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The Legal Environment of Physician Compensation

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ABSTRACT

We provide a review of the U.S. legal environment that impacts physician compensation plans. We also identify areas where the legal environment places a binding constraint on an organization's ability to design compensation plans. We review current research on models used for physician compensation, and identify areas for future work.

Key words: *Physician compensation, Stark law, False Claims Act, Anti-kickback Statue, Internal revenue Code*

1. Introduction

In this paper, we review current work related to compensation of physicians with emphasis on quality, and highlight the legal environment that serves as a constraint on the development of multiple physician compensation models.

In its 2014 report to the US Congress, the Medicare Payment Advisory Commission notes that the total healthcare spending in the US rose from approximately 9% of GDP in 1980 to more than 17% in 2009, with a projected share of 19% of GDP by 2022[1]. As a significant component of the economy, healthcare costs are also the subject of significant research interest. A 2011 report[2], quoting the Center for Medicare Services (CMS) pegs physician compensation at around 7.5% of health care costs in the US. Although this is not the major driver of overall costs, physicians are at the center of health care delivery, and have substantial influence over its costs—especially in hospitals. It has been said that the most expensive piece of equipment in a

hospital is the physician's pen. Hence, it is not surprising that significant interest is on how physicians are compensated.

The first part of the present paper reviews some current research on physician compensation. We then provide an overview of the legal environment relevant to this area. Finally we provide an overview of economics and accounting research that could help frame the discussion on incentives and compensation. We conclude with our recommended approach.2

2. Physician Compensation

Research in healthcare broadly looks at three broad types of physician compensation—salary, capitation, and fee-for-service[3]. A pure salary structure provides the physician with little incentive to increase the volume of patients seen, capitation could incentivize reduced volume at the expense of quality, and fee-for-service could exacerbate volumes and costs. Landon *et al*. (p. 805)[4] document through a survey using Medicare claims that for primary care physicians (PCPs) "PCPs paid via productivity formulas delivered care of higher quality than those paid by straight salary", and "physicians in highly capitated environments delivered care of similar or better quality compared with physicians in other environments across most measures."

More recent research has documented the incentive component (example: productivity and quality parameters) in physician compensation. In its 2014 report[5], the Medical Group Management Association (MGMA) reports that quality-based metrics accounted for 3.67% of primary care physician compensation (3% for specialty care physicians), and patient satisfaction 1% in the case of primary care (2% for specialty care physicians). According to this report, these were higher than in 2013. Further, Gosfield (p. 37)[6] reports on a Minnesota-based physician practice that applies a 10% weight on patient satisfaction, and 40% on quality measures. Bunkers, Koch, McDonough and Whited[7] report on a Mayo Clinic physician compensation system that uses measures of patient outcomes, safety and patient experience in compensating physicians. In an article about the Geisinger Health System, Lee, Bothe and Steele[8] note that quality, efficiency, and growth-related metrics account for approximately 20% of expected physician compensation. To summarize, research has documented the following:

a. Physician compensation models are developing, and
b. Quality is playing an increasingly important role in determining total compensation, and
c. Weights associated with specific quality measures are being determined by organizations taking into account their own business environment.

However, the legal environment applies an important constraint—all compensation models need to meet the test of Fair Market Value (FMV). As Johnson and Higgins[9] (p. 80) note, "regulatory constraints imposed by the IRS on tax-exempt organizations, by the Centers for Medicare & Medicaid Services(CMS) under the Stark law, and the Office of Inspector General (OIG) under the ant kick-back statue require FMV as a standard."

We now provide a detailed description of the legal environment that constrains the development of physician compensation models.

3. Physician Compensation in the Regulatory Environment: The Fair Market Value Requirement

Four federal laws regulate various aspects of physician compensation arrangements: the Stark Law, the federal Anti-Kickback Statute, the False Claims Act and the Internal Revenue Code. As a central organizing philosophy that underscores all of these pieces of legislation is the

notion that physician compensation should not exceed fair market value benchmarks for the provision of services. Notably, federal regulation is not exclusive in the field. Indeed, many states have instituted their own laws to control physician compensation based on the same premise of fair market billing controls as well.

Fair market value is defined by the Stark Law as the "value in arm's length transactions, consistent with the general market value…"[10]. The federal regulations have interpreted "general market value" to refer to the compensation that would be included in a service agreement as the result of a bona fide bargaining arrangement between well-informed parties to the agreement, who are not otherwise in a position to generate business for the other party, at the time of the service agreement. For example, fair market value constraints require that compensation paid to physicians by hospitals cannot be based on the "value" of business or the volume of referrals that an employed physician brings to the hospital or its affiliates[11]. Instead, paid compensation must be consistent with fair market value for the actual services provided by the physician on behalf of the hospital and based on the value of the physician's own personal productivity[12]. As part of the negotiation process, fair market value determinations are frequently based on a compensation review performed by an independent valuation firm.

3.1 Fair Market Value Surveys

CMS (Centers for Medicare and Medicaid Services) recommends the use of third party objective and independently published surveys for evaluating the FMV of physician compensation[13]. Commonly used surveys to determine the FMV of a physician's compensation are the (i) Medical Group Management Association (MGMA) compensation survey, (ii) the Group Practice Compensation Trends survey published by the American Medical Group Association and (iii) the Physician Marketplace Statistics survey published by the American Medical Association. Using fair market value surveys alone, however, is not enough. The surveys must be appropriately applied to the given compensation arrangement and considered alongside other factors. For example, the base data used to calculate future compensation should be a reasonable indicator of future productivity, *i.e.* there should be no cherry-picking of baseline data to yield a higher future compensation figure. Ancillary profits should not be taken into account when evaluating compensation. The survey should not use median survey figures to determine compensation for all physicians—a physician's compensation should generally reflect individual levels of productivity. Finally, a hospital should account for all sources of physician revenue and provide a factual basis to demonstrate the compensation is commercially reasonable[14]. Thus, for example, if a physician holds several medical director positions, is eligible for bonuses, and maintains a private practice, consideration must be given to each of these revenue sources when determining the FMV of physician's compensation.

3.2 Regulations

3.2.1. The Stark Law

The Stark Law (Stark I) was enacted by Congress in 1989 in response to billing irregularities evidenced by the unnecessary utilization of lab services by referring physicians having a financial interest in the laboratories. The official name of the statute is the Ethics in Patient Referrals Act. In1993, the Stark Law was amended ("Stark II") to cover 10 other "designated health services" (DHS)[15].

Today, the Stark Law generally prohibits a physician or immediate family member who has a financial relationship with a healthcare facility from making referrals to that entity for DHS covered by Medicare, unless a specific exception applies. The Stark Law, like the Anti-Kickback Statute, has an exception for bona fide employment arrangements. It is, however, a strict liability statute meaning that intent to violate the law is not required to impose liability. Any violation by a physician, whether knowing or unknowing, by engaging in any prohibited financial referral arrangement may be subject to civil penalties.

Known as Stark-II Phase III, in 2007 the Stark-II regulation implementation was extended to include physicians' contractual relationships.[16] The "stand in the shoes" provisions were added to treat compensation arrangements between designated health services (DHS) entities and group practices as if the arrangements are with the group's referring physicians. If a DHS entity leases office space to a group practice, the lease is deemed a direct compensation arrangement with each physician in the group practice. The definition of "physician organizations," in whose shoes the referring physician will stand, includes the referring physician's professional corporation, physician practice, or group practice. A physician is deemed to have a direct compensation arrangement with an entity furnishing DHS if the only intervening entity between the physician and the DHS entity is his or her physician organization. When a physician stands in the shoes of his or her physician organization, he or she is deemed to have the same compensation arrangement (with the same parties and on the same terms) as the physician organization has with the DHS entity.

The penalties for Stark violations include denial of payment for claims that violate the law, refunds of all payments that were made pursuant to unlawful referrals, civil fines of up to $15,000 for each claim for a service that a person knew was made under a prohibited arrangement, and civil fines of up to $100,000 for each referral where the principle purpose was to circumvent the law. Additionally, a violation can result in debarment (program exclusion) of both the entity and physician from federally funded health care programs.

Finally, some courts have now held that a violation of the Stark Law can result in liability under the federal False Claims Act which prohibits any person from submitting a "false" claim for payment to the government. Violations of the act are subject to civil and criminal punishment. These cases are typically instituted by third-party whistleblowers who may receive an award of 10–30% of any successful judgment.

3.2.2. The Anti-Kickback Statute

The Anti-Kickback Statute, known as the Fraud and Abuse Statute, is a broadly worded statute that makes it a crime to pay, offer, solicit or receive remuneration, directly or indirectly, to induce referrals or services of Medicare or Medicaid business, unless a safe harbor applies. The Office of the Inspector General (OIG) has defined by regulation the safe harbors. If an arrangement does not meet a safe harbor, the arrangement is not presumptively illegal. Because the statute is intent-based the payment or receipt of payment must also be made "knowingly and willfully." In order to constitute a violation, only one purpose of the payment must be to influence referrals. A violation of the Anti-Kickback Statute is a felony punishable by up to five years in prison and/or a $25,000 fine[17].

The Anti-kickback statute contains a few exceptions where the statute will not apply, including bona fide employment relationships as discussed above. That exception provides that the statute will not apply to: "Any amount paid by an employer to an employee (who has a bona

fide employment relationship with such employer) for employment in the provision of covered items or services."

In 1994, the OIG had promulgated 13 safe harbor regulations. In November 1999, the OIG finally published a final rule adopting several clarifications to the existing safe harbors and adopting eight new safe harbors[18].

The most relevant safe harbor to physician compensation arrangements (beside the employee exception/safe harbor) is the personal services and management contracts safe harbor, which requires that:

1. the agreement be in writing and signed by the parties;
2. the agreement cover all of the services between the two parties for the term of the agreement and specify the services to be provided by the physician;
3. if the services are on a part-time basis, then the agreement must specify the exact schedule for the services;
4. the term of the agreement is for not less than one year;
5. the aggregate compensation paid is set in advance, is consistent with fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be paid under Medicare or a state health care program;
6. the services performed do not involve the counseling or promotion of a business arrangement or other activity that violates state or federal law; and
7. the aggregate services called for in the agreement must not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

3.2.3. The False Claims Act

A claim for payment for items or services in violation of the Stark Law or the Anti-Kickback Statute may also constitute a false claim under the False Claims Act (FCA)[19]. The FCA imposes both civil and criminal liability on persons and companies who defraud governmental programs. The FCA also includes a "*qui tam*" provision that allows private citizens to act as "whistleblowers," authorizing them to file suit on behalf of the government, and share a portion of any recoveries. The whistleblower generally must base their allegation on inside information not otherwise publically available. So one defense is for the culpable healthcare organization to make a press release regarding the matter, rendering the evidence public information.

3.2.4. The Internal Revenue Code

Section 501(c)(3) of the Internal Revenue Code provides the requirements for an entity to qualify as a charitable organization exempt from federal income taxation. This exemption provides numerous benefits in addition to tax exemption, such as the ability to apply for certain grants and use of tax-exempt bond financing. The exemption also carries many obligations, such as the requirement that organization must serve a public, rather than a private, interest. In this regard, the IRS regulations create special rules regarding compensation structures for employed physicians. Specifically, a tax-exempt hospital cannot pay more than reasonable compensation for services rendered to the organization. Violations of the IRS guidelines may cause a hospital to lose its tax-exempt status and may result in the imposition of civil sanctions.

3.3. IRS guidelines and tax-exempt entities.

The IRS has stated that when determining whether a physician's compensation is appropriate, the tax-exempt hospital should ensure the total compensation package provided to a physician is reasonable for the physician's specialty and geographic area. The IRS created a rebuttable presumption whereby physician compensation is reasonable if:[20]

1. the compensation arrangement is approved in advance by an authorized body of the applicable tax-exempt hospital, which is composed of individuals who do not have a conflict of interest concerning the employment arrangement;
2. prior to making its determination, the authorized body obtained and relied upon appropriate data as to comparability; and,
3. the authorized body adequately and timely documented the basis for its conclusion.

The regulations further provide that if an employment arrangement does not satisfy the rebuttable presumption requirements, the IRS will examine all relevant facts and circumstances, and intermediate sanctions may be imposed if compensation is determined to be excessive. Intermediate sanctions may include the imposition of an excise tax against the physician and the hospital manager who approved the employment arrangement[21, 22]. The intermediate sanctions rules only apply to compensation arrangements with "disqualified persons." Disqualified persons are persons who are in a position to exercise substantial influence over the organization; this can include employed physicians, especially where the employed physician is highly compensated or holds an administrative position. However, even if a compensation arrangement does not involve a disqualified person, a tax-exempt institution cannot pay more than fair market value due to the restrictions on private inurement.

3.4. No payment for ancillary services.

Under the Stark Law and the Anti-Kickback Statute, physicians cannot receive payment for the volume or value of referrals made for technical services. Specifically, this means that although a physician may be compensated for the services that he or she personally performs (*e.g.* consultations and surgeries), the physician cannot be compensated in any manner for referring a patient for ancillary services such as diagnostic tests, physical therapy or the prescription of durable medical equipment. A physician, however, may be compensated for personally performing the professional component of an ancillary service (*i.e.*, radiology reads). The rules regarding ancillary services in a hospital-physician relationship are different than the rules regarding ancillary services applicable to a physician practice. In a physician group practice setting, under certain circumstances the practice is permitted to distribute revenues generated from ancillary services to physician members of the group practice—a hospital, however, is strictly prohibited from making such payments to its physician employees.

3.5. Exceptions

As noted previously, for a physician compensation arrangement to comply with the Stark law, it must fall within one of the specific exceptions set forth in the statute or regulations. The following are some of the exceptions that have specific application to typical physician compensation arrangements. In-Office Ancillary Services and Referrals for designated health services (other than durable medical equipment (except for infusion pumps), and parenteral and enteral nutrients, equipment and supplies) do not violate the Stark Law if:

1. the services are furnished:
    a. personally by the referring physician, member of the referring physician's group practice or individuals under the supervision of the referring physician or group member; and
    b. in a centralized building or a building in which the physician or the physician's group furnishes substantial physician services (unrelated to the furnishing of DHS); and
2. the services are billed by the physician performing or supervising the services, by the group practice or by an entity wholly owned by the performing physician or such group practice.

Definitions are important here. "Same building" means a structure or combination of structures that share a single street address, but does not include a mobile van or trailer. "Centralized building" means all or part of a building (including a mobile van or trailer) that is owned or leased on a full-time (24 hours per day, seven days per week) basis by a group and that is used exclusively by the group. Physicians qualify as "members" of a group only during the time they furnish services to patients of the group practice that are furnished through the group and are billed in the name of the group.

Likewise, with regard to the In-Office Ancillary exception, the definition of "group practice" significantly limits the exception. The statute defines a group practice as:

A group of two or more physicians organized in a legally recognized entity:

1. in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides;
2. for which substantially all of the services provided by group members are provided through the group and are provided and billed under a group billing number;
3. in which the expenses and income are distributed according to a "previously determined" method;
4. in which no physician member receives, directly or indirectly, compensation based on the "volume or value of referrals" by the physician member (unless allowed by the special rules); and
5. in which physician members personally conduct no less than 75% of the physician/patient encounters of the group.

There are special accounting rules and compensation methodologies that apply as well.

1. A physician member may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed (or incident to services personally performed) so long as such bonus is not directly related to the volume or value of referrals of the physician member.
2. A "previously determined" method for distributing costs and revenues must be set and in place prior to the receipt of payment for the services giving rise to the overhead expense or producing the income.
3. A group can adopt cost center and location based accounting providing that the group meets certain definitions (*e.g.*, a minimum of five physicians in the cost center).
4. A group cannot compensate physician members based on the volume or value of referrals for DHS paid by Medicare or Medicaid.
5. Productivity bonuses are allowed, if they do not take into account referrals for DHS.

6. Sharing of overall profits is acceptable, as long as they are not determined in a manner that directly relates to the volume or value of DHS referrals by the physician.

Stark I also requires physician groups engage an in depth review of their compensation methodologies to ensure compliance.

3.6. Bona fide employment arrangements.

Both the Stark Law and the Anti-Kickback Statute contemplate employment of physicians by hospitals, and accordingly, both include an exception to recognize the economic model where compensation is paid by a hospital employer to a physician employee. The Bona Fide Employment Relationship exception to the Stark Law provides that physicians are permitted to be compensated as employees of hospitals as long as the amount paid to the physician is: (i) for identifiable services, (ii) is consistent with the fair market value for services performed, and (iii) is not determined in a manner that takes into account the volume or value of referrals by the referring physician to the hospital. Further, the compensation agreement providing for "remuneration" by the hospital to the physician must be commercially reasonable even if no referrals are ever made by the physician to the hospital.

The Anti-Kickback exception safe harbor is less restrictive than Stark I and provides that "remuneration" does not include any compensation paid by an employer to an employee, who has a bona fide employment relationship with the employer.

3.7. Personal Services Arrangements

Personal services arrangements will not be considered "compensation arrangements" if they meet the following requirements: (i) the arrangement is in writing, signed by the parties, and specifies the services covered by the arrangement; (ii) the arrangement covers all of the services provided by the physician (or immediate family member) to the entity; (iii) the aggregate services do not exceed what is commercially reasonably for the legitimate business needs of the entity; (iv) the term of the agreement is for at least one year; (v) the compensation is set in advance, does not exceed fair market value, and does not take into account the volume or value of any referrals (unless it qualifies as a "physician incentive plan") or other business generated between the parties; (vi) the services do not involve the counseling or promotion of any business arrangement that violates any state or federal law; and (vii) the arrangement meets other requirements or regulations protecting against fraud and abuse.

3.8. Other potentially applicable exceptions:

- Equipment and Space Rentals;
- Remuneration unrelated to provision of designated health services;
- Recruiting;
- Isolated transactions; and
- Payments made by a physician.

None of these exceptions were addressed in Phase I.

4. Conclusions

It is clear that approaches to compensating physicians are changing. Organizations are increasingly focusing on their own economic and business environment in developing such models. However, it is equally important that they consider the significant legal environment

under which they operate before implementing compensation models. Our purpose was to focus on this important constraint. Future work could possible look at how physician compensation models could be improved, by drawing lessons from economics and accounting literature.

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