B. Compensating Employed Physicians—Tax Law, Stark, and Anti-Kickback Implications

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Overview

- Industry conditions leading to surge in physician employment
- Compensation objectives and concerns for both parties
- Federal laws impacting compensation of employed physicians
- Application of laws to various scenarios
- Administration of physician compensation
- Implications of healthcare reform and industry changes
Industry Conditions Leading to Surge in Physician Employment

Key reasons for physicians to consider employment by hospitals/systems:
- Incomes flat or decreasing
- Recruitment challenges
- Practice management issues
- Declining reimbursement
- Addition of ancillaries = duplication of services
- Complexity and costs of compliance with laws/regulations
- Capital required for EHRs, etc.
- Market pressures
Industry Conditions (cont’d)

- Key reasons for hospitals/systems to pursue employment of physicians
  - Utilization
  - Incentives not aligned with independent physicians
  - Recruitment challenges
  - Managed care contracting
  - Competition
  - Future affiliation/acquisition prospects
  - Pressure to increase market share through acquisition and employment of physicians

Industry Conditions (cont’d)

- Motivation for both physicians and hospitals - healthcare reform
  - New reimbursement models depend on coordination of care
  - EHR implementation
  - The devil you don’t know
  - Fear of being the last one standing
  - Market repositioning
Industry Conditions (cont’d)

- The win-win scenario offered by employment
  - Income stabilization for physicians at fair market levels
  - Effective/efficient utilization of hospital resources
  - Coordination of care
  - Aligned economic and strategic objectives
  - Recruitment and retention
  - Managed care contracting
  - Competitive position
  - Preparation for “future state”

Compensation Objectives and Concerns for Both Parties
Objectives & Concerns

- Physician compensation objectives:
  - Income stability and predictability
  - Compensation at FMV, reasonable levels
  - Level playing field
  - Protection from risks of:
    - Deeper payor discounts
    - Adverse changes in payor mix
    - Care for indigent, uninsured and underinsured
    - Practice inefficiencies
    - Effects of hospital/ system strategic or operational decisions
    - Legal landmines

Objectives & Concerns (cont’d)

- Hospital/ system compensation concerns:
  - Potential financial drain/ losses
  - Ease/ difficulty of administration
  - Ensuring physician motivation to work hard, effectively utilize resources
  - Alignment with changing reimbursement models
  - Legal compliance
Objectives & Concerns (cont’d)

- Particular challenges:
  - Guarantees during transition or start-up periods
  - Loss of income from ancillaries, advanced practice clinicians
  - Changes in organization’s compensation model over time
  - Implications of new recruits or laterals
  - Potential reassignment to other practice sites
  - Hospital-based physicians
  - Reduced producers
  - Administrative, supervisory and outside income
  - The unknown – “right to deviate”

Federal Laws Impacting Compensation of Employed Physicians
Federal Laws -- Tax

- The concerns under IRC Sections 501(c)(3)/4958:
  - IRC Section 501(c)(3)
    - Private benefit, substantial non-exempt purpose
    - Inurement
  - IRC Section 4958
    - Excess benefit based on amounts exceeding FMV
    - “Prohibited revenue-sharing arrangements” still undefined

- Background reading:
  - Chapters listed in outline

Federal Laws -- Tax (cont’d)

- General principles:
  - Overall compensation not above reasonable, FMV levels
  - Caps - hard or soft
  - Distinguishable from private practice
    - No quasi-equity (share in net income)
    - Criteria for incentives should be tied to factors based on physician’s own performance
    - If compensation is tied to net income, focus only on physician’s own activities (including those under direct supervision)
    - Caution with using net income at all; maybe only as trigger or circuit-breaker
Federal Laws – Tax (cont’d)

- General principles (cont’d):
  - Avoid disincentives based on payor source (or lack thereof)
  - Adhere to the rebuttable presumption process (Section 4958)
    - Review and approval by independent board or committee
    - Based on review of independent market data
    - Thorough and timely documentation
  - Ensure proper reporting
  - No violations of Stark or Anti-Kickback Laws

Federal Laws – Stark and AKS

- Principal concepts to keep in mind:
  - Fair market value
  - Commercial reasonableness
  - Not “taking into account” the value or volume of referrals or other business generated
  - Enforcement climate is increasingly focused on FMV and commercial reasonableness
Federal Laws – Stark and AKS (cont’d)

- **Stark Law Basics**
  - Prohibits a physician from referring to an entity for “designated health services” (DHS) if physician has a “financial relationship” with the entity UNLESS:
    - Arrangement satisfies **ALL** requirements of a Stark exception
    - Exceptions for common compensation arrangements require that compensation = FMV
    - And is **commercially reasonable**
    - DHS include **ALL** inpatient and outpatient hospital services

Stark Law Example

- **Community Hospital**
  - Physician
    - Employment
  - **Community Hospital**
    - NO Referral for Inpatient or Outpatient Hospital Service
    - Physician

- **UNLESS** satisfies Stark Employment Exception
Federal Laws – Stark and AKS (cont’d)

- Stark Employment Exception
  - Excepts payment by employer to a bona fide employee physician for services if:
    - For identifiable services
    - Consistent with FMV of the services
    - Does not take into account (directly or indirectly) the volume or value of any referrals by the referring physician
    - Agreement would be commercially reasonable even if no referrals were made to the employer
    - Payment may include a productivity bonus based on the physician’s personally performed services

Federal Laws – Stark and AKS (cont’d)

- Stark and Commercial Reasonableness
  - Commercial reasonableness = Would a prudent person enter into the arrangement even if no referrals?
  - Consider business purposes such as:
    - Strategic objectives
    - Demonstrated community need for specialty or service
    - Objective to add or expand services to community or segment of patients (e.g., indigent, submarket)
    - Quality improvement goals
    - Unique skills of the physician
Federal Laws – Stark and AKS (cont’d)

- Stark Law permits an employer to condition an employed physician’s compensation on the physician referring patients to specified providers (i.e., within the system) if the compensation arrangement:
  - Is set in advance for the term of the agreement
  - Is consistent with FMV for the services (and payment does not take into account the volume or value of anticipated or required referrals)
  - Otherwise complies with a Stark exception
  - Complies with both of the following:
    - Referral requirement is in a written agreement signed by the parties
    - Referral requirement does not apply if the patient expresses a preference for a different provider, or the patient’s insurer requires a different provider, or the referral is not in the patient’s best medical interest in the physician’s judgment
  - The required referrals relate solely to the physician’s services covered by the employment

Federal Laws – Stark and AKS (cont’d)

- Anti-Kickback Statute
  - Prohibits “remuneration” to induce or reward referrals for governmental items/services
  - Focus on intent of the parties (on one or both sides)
  - “Remuneration” (= anything of value)
  - Commercial reasonableness
  - Nexus to referrals
    - If even one purpose of an arrangement is to induce or reward making or arranging for referrals, the arrangement is tainted
Federal Laws – Stark and AKS (cont’d)

- **AKS Safe Harbors and Risk Generally**
  - “Safe harbors” -- if ALL criteria are met, little risk of fraud and abuse
    - Commercially reasonable (i.e., intrinsic commercial value to purchaser) items or services
    - Exchanged for FMV
  - If fail to satisfy an exception or safe harbor:
    - Analyze facts and circumstances
    - Scrutinize intent of parties
    - In the grey/risk zone

- **AKS Employment Safe Harbor**
  - “Remuneration” does not include any amount paid by an employer to an employee who has a bona fide relationship with the employer for employment in the furnishing of any item or service payable by Medicare, Medicaid, or other federal health care programs
  - Employee has same meaning as in 26 U.S.C. § 3121(d)(2)
  - Does not include FMV or commercial reasonableness
  - Payment must be for physician’s covered services
Federal Laws – Stark and AKS (cont’d)

- Common AKS problems
  - Failure to satisfy ALL elements of statutory exception or regulatory safe harbor
  - Failure to establish FMV and/or commercial reasonableness
  - Evidence of improper intent to induce referrals (i.e., bad facts)
  - Whistleblowers

Consequences of Violating Federal Laws

- Potential penalties under tax law:
  - Penalty taxes on physician(s) and board/management
  - Loss of tax-exempt status
- Potential penalties under Stark and AKS:
  - Medicare nonpayment or refund of tainted DHS claims
  - Civil penalties
  - Imprisonment or fines
  - Exclusion from Medicare/ Medicaid programs
  - False Claims Act liability
- Reputational risk
- Diversion of organizational resources
Application of Laws to Various Compensation Arrangements

Scenario A

- Compensation is paid to newly-employed primary care physician at guaranteed, fixed annual rate
  - Community has demonstrated shortage of PCPs
  - Contract is for term of 5 years
  - Amounts are approximately 80th percentile of market
  - No incentives for productivity, quality or patient satisfaction
  - Referrals must be kept “within the System”
  - Anticipate losses of $200,000 year, but . . .
  - Signing bonus of $50,000 (loan, forgiven ratably over 5 years)
  - Boredom leads to material outside income
Scenario B

- Compensation is paid to employed ortho surgeon based on production (net collections from SPP)
  - No cap on total comp; comp at or above 2 x (90th percentile)
  - No mid-year review by board or committee
  - Big referrer to flagship hospital
  - Threat of physician participation in ASC nearby
  - “Services personally performed” include those of mid-level providers at same office
  - Peer review based on quality concerns/outcomes
  - High patient satisfaction

Scenario C

- Compensation is paid to employed OB/GYN based on guaranteed salary + call pay + incentive
  - Guarantee at 25th percentile of market
  - Fixed fee for each weeknight and weekend call shift
  - Fixed fee for each delivery at a System hospital, including by residents while Physician is on call
  - “Cut” for any deliveries by other employed OB/GYNs as to Physician’s own patients (when Physician is not on call)
  - Wife of System CEO
Scenario D

- Compensation is paid to employed gastroenterologist based on fixed salary determined at start of each year based on wRVUs produced in prior year
  - Early in year, Physician cuts back schedule (thinking of retiring)
  - Elected chief of hospital medical staff, ex officio non-voting board member
  - Office-based labs or imaging billed under Physician’s provider number to ensure wRVU credit
  - Office manager feels mistreated, considering quitting

Scenario E

- Compensation is paid to group of 4 employed primary care physicians based on overall performance of their clinic
  - Comp pool established based on clinic net income
  - Each full-time physician gets ¼ of pool
  - Clinic includes 6 mid-levels (with their own patient panels)
  - Robust on-site lab and basic imaging at clinic
  - System decides to recruit 2 new physicians to occupy unused space at clinic
    - One will be half-time; comp pool will be split on 1/5.5 basis
Scenario F

- Compensation is paid to hospital’s employed hospitalists based on guaranteed base salary
  - Hard to recruit, so hospital paying at 90th percentile of market
  - No production-based incentive, but $50 per inpatient under a physician’s care during a shift
  - Incentive of 15% of base for achievement of quality and patient satisfaction metrics across the program each year
    - Hospitalists as a group get to decide what the metrics will be for the calendar year; must let hospital know by April 1st or so
  - Scheduling on “week on/week off” basis
    - Several work extra shifts for nearby hospitals during “off” weeks

Administration of Physician Compensation
Administering Physician Compensation

- Consider physician compensation philosophy statement
- Written physician compensation plan or policy
  - Clearly designate responsibility and authority
  - Administrative action versus board or board-delegated committee or officer
  - Free of conflicts of interest
- Specify where outside analysis will be sought
- Outline documentation requirements
- Follow rebuttable presumption procedure where applicable
- Establish discipline and consistency
- Anticipate and review proposed reporting
- Get physician buy-in by involving and educating

Implications of Healthcare Reform and Industry Changes on Physician Compensation
Implications of Healthcare Reform

- New influences on physician behavior (and comp):
  - ACOs
  - Population health management
  - Payment reform

- Production incentives increasingly coupled with other enterprise goals (quality, evidence-based medicine, etc.)

- Will laws/regulations keep pace?
  - Challenge of applying “old laws” to new payment and care delivery models
  - Uncertainty and risk prevail, for now