

A New Take on Managing Physician Compensation Arrangements

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Stark History

- Study: Owners of scanners are more likely to order scans.
- Named for Pete Stark, D-CA.
- Original Stark: 1989. Lab only.
- Stark II: Adds 11 “designated health services.”
- Stark on Stark: “It doesn’t apply to crutches”—1995. “Repeal it”—2013.

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Mind the Gap

- 4 cases discuss Medicare Manual language from 1992 that was “written with Stark in mind.”
- The discussion relates to hospital services.
- Stark I (1989) only applied to laboratories. Hospital services were added in Stark II.

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Regulatory Framework

- Statute: § 1877 of the SSA/42 USC 1395.
- Regulations: 42 CFR 411.351-389.
- Federal Register preamble.
- Annual list of Designated Health Services (DHS) in the Medicare Physician Fee Schedule.

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The Big Picture

- If a physician (or immediate family member) has a financial relationship with an organization that provides DHS ordered by the physician, Stark applies.
- Any value will do it, needn't relate to DHS.
- Intent doesn't matter.*

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*Does Intent Matter??

“In some cases, relationships clearly will not involve a transfer of remuneration and thus will not trigger [Stark]. In others, activity might involve transfer of remuneration and there may be no readily apparent exception. We expect that questions of [this] kind will arise with some frequency. Parties may submit advisory opinion requests...”

- 72 FR 51058

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“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.
- Outpatient SLP services.

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What About the Anti-Kickback Statute?

- For employees there is the statutory employment exception: 42 USC § 1320a–7b(b)(3)(B).
- It exempts “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer).”
- Often overlooked preamble for payments within an entity.

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Anti-Kickback Inapplicable Internally

“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.”**

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

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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)

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*Note that "FMV" does not appear here at all!!

Indirect Comp: Plain English

- Does the payment “take into account” the volume or value of referrals?
- Mathematical question, but also a metaphysical one.
- FMV doesn’t appear in the definition, but courts consider “anticipated referrals” as “taking into account” referrals, and analyze FMV.

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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.”

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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 and commercially reasonable if no referrals, but need not be written).
- Does not violate Anti-Kickback Statute.

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Survey Data

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What Is the Relevance of Survey Data?

- Is there a FMV ceiling? 50th percentile? 75th? 90th?
- What is the quality of the survey data? Number, quality of respondents.
- How does call pay, medical director comp, etc. factor in?
- How to view survey data in light of all other circumstances in the case?

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69 Fed. Reg. 16054, 16067 (Mar. 26, 2004)

Terms of exception	Group practice physicians [1877(h)(4); 411.352]	Bona Fide employment [1877(e)(2); 411.357(c)]	Personal service arrangements [1877(e)(3); 411.357(d)]	Fair market value [411.357(1)]	Academic medical centers [411.355(e)]
Must compensation be "fair market value"?	No	Yes—1877(e)(2)(B)(i) ...	Yes—1877(e)(3)(A)(v).	Yes—411.357(1)(3) ..	Yes—411.355(e)(1)(ii).
Must compensation be "set in advance"?	No	No	Yes—1877(e)(3)(A)(v).	Yes—411.357(1)(3) ..	Yes—411.355(e)(1)(ii).
Scope of "volume or value" restriction.	DHS referrals—1877(h)(4)(A)(iv).	DHS referrals—1877(e)(2)(B)(ii).	DHS referrals or other business—1877(e)(3)(A)(v).	DHS referrals or other business—411.357(1)(3).	DHS referrals or other business—411.355(e)(1)(ii).
Scope of productivity bonuses allowed.	Personally performed services and "incident to", plus indirect—1877(h)(4)(B)(i).	Personally performed services—1877(e)(2).	Personally performed services—411.351 ("referral") and 411.354(d)(3).	Personally performed services—411.351 ("referral") and 411.354(d)(3).	Personally performed services—411.351 ("referral") and 411.354(d)(3).
Are overall profit shares allowed?	Yes—1877(h)(4)(B)(i)	No	No	No	No.
Written agreement required?	No	No	Yes, minimum 1 year term.	Yes (except for employment), no minimum term.	Yes, written agreement(s) or other document(s).

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?

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Real World Example

- 90th Percentile Interventional Cardiology 2012:
 AMGA: \$102.06 MGMA: \$86.47
- 90th Percentile RVU:

2009	16,758
2010	18,316
2011	16,136
2012	15,208 (20% swing from 2010!)

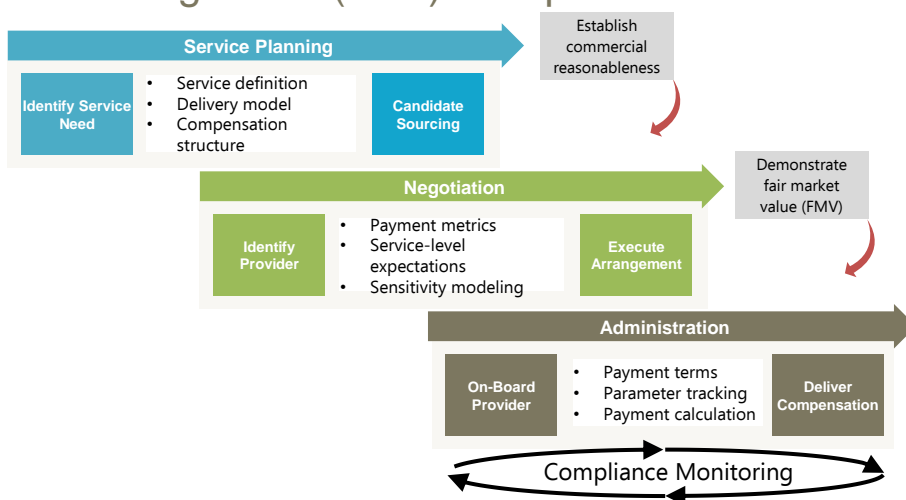
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“We Lost Money on Every Physician.”

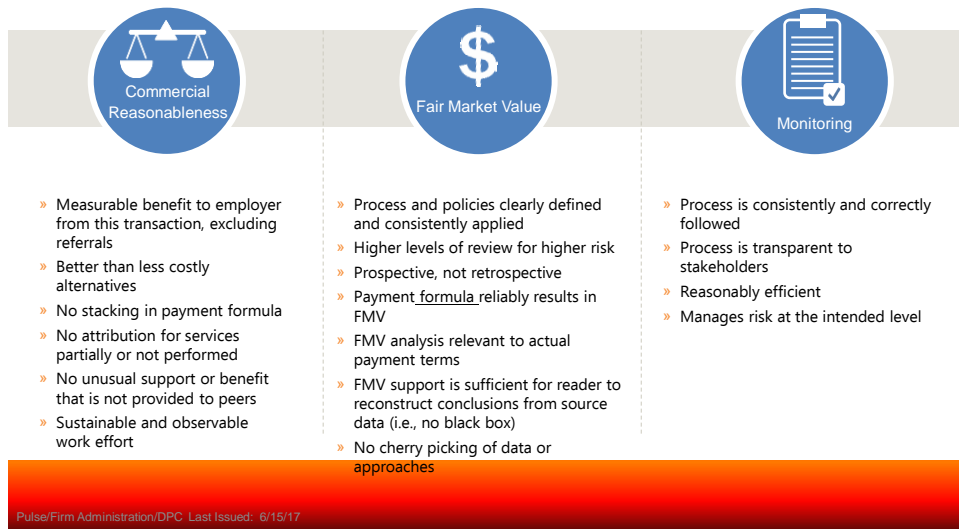
- If true, is this a problem?
- Is it true?
 - How is overhead calculated and allocated?
 - How is revenue allocated?
- What about ancillaries?

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Mapping the Physician Financial Arrangement (PFA) Compliance Process



Key Elements of PFA Compliance



Which Benchmark Percentile is FMV?

- In most tax court cases of reasonable compensation, “at market” or “consistent with benchmarks” refers to:
 - Mean or median of a relevant survey, or
 - The observed range within a custom peer group
- From the government’s expert witness in Tuomey and Halifax, Katherine McNamara:
 - As a general rule, any compensation ratio above the 50th percentile requires reasons and analysis
 - In light of survey data limitations, Ms. McNamara gave the benefit of the doubt when payment ratios were up to the 75th percentile

Reconciling the Contradiction

- How can payment ratios above the 75th percentile be outside FMV when, by definition, there will always be 25% of physicians above the 75th percentile?
- The answer lies in a widely known, but often poorly understood reality of the surveys – physicians with the highest payment ratios tend to be low 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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The Importance of Relevant Cohorts

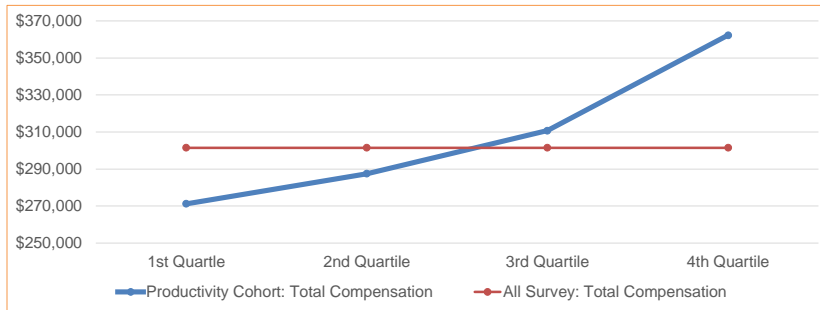
- It is widely understood that the least productive doctors are not peers of the most productive doctors when evaluating total cash compensation
- It is less known, but equally true, that the least productive doctors are also not peers of the most productive doctors when evaluating compensation ratios

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Total Cash Compensation by Productivity Cohort: Hospitalists

Most users of survey data intuitively understand that compensation paid to the least productive doctors is not relevant to the highest producing cohort. For high producers, compensation paid to low producers (and even to median producers) is not relevant. Instead, we benchmark against similarly productive peers.

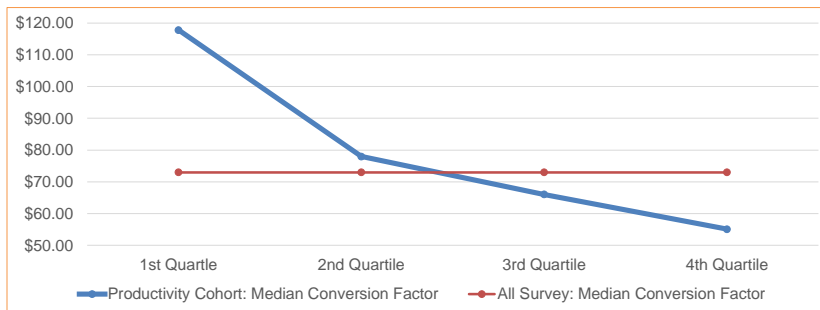


Source: MGMA Data Dive, 2019 report using 2018 data

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WRVU Conversion Factor by Productivity Cohort: Hospitalists

Likewise, the WRVU conversion factor for low producers (or even median producers) isn't relevant to high producers. In fact, the WRVU conversion factor is more differentiated among the productivity cohorts than is total cash compensation.

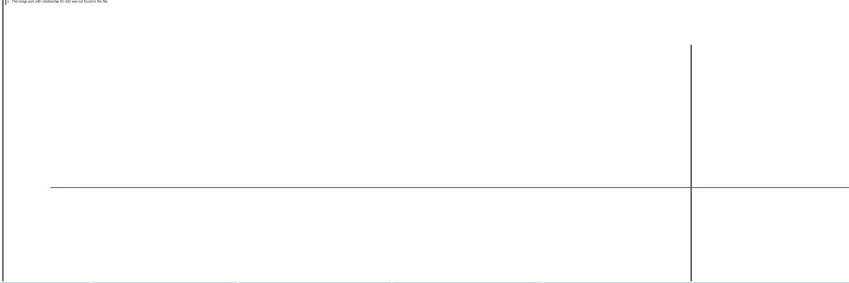


Source: MGMA Data Dive, 2019 report using 2018 data

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Productivity Cohort, Expanded View

An employer who pays \$85 per WRVU may believe they are paying below the 75th percentile. However, when this rate is extended to high producers, the resulting pay will be materially in excess of the 90th percentile of similarly productive peers.



	Quartile 1	Quartile 2	Quartile 3	Quartile 4	All Data
10 th %ile	\$78.22	\$61.52	\$52.18	\$42.90	\$50.28
25 th %ile	\$95.76	\$68.80	\$58.06	\$48.21	\$59.01
50 th %ile	\$117.80	\$77.96	\$66.00	\$55.06	\$72.96
75 th %ile	\$152.13	\$89.31	\$75.27	\$65.45	\$93.92
90 th %ile	\$212.95	\$101.95	\$85.95	\$75.82	\$133.24

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Takeaways

- A PFA compliance program based only on retrospective reviews doesn't adequately inform whether the controls are effective
- To assess the effectiveness of your controls:
 - Evaluate whether the policy and process are followed as intended
 - Confirm that the controls, when followed, actually result in physician compensation that is consistent with the organization's risk tolerance
- Recommended elements of a PFA compliance program:
 - Prospective evaluation of both commercial reasonableness and FMV
 - Testing of the compensation formula to ensure that it reliably results in FMV across the continuum of potential performance levels
 - Use median benchmark ratios (or up to the 75th percentile with analytic support) derived from relevant cohorts

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Compliance *AFTER* the Contract...

The contract is signed and we have a FMV opinion, so we're good, right?

Don't Set it and Forget it!

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Physician Compensation Policy

- **Total compensation definition:**
 - Base, incentive, call coverage, faculty and administrative compensation, plus signing and retention bonuses, student loan payments and moving expenses
- **Requirements for compensation >75th %tile:**
 - Contract Approval Committee
 - Supporting FMV and commercial reasonableness opinions (up to 2)
 - Coding audit review
 - Objective measures analysis, such as OPPE or other quality metrics
 - Consultant review of last 25 claims in accordance with national utilization criteria (for total compensation >150% of the 90th percentile benchmark rate)
 - If physician has <= 2 years' experience, compensation can never exceed 90th %tile.

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Physician Compensation Policy

- **Payment Controls**
 - President's Attestation
 - Payroll and A/P stop the line
- **Tracking Spreadsheets**
 - All payments tracked against contract terms

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Auditing and Monitoring

Monitoring – Does your agreement have:

- ☐ Medical Directorships or other types of Administrative Services? Implement timesheets and other methods for tracking/documenting that administrative services are performed. Have job descriptions or other formal documentation outlining the administrative responsibilities.
- ☐ Leased Space (Time Shares)? Audit compliance with space use. Consider audit checklists to be completed regularly by management.
- ☐ Specialty ambiguity? Ensure the specialty used to determine compensation aligns with the majority of services performed by the provider. Run a CPT report, if unsure.
- ☐ Other purchased services, staff, etc.? Ensure services or staff provided to the physician do not exceed what's in the agreement.

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Nonmonetary Compensation Policy

Non-monetary Comp Definition:

- Compensation from an entity in the form of items or services (not including cash or cash equivalents) that are subject to annual Non-Monetary Compensation Limits
- Tickets to sporting events, free car washes, holiday hams or turkeys, tickets to concerts/theatre/galas, welcome baskets, birthday gifts, holiday baskets, the non-deductible portion of attendance at a charitable event, etc.
- \$416 annual limit in 2019 – Use a log to track

Medical Staff Incidental Benefits

- Benefits an entity may confer on physicians who are members of the medical staff provided they are valued at less than the Medical Staff Incidental Benefit Compensation Limit
- Free parking, meals in the cafeteria/doctors dining, lab coats
- \$35 per occurrence max in 2019

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Compliance Reminders

- Remember that diligence is required on ALL providers (including employed providers) and ALL compensation levels
- Non-monetary compensation must be tracked
- **Issue payments in accordance with the contract terms:**
 - Have a process to verify the payment is in accordance the contract terms *at the time of payment approval*. For example, if the contract is set up to pay a group, who then disperses money to physicians, then we should not pay physicians directly
- Track total physician compensation to ensure payments do not exceed comp caps set in the agreements

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Compliance Reminders

- Document! Document! Document!
- Parties need to understand terms of agreements and how to operationalize... do not provide more or less than what is contemplated for in the agreement
- Carefully review the agreement prior to signing to ensure all compensation terms are comprehensive and accurate
- Actively monitor the agreement
- Contact Compliance and Legal as soon as an issue is identified

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Resolving Noncompliance

- Resolve issues via the written contract
- Voluntary refund
- Self-disclosure
- Look-back period of 6 years from the date the overpayment was received
- Reasonable timeframe for investigation, but don't delay or stall out

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DISCUSSION: Q&A Time



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