant to FMV
- Analysis of FMV is tailored to the particular arrangement – typically not a standardized approach

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Common FMV Assumptions

- Productivity-based compensation programs are "safe"
- Payment for high levels of production is low risk as long as the WRVU conversion factor is below a threshold
- "Hard to recruit" acceptable justification for higher percentile compensation
- If an external valuation opinion is on file, compensation risk has been sufficiently mitigated

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Other Risk Management Controls

- Arrangements may require "sign off" by various levels of management and executives, sometimes general counsel and/or the compliance officer
- Typically these individual receives lengthy summary forms with check boxes referencing documentation "supporting" the arrangement, sometimes the documentation is attached, but often just a summary provided
- Variability in how/if commercial reasonableness is assessed: may be delegated to third parties who have limited context and information
- Oversight committee reviews some or all arrangements with emphasis on whether compensation is supported, rather than if the risk of the arrangement overall fits matches the organizations desired risk profile

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MYTH(S) OF MEDIAN TO 75TH: WEAKNESSES AND FAILURES OF TYPICAL APPROACHES TO MANAGING PHYSICIAN COMPENSATION RISK

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4 Monumental Myths – Debunked

1. **FMV** is **the** most important consideration in risk mitigation
2. **Commercial reasonableness** can be assumed/less important if compensation within the 50th to 75th percentile
3. **Process makes perfect!** Having a documented approval process will result in consistent and effective application of controls
4. **Post-approval risk management activities** only needed for "high risk" arrangements

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Myth 1 Regarding FMV Compliance Starts and Ends with FMV

- Survey statistics are population-level observations with limited applicability to individual arrangements
- Rules of thumb are not reliable valuation methodologies; using "median to 75th" as presumptive FMV is potentially problematic
- Determination of FMV generally by executives with good reasons for wanting all arrangements to be deemed FMV
- Lack of independence among external valuation consultants: those who can't find a way to "bless" arrangements with high strategic value far less likely to be hired in the future
- Most whistleblower cases center on enterprise level challenges to commercial reasonableness, where FMV is among the allegations

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Myth 1: FMV
75th Percentile as a Bright Line Test

Question: If payment per WRVU above the 75th percentile is excessive, are the 25% of physicians in the survey that receive above 75th percentile per WRVU paid above FMV?

Answer: Physicians with the highest payment ratios tend to be the lowest producers with guaranteed compensation

- Not every doctor in the survey is a peer of every other doctor
- The least productive doctors are not peers of the most productive doctors

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Myth 1: FMV
Importance of Relevant Cohorts

- When evaluating physicians with high productivity, WRVUs are considered relevant to FMV.
- For unproductive doctors, WRVUs are disregarded; they end up receiving compensation that it is high in proportion to WRVUs
- The conundrum: If WRVUs really aren't relevant to unproductive doctors, why use benchmarks rates per wRVU when evaluating FMV of productive doctors?

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Myth 1: FMV Productivity Compensation and FMV Risk

- By including unproductive physicians in the dataset, benchmark rates per wRVU become artificially inflated
- Multiplying such inflated benchmarks by high wRVUs can result in payments greatly in excess of what similarly productive peers actually receive

Hospital Medicine: Compensation per wRVU

	All Physicians	Least Productive	Most Productive
25th percentile	$59.01	$95.76	$48.21
50th percentile	$72.86	$117.80	$55.06
75th percentile	$93.92	$152.13	$65.45

Source: 2019 MGMA Data Dive

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Myth 2: Commercial Reasonableness The More Significant and Challenging Risk

- Arguably, commercial reasonableness (CR) is the MOST important factor to consider (FMV necessary but not sufficient)
- CR isn't secondary to FMV, and cannot be presumed
- Unlike FMV, CR cannot be reduced to a quantitative conclusion using commonly accepted professional standards
- Having an FMV consultant "bless" CR provides minimal or no protection if there are subsequent adverse CR findings
- A third-party CR opinion is useful to the extent it identifies actual CR risks that inform an executable mitigation plan

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Myth 2: Commercial Reasonableness Due Diligence and Case-by-Case Reviews

- Because CR involves enterprise level concerns, addressing CR on a case-by-case basis generally isn't sufficient to identify variations in analysis
- Often physicians have multiple compensation relationships with different entities in a system (e.g., medical director, administrative leadership positions, call, etc.) but enterprise level information is rarely available to review bodies to weed out duplicative roles and duties across multiple physicians
- Selective, inconsistent, or partial approaches to assessing CR can CR create the impression of "cherry picking" support

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Myth 2: Commercial Reasonableness Don't Ask, Don't Tell Is the Norm

- Reviewers of compensation may be unaware of "other" reasons for a proposed compensation level (e.g., downstream referrals)
- Paper review does not offer opportunity for review body to ask probing questions
- No good way to track pre-arrangement communications between the parties, other business analysis performed, proper or improper factors considered in setting the compensation terms

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Myth 3: Process Alone Does Not Mitigate Risk

- Recognition in other areas of the law of physician compensation that review by **disinterested** individuals is more likely to result in comprehensive process
  - Most often individuals applying the policy, and the majority of members of committees that consider the proposed arrangements, are populated by individuals who have an interest in getting to "yes"
- Having a documented approval process does not necessary result in consistent and effective application of controls without specialized training

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Myth 3: Process Alone Does Not Mitigate Risk *(continued)*

- Case by case evaluation may result in myopic view of arrangement, and inconsistent rationale for similar arrangements
- Often the "deal is done" before it gets to the review body, and focus is on justifying an arrangement that was already negotiated
- If everyone is responsible, no one is responsible
  - The greater the number of individuals involved in reviewing and approving the arrangement the more individuals are likely to rely on their peers to have scrutinized the arrangement

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Myth 4: Upfront Controls and Retrospective Monitoring Sufficient

- Post-approval risk management activities are critical component of managing risk
- Important to have implementation process with redundancies to verify compliance with contract terms, payment terms, and conditions of any FMV opinion
- Rare that institutions have post-approval implementation monitoring
- Individuals who are involved require specialized training

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STRATEGIES TO IMPROVE EFFECTIVENESS OF CONTROLS AND ENHANCE SUCCESS OF RISK MITIGATION EFFORTS

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Observation: Risk Management Controls for Physician Compensation Differ From Other High Risk Areas

- Process owners/review bodies typically:
  - Are not disinterested parties (e.g., job performance related to successful recruitment of physicians or financial success of operations, recruiting efforts frequently originate with service line)
  - Do not have access to enterprise level data for points of comparison (e.g. break down of number of medical directors across different service lines to identify overlapping responsibilities)
  - Lack clarity regarding organizational risk tolerance
  - Are required to apply policy guidelines that are designed to allow exceptions (e.g., FMV/CR approach not always prescriptive or well defined)
  - Have not received specialized training

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Observation: Risk Management Controls for Physician Compensation Differ From Other High Risk Areas *(cont'd)*

- No structural check and balance as seen with other areas of high financial risk like coding (separate department with specialized experts (e.g., certified coders) provides process check)
- Oversight focused on retrospective validation rather than proactive standards (emphasis on whether compensation is supported, rather than if the risk of the arrangement overall fits matches the organizations desired risk profile)
- Involvement of general counsel as business partner rather than "independent" check/balance (consider ability to provide objective oversight when involved in business decision?)
- Often compliance officers do not play active role in providing oversight – oversight provided by general counsel

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Contrasting Compliance Oversight

Program Element	Coding and Documentation	Physician Compensation
Independence	By independent reviewers who have no interest in deeming all transactions proper	Review and approval by executives who want all arrangements to be deemed proper
Pattern Identification	Spot review with emphasis on identification of anomalous outlier patterns in the population	Case by case review of arrangements
Risk Priorities	Process changes based on new information regarding risk priorities	Process tends to be static
Confidential Reporting and Response	Reporting and remediation programs are well established	Suspected misconduct rarely acted on, or even reported

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Consider Inclusion of Disinterested Oversight

- Use of compensation committee that satisfies IRS standards for rebuttable presumption?
- Separation of approval from “business owners”?
- Use of subject matter experts?

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Collect and Analyze Enterprise-Level Data to Promote Comparative Analysis and Pattern Identification

- Track and monitor compensation variation within cohorts as well as across specialties/geographic markets
- Build mechanisms to monitor, report and analyze institutions risk exposure profile and outliers arrangements (e.g., what percentage of physicians paid at or above median)
- Devise mechanisms to provide enterprise level data to decision-makers, such as medical direction complement across overlapping specialties/service lines/geographic markets

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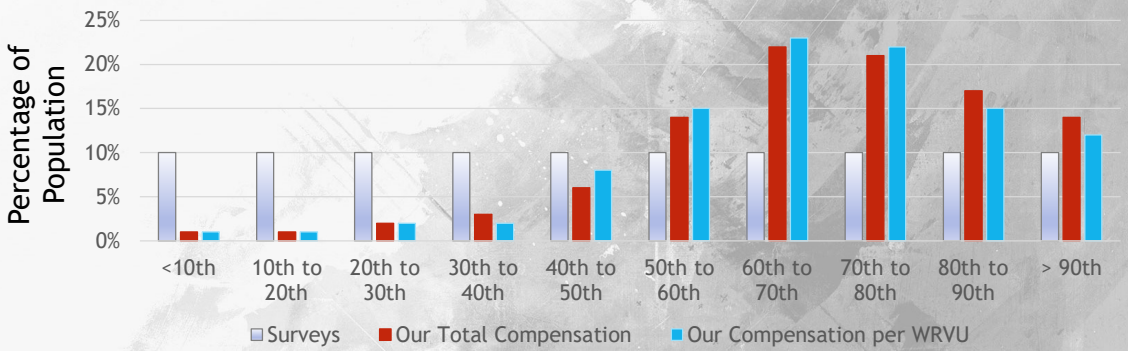
Individual Vs. Enterprise-Level Risk

- Evaluation of each agreement in isolation most common
  - Case-by-case analysis asks: "Can we justify this doctor as not being ***too much*** of an outlier?"
  - Enterprise-level comparisons can identify problematic patterns



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Prospectively Define Process To Reflect Risk Tolerance

- Develop risk parameters that can be applied prospectively rather than determining risk toleration on case by case basis
- Institute consistent FMV methodology
- Devise standardized measures to assess commercial reasonableness
- **ASK**: Is process designed to implement the organization's code of conduct around physician relationships in manner that reflect Board-defined risk tolerance?

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Elements of CR in an Internal Assessment

- What is the "legitimate business purpose" of entering into this transaction/arrangement?
- Why is the transaction/arrangement necessary to accomplish the legitimate business purpose?
- What are the available alternatives to the transaction/ arrangement, and why is this transaction/arrangement better than the alternatives, including not entering into it?
- To the extent any terms differ from what is customary, what is the rationale for those non-standard terms?
- What reasonable performance expectations have been defined, and how will performance be monitored and verified?

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Institute Post-Approval Risk Management Activities

- Important to have implementation process with redundancies to verify compliance with contract terms, payment terms, and conditions of any FMV opinion
- Provide specialized training to individuals who are involved in providing oversight
- Devise reporting structure when issues identified
- Apply continuous process improvement principles

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Is Culture of Compliance Apparent in Process?

- Does review process promote the exercise of due diligence and critical thinking?
  - Is the deal done before it is approved?
  - Are participants truly free to say no to an arrangement?
  - Are there professional consequences to raising concerns?
- Is process designed to provide retrospective justification or promote prospective investigation and evaluation?
  - Is goal to get to "yes" to the deal or "yes" the compensation reflects our desired level of risk?

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Measure Effectiveness

- How often does approval body reject an arrangement? What is the focus of review meetings?
- Would confidential survey of those involved reveal:
  - Participants feel free to question arrangements without fear of retribution?
  - Participants actively scrutinize documentation do not rely on others in process to scrutinize documentation?
  - Do not feel adequately training/qualified to make FMV/CR decisions?
- Is there transparency in reporting to the board about *actual* risk exposure "surface area"?

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Questions?

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