

Strengthening Your Organization's Physician Compensation Compliance Plan

Recent Cases Underscore Importance of Reviewing and Updating Policies and Arrangements

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Virtually all compliance plans require, or certainly should require, physician compensation to be consistent with fair market value, whether such compensation is paid to a physician employee or to a physician acting as an independent contractor under a professional services agreement. One of the main reasons why this requirement exists is to ensure compliance with the federal physician self-referral statute (commonly referred to as the "Stark law") and other regulatory requirements. Many organizations go a step further and set specific requirements as to how the organization is to determine and document that compensation for physician services is, in fact, consistent with fair market value.

In light of several recent settlements and court cases related to hospital-physician employment agreements and the increasing hospital/physician affiliation and transactional activity in the market, hospital and health system compliance officers should take an opportunity to review their policies related to physician compensation, specifically as it relates to fair market value and the related concept of commercial reasonableness. While many, if not most, compliance plans have a physician compensation policy in place, this article attempts to provide additional guidance as to the steps necessary to document and support amounts paid, remind those responsible for compliance of the key and common risk areas in structuring physician compensation, ensure that timely and consistent reviews of physician arrangements occur as part of the compliance program auditing



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and monitoring activities, and encourage the establishment or enforcement of policies that require an administrator to seek outside advice for arrangements that meet certain criteria.

REVIEW OF RECENT COURT CASES AND SETTLEMENTS

In 2009, Covenant Medical Center in Waterloo, Iowa, paid \$4.5 million to settle a False Claims Act case in which the government contended that the hospital had paid five of its employed physician specialists in excess of fair market value. In addition to being paid more than the hospital's other physicians, these doctors were allegedly among the highest paid hospital-employed physicians in the entire United States. While the hospital maintained that compensation to the physicians was consistent with its approved compensation plan and was in line with each physician's productivity, the government's investigation ultimately led prosecutors to the conclusion that Covenant was paying physicians for referrals, in violation of the Stark law.

Also in 2009, the University of Medicine and Dentistry of New Jersey (UMDNJ) paid \$8.3 million to resolve Justice Department claims that it had been operating a kick-back scheme with community cardiologists under which it paid for referrals to stave off

declining cardiac volumes, which threatened the hospital's Level I Trauma Center designation. According to the government, UMDNJ hired the physicians as part-time clinical professors under an agreement that would pay them up to \$150,000 each year for work including teaching, call coverage, and research support. The government alleged, however, that the physicians were paid despite spending minimal time providing services at the hospital. Ultimately, in addition to the charges against UMDNJ, the government also sought damages from the physicians, two of whom ultimately pleaded guilty to criminal embezzlement.

At times, it can be easy to read the details of cases like these and think that they represent extreme situations and that the arrangements in place at one's own facility do not raise the same risk. Experience indicates, however, that it is not uncommon for organizations to have arrangements that may have some of the same characteristics, have not been thoroughly vetted for fair market value, have not been reviewed for many years, or have been driven based on not wanting to lose the physicians to a competitor. All of these issues can create significant risk.

The government has continued to pursue legal action against health care organizations that it deems to have unlawful physi-

Figure 1: National Weighted Average Annual Cash Compensation by Specialty*

Specialty	25th Percentile	Median	75th Percentile	90th Percentile
Anesthesiology	\$326,000	\$394,000	\$456,000	\$534,000
Family Practice	\$158,000	\$191,000	\$235,000	\$290,000
Gastroenterology	\$328,000	\$417,000	\$529,000	\$668,000
General Pediatrics	\$158,000	\$195,000	\$253,000	\$320,000
General Surgery	\$271,000	\$336,000	\$424,000	\$533,000
Hospital Medicine	\$186,000	\$209,000	\$241,000	\$288,000
Internal Medicine	\$166,000	\$200,000	\$247,000	\$306,000
Obstetrics/Gynecology	\$226,000	\$276,000	\$352,000	\$453,000

* The values in this table were calculated by taking the national total cash compensation benchmarks reported at each percentile in the physician compensation surveys published by Medical Group Management Association, Sullivan Cotter & Associates, and American Medical Group Association for 2010 and weighting by the number of respondents for each specialty in each survey.

cian compensation arrangements. An ongoing lawsuit against Tuomey Healthcare System is probably the most widely discussed case regarding payments to part-time physician employees. Several surgeons, who were employed by Tuomey, were paid only when they operated at the hospital's outpatient surgery center. This arrangement was allegedly established by Tuomey to deter the physicians from referring patients to a new competing surgery center.

Because the physicians' compensation from Tuomey was deemed to consider the "value" or "volume" of referrals and was greater than amounts collected from patients and third-party payors for the professional services performed by the physicians, the government argued that the physicians' compensation was excessive (*i.e.*, above fair market value) and was thus in violation of the Stark law. In early 2010, a jury agreed, and the trial judge ordered Tuomey to pay the government a penalty of \$44.9 million plus interest. This decision is being appealed by the health system, and the government is separately pursuing a new trial, seeking a total of \$227.5 million under the False Claims Act.

If nothing else, these cases, and the significant price tags attached to them, should cause compliance officers to take note of their current physician employment compensation compliance plans, particularly as they relate to commercial reasonableness, fair market value, and policies to

ensure that all compensation paid to employed and otherwise engaged physicians meets both standards.

DEFINING COMMERCIAL REASONABLENESS AND FAIR MARKET VALUE

In order to limit conflicts of interest in patient care decisions, the Stark law prohibits physicians from referring patients for certain "designated health services" to hospitals or health systems with which the physician (or a physician's family member) has a "financial relationship," unless an exception applies. While physician employment and other personal services arrangements are clearly financial relationships, such arrangements are permissible under the Stark law and will satisfy an exception, as long as they meet certain conditions:

- the services that will be provided by the physician must be identifiable;
- the amount of compensation to the physician under the arrangement must be consistent with the fair market value of these services and, except for certain productivity bonus arrangements, must not take into account the volume or value of any referrals made by the physician; and
- the compensation must be commercially reasonable, even if no referrals are made by the physician to the hospital or health system.

The Stark law's definition of fair market value is as follows:

Figure 2: Potential Issue Created by Use of Compensation per wRVU Benchmarks in Compensation Calculation

Specialty	Physician wRVUs	75th Percentile Comp. per wRVU Benchmark	Comp. Calculated Using wRVUs and Benchmark	For Comparison, 90th Percentile Comp. Benchmark	Calculated Comp. as a Percentage of 90th Percentile Benchmark
Internal Medicine	7,214	\$50	\$359,009	\$316,038	113.6%
General Cardiology	12,450	\$70	\$868,245	\$637,929	136.1%
Hematology / Oncology	7,905	\$103	\$816,194	\$783,651	104.2%

Fair market value means the value in arm's-length transactions, consistent with the general market value. General market value means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the agreement.¹

A hospital-physician arrangement is generally considered commercially reasonable under the Stark law if the arrangement would make commercial sense if entered into by a reasonable hospital or health system of similar type and size and a reasonable physician of similar scope and specialty, even if no referrals were made between the parties.

The remainder of this article will focus on actionable recommendations for strengthening your organization's compliance plan to ensure that the commercial reasonableness and fair market value of every physician arrangement is determined and well documented. Doing so is one of the best ways to avoid expensive litigation and penalties such as those described above.

DETERMINING AND DOCUMENTING COMMERCIAL REASONABLENESS

Because commercial reasonableness, as defined by the Stark law, is based on the concept of "making commercial sense," documenting the commercial reasonableness of an arrangement can be a fairly complicated process. That said, regulators have begun to challenge hospitals and health systems not just on the value

of compensation arrangements but also on whether or not such arrangements are commercially reasonable.

For instance, a hospital may be paying a surgeon a fair market value rate for medical directorship services, but the amount of hours that the facility has determined it needs to pay for may be unreasonable, or there may be a question as to whether the services are actually needed at all. These questions may arise, for example, if there is a medical director for a particular subspecialty with relatively low volume being paid for the same number of hours as a medical director for a broader service under which that subspecialty falls.

The first step in determining and documenting the commercial reasonableness of a physician arrangement is to draft a list of all of the duties that will be required of the physician under a potential employment arrangement. Administration then should evaluate the services and answer a standard set of questions to document the commercial reasonableness of the arrangement. The following are the types of questions your organization may consider:

- Are the services essential to the functioning of the organization, given its size and scope?
- Is it necessary to have a physician perform the services? If so, is it necessary for the physician to possess a certain level of specialty training to perform the services?
- Would contracting for the services help the organization meet patient needs for accessible, high-quality health care services?
- Does the arrangement incentivize the physician to provide any unnecessary services or referrals?
- What type of regular oversight will be put in place to ensure that the physician is performing the services and that there is a bona fide need to continue compensating the physician to provide the services?
- How much time and effort does this particular function require relative to other arrangements already in place?

DETERMINING AND DOCUMENTING FAIR MARKET VALUE

In addition to being commercially reasonable, the total aggregate amount of physician compensation paid under an arrangement (*i.e.*, salary, bonus, and benefits) must be consistent with fair market value. The determination of fair market value for a set of physician services can be complicated, as limited data is available with which an exact comparison can be made.

Within Stark II, Phase II, the Department of Health and Human Services provided some guidance in the form of a “safe harbor” that included a process of reviewing and averaging four compensation benchmark surveys to arrive at a fair market value hourly rate for the services of a physician within a given specialty in the organization's geographical area. Among these surveys were publications of the Medical Group Management Association, Sullivan Cotter & Associates, The Hay Group, and Watson Wyatt (now Towers Watson). While the safe harbor was removed with the publication of Stark II, Phase III, the safe harbor provides a potential start for documenting fair market value in a manner that regulators can draw reference to previously published regulatory guidance.

Figure 1 includes some examples of the weighted average national benchmarks for total cash compensation (*i.e.*, not inclusive of benefits) for several specialties.

The rates for each of the specialties shown in Figure 1 reflect benchmarks derived from several hundred, or several thousand, physician responses. In some circumstances, the survey data for a given specialty or subspecialty may be fairly limited. In these cases, the surveys should be supplemented by additional research, including the use of more specialized surveys, reviews of public data (*e.g.*, form 990 for not-for-profit health systems), outside advisors who may have their own data or methodologies, and/or documentation of the compensa-

tion paid for similar services at similar organizations.

Once a range of total aggregate compensation is determined for a physician's specialty, representing the compensation paid to similar physicians for similar services, the range must be refined to account for the specific circumstances of the arrangement. Refining the range is both a qualitative and quantitative exercise. In general, compensation increases as a result of a number of different factors including productivity or hours worked, level of education, leadership ability, specialized training, years of experience, reputation, and quality of work product.

That said, there are myriad factors that experienced compensation analysts take into account both quantitatively and qualitatively to arrive at supportable conclusions, which is why it is generally recommended that arrangements at higher levels of compensation, which pose the most risk, be reviewed in one way or another by an individual or organization with that type of experience. When organizations get in trouble in this area, it is often the result of having applied conclusions from one situation to another without factoring in material differences between the two arrangements.

While a major component of compensation paid to physician employees is typically related to clinical duties, many hospitals and health systems also pay for other types of activities or incentives, including call coverage and other nonclinical duties/accomplishments.

Call Coverage Compensation

With the changes in health care operations (*e.g.*, the movement of cases out of hospitals and into outpatient settings) and in the payor mix of hospital emergency departments, hospitals and health systems throughout the country are finding it necessary to compensate physicians for the provision of call coverage. Hospitals generally will pay a fixed fee

per 24-hour shift, a fixed amount when the on-call physician is required to present in the emergency department, a fixed fee per procedure for services provided to indigent patients, or a combination of the three.

In its Advisory Opinion 07-10, the Office of Inspector General (OIG) for the Department of Health and Human Services suggested that a hospital consider the following factors when determining compensation for coverage arrangements:

- the severity of illness typically encountered by that specialty in treating a patient presenting at the emergency department;
- the likelihood of having to respond when on call at the emergency department;
- the likelihood of having to respond to a request for inpatient consultative services for an uninsured patient when on call; and
- the degree of inpatient care typically required of the specialty for patients that initially present to the emergency department.

OIG's Advisory Opinion 09-05 further clarified that hospitals should be careful not to pay physicians:

- for "lost opportunity" or similarly designed payments that do not reflect bona fide lost income;
- using payment structures that compensate physicians when no identifiable services are provided;
- aggregate on-call payments that are disproportionately high compared to the physician's regular medical practice income; or
- payment structures that compensate the on-call physician for professional services for which he or she receives separate reimbursement from insurers or patients, resulting in the physician essentially being paid twice for the same service.

One commonly used methodology begins with the determination of the number of physicians required to provide the call coverage. This is not equivalent to the number of physicians on the call panel but instead is a number of full-

time equivalent physicians calculated using a discount factor to account for the fact that a physician who is on-call for 24 hours will not spend the whole 24-hour shift providing services. In a low-volume emergency department, for example, a physician may be able to maintain a full-time clinical practice while providing call coverage.

The net cost of providing the call coverage is typically the total cost per full-time equivalent physician, multiplied by the required number of full-time equivalent physicians, less the collections expected as a result of providing services to patients while on-call. This total net cost can then be apportioned according to the payment mechanism (*i.e.*, per 24-hour shift, per appearance in the emergency department, or per indigent patient).

Nonclinical Compensation

In addition to clinical compensation and call coverage, hospitals and health systems pay some physicians nonclinical compensation, including payments for medical directorships or other management services. An increasing number of organizations are also providing physicians with bonuses related to quality and other benchmarks.

While significant benchmark data is available related to total compensation, as discussed above, the data specific to nonclinical compensation is relatively limited. Certain benchmark surveys specific to administrative services are available, but the number of respondents is limited. To determine fair market value compensation, these surveys may need to be supplemented to develop a reasonable data set. With all these changes and evolutions within physician compensation, compliance officers are encouraged to look carefully at total compensation, percentages of compensation derived from nonclinical duties and incentives, and other such factors to ensure that, in the end, regardless of the various com-

ponents, an individual physician's total compensation is reasonable.

STRUCTURING FAIR MARKET VALUE-COMPLIANT PHYSICIAN COMPENSATION PLANS

Once total aggregate compensation is determined, including all of the components, the compensation should be apportioned in a manner that aligns the goals of both the health system and the providers.

A significant number of health system-based physician compensation plans use formulas that include either compensation per work relative value unit (wRVU), a commonly used measure of physician productivity, or compensation as a percentage of professional collections as a major component. Instead of using the compensation per wRVU benchmarks provided in the surveys, compensation per wRVU should be a derivative of the total aggregate compensation (with non-clinical compensation carved out, if applicable) and the expected total wRVUs.

Figure 2 shows a hypothetical example of a plan in which a health system used the 75th percentile benchmark for compensation per wRVU and ended up exceeding the 90th percentile benchmarks for total aggregate cash compensation.

The reason why this situation occurs can be partially explained by a 2009 Medical Group Management Association analysis that determined that an inverse relationship exists between both compensation and compensation per wRVU, and between wRVUs and compensation per wRVU.² That is, the more productive the physician and the more money a physician earns, the lower the compensation per wRVU. Theoretically, a physician at the median wRVU benchmark for his or her specialty could earn total compensation per wRVU above that of a physician that achieves a higher level of wRVUs as a result of the first physician having access to other forms of nonclinical compensation.

This is an incredibly common mistake being made in the market and one that can lead to compensation that is not supportable as fair market value even though it is based on publicly available, independent data. The notion that a physician deserving 75th percentile compensation should have his or her productivity-based compensation derived from something other than the 75th percentile of the compensation per wRVU benchmark is counterintuitive, no doubt.

That said, health systems, legal counsel, and outside advisors must be aware of this issue and address it early in discussions with physicians. They must present the data to support the conclusions and ensure that the physician compensation resulting from a compensation per wRVU times wRVUs produced type formula is appropriate when looking at the aggregate level of compensation for professional services being paid relative to a physician's productivity.

CONCLUSION

In conclusion, the importance of determining and documenting that physician compensation is commercially reasonable and consistent with fair market value is more important than ever. Recent cases and settlements underscore the importance of reviewing and updating, as necessary, compliance program policies and specific compensation analyses of given arrangements for both commercial reasonableness and fair market value.

Auditing and monitoring and applying criteria for compliance purposes on physician arrangements should be no different than for coding or reimbursement or other significant risk areas. Every health system should perform disciplined maintenance of its review program, follow-up procedures, and education. Participation from the appropriate internal and external resources is necessary to help achieve and maintain compliance with physician arrangements just like it does

in all the other risk areas. Finally, if an organization is going to perform these analyses internally, it is important to consider the appropriate criteria in selecting compensation benchmarks and in making appropriate marketplace adjustments to those benchmarks, as well

as to document the process undertaken to make these determinations.

Endnotes:

1. The Stark II, Phase III Final Rule (42 CFR §411.351).
2. Litzau, David. Key Findings from MGMA's 2009 Physician Compensation Survey. August 7, 2009.

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