AIS’s Management Insight Series

Best Practices to Make Your Physician Contracts Stark Compliant

Adapted from an AIS webinar presented by

Robert Wade
Partner
Krieg Devault
Mishawaka, Indiana

Edited by Frances Fernald, Managing Editor, AIS
AIS’s Management Insight Series is designed to provide practical solutions to complex business challenges with the help of the industry’s most insightful advisors and managers. See a full list of titles in this series at http://aishealth.com/marketplace/insight-series.

Other Related Publications from AIS
A Guide to Complying with Stark Physician Self-Referral Rules
Report on Medicare Compliance
Report on Patient Privacy

Call 800-521-4323, or visit the MarketPlace at www.AISHealth.com, for a catalog of AIS books, newsletters, Webinars, Web and looseleaf services, and other information products.

This publication is designed to provide accurate, comprehensive and authoritative information on the subject matter covered. However, the opinions contained in this publication are those solely of the authors and not the publisher. The publisher does not warrant that information contained herein is complete or accurate. This book is published with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent person should be sought.

ISBN: 978-1-936230-93-8

Copyright © 2015 by Atlantic Information Services, Inc. All rights reserved. No part of this publication may be reproduced, stored on a retrieval system or transmitted by any means, electronic or mechanical, including photocopying and transmittal by FAX, without the prior written permission of Atlantic Information Services, Inc.

For information regarding individual or bulk purchases, contact Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, DC 20036 (800-521-4323; 202-775-9008).
# Table of Contents

**Introduction** .......................................................................................................................................................... 1

**The Stark Law Basics** ........................................................................................................................................... 3

The Exceptions ............................................................................................................................................................. 4
   - *Personal Service Arrangements Exception — Compensation* ................................................................. 6
   - *Fair Market Value Exception* ......................................................................................................................... 7
   - *Bona Fide Employment Exception* .................................................................................................................. 7
   - *Volume or Value of Referrals* .......................................................................................................................... 8
   - *What Is Commercially Reasonable?* ................................................................................................................ 10
   - *Fair Market Value* ........................................................................................................................................... 11

Medical Directors ....................................................................................................................................................... 15
Real Estate .................................................................................................................................................................... 17
   - *Time Share Arrangements* ............................................................................................................................. 18
Operationalizing the Contract Process ..................................................................................................................... 19
Conclusion .................................................................................................................................................................. 21
Question and Answer Session ................................................................................................................................. 22

**Appendix A: Medical Director Tracking Tool** ...................................................................................................... 29

**Appendix B: Excerpts from AIS’S A Guide to Complying with Stark Physician Self-Referral Rules** .................................................................................................................................................. 31

Key Elements of the Compensation Exceptions ...................................................................................................... 31
Personal Service Arrangements ............................................................................................................................... 39
Employment Arrangements Between a Physician and a Hospital ............................................................................. 44
Non-Productivity Compensation ................................................................................................................................ 47

**Appendix C: Articles from AIS’s Report on Medicare Compliance** ........................................................................ 49

The *Tuomey and Halifax Cases* .................................................................................................................................. 49
   - *Tuomey Faces Big Fines After Losing Stark, False Claims Trial* ................................................................. 49
   - *Eleven Tips for Hospitals to Consider After the False Claims Verdict Against Tuomey* ....................... 50
   - *As Tuomey Post-Mortem Continues, Judge Orders Health System to Pay $237 Million* .................... 53
   - *Court: Halifax Hospital Violated Stark but Issues Are Unresolved* ......................................................... 56
   - *Another Halifax Compensation Deal Gets Different Response From Judge* ............................................ 57

Compensation Models ................................................................................................................................................... 58
   - *Stark Law Is Not Obstacle for Providers Shifting to Quality-Based Productivity Pay* ............................ 58
   - *Hospitals That Move to ‘Nonproductivity' Comp Face a New Kind of FMV Analysis* ....................... 61
Introduction

A hospital or other health care facility has many reasons to negotiate and execute contracts with physicians, ranging from arrangements for medical directorships or emergency room coverage to leasing space or equipment to actually purchasing a practice. Careful drafting of contracts with physicians for services or for leases or other property arrangements is essential to avoid running afoul of the Stark law because such contracts create “compensation arrangements” between the physician and the facility. A physician with an ownership interest in or a compensation arrangement with a facility may not refer patients or other business to the facility for certain services unless the circumstances fall under one of the exceptions enumerated in the law. If the compensation arrangement does not comply with Stark, the penalties may be severe, including denial of payment or refund; civil money penalties (up to $100,000) and exclusions from federal and state programs. And with more and more frequency, *qui tam* lawsuits involve allegations of Stark law violations with potentially expensive consequences for the hospitals.

Two recent high profile lawsuits both involved violations of Stark because of the facilities’ contracts with physicians. Halifax Hospital, just as it was to go to trial, settled with the government in March 2014 for $85 million, and in September 2013, the U.S. District Court of the District of South Carolina ordered Tuomey Healthcare System to pay more than $237 million.

This report discusses the types of contractual relationships that implicate the Stark law, including medical directorships, rental of office space, service agreements, and bonus arrangements. It explains in layman’s terms the types of physician compensation scenarios you and other members of your compliance team should watch for.

*Best Practices to Make Your Physician Contracts Stark Compliant* provides reliable answers to these and other key questions:

- What is a Stark-compliant bonus program? Which programs could lead to trouble?
- What are the restrictions on contracts with physicians for medical directorships?
- What are the chief pitfalls in leasing space to physicians?
- How can you determine whether the volume and value of referrals will affect compensation?
- Where do physician contract rules come into play with employee physicians?
- What are the main components of best practices for physician contracts?

The report was adapted from a Sept. 23, 2014 conference, “Stark Law Do’s and Don’ts: Best Practices for Your Physician Contracts,” presented by Robert Wade and sponsored by Atlantic Information Services, Inc. Mr. Wade is a partner and health care practice group leader with the firm of Krieg DeVault in Mishawaka, Indiana. He has extensive experience representing health care clients on issues related to the Stark law,
anti-Kickback statute, False Claims Act, and Emergency Medical Treatment and Active Labor Act. Mr. Wade is nationally recognized in all aspects of health care compliance. He is the legal editor of AIS’s *A Guide to Complying with Stark Physician Self-Referral Rules*. At the end of the conference, Mr. Wade answered a series of questions from the audience, which are reproduced following the text.

Three valuable appendices give you a hands-on time tracking tool, excerpts from AIS’s *A Guide to Complying with Stark Physician Self-Referral Rules* that explore some of the contracting issues in more depth, and selected articles from *Report on Medicare Compliance* on the Halifax and Tuomey cases as well as articles on Stark physician contract issues. They are:

- **Appendix A**: Medical Director Tracking Tool
- **Appendix B**: Excerpts from *A Guide to Complying with Stark Physician Self-Referral Rules*
- **Appendix C**: Selected articles from *Report on Medicare Compliance*

Frances Fernald
Managing Editor
Atlantic Information Services
The Stark Law Basics

The Stark law prohibits a physician from making

- A referral
- to an entity
- for the furnishing of a Designated Health Service (DHS)
- for which payment may be made under Medicare
- if the physician (or an immediate family member) has a Financial Relationship with the entity.

Proof of intent is not required.

The definitions of the italicized words are critical to understanding liability under the Stark law.

A referral includes the following:

- A request for an item or a service by a physician;
- A request by a physician for consultation with another physician, and any tests or procedures the other physician orders, performs or supervises; or
- A request for or a plan of care that includes provision of DHS.

A referral is not a DHS personally performed by a physician.

A referral also does not include a request by:

- Pathologists for clinical diagnostic laboratory tests and pathological examination services;
- Radiologists for diagnostic radiology services;
- Radiation oncologists for radiation therapy.

However, the request for the service must result from a consultation requested by another physician (whether made to a particular physician or an entity with which the physician is affiliated), and the tests or services must be furnished by, or under the supervision of, the pathologist, radiologist, or radiation oncologist or under the supervision of another pathologist, radiologist, or radiation oncologist in the same group practice as the requesting pathologist, radiologist, or radiation oncologist.

Designated health services include the following:

- Clinical laboratory services;
- Physical therapy and occupational therapy services;
- Radiology or other diagnostic services (including MRI, CAT scans);
- Radiation therapy services;
- Durable medical equipment;
Parental and enteral nutrients, equipment and supplies;
Prosthetics, orthotics and prosthetic devices;
Home health services;
Outpatient prescription drugs; or
Inpatient and outpatient hospital services (encompassing almost every type of medical procedure).

Ambulatory surgery center (ASC) services are not DHS.

A financial relationship includes the following:

Ownership interests through equity, debt, compensation or other means.
Compensation arrangements, which include virtually any form of direct or indirect remuneration (i.e., personal service contracts, medical directorships, lease agreements, consulting arrangements, medical service provider arrangements).

Remuneration is defined in 42 CFR §411.351 as “any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.”

The Exceptions

The Stark law has numerous exceptions to its restrictions, some of which apply to compensation arrangements, some to ownership interests, and some to both. However, all of the exceptions have their own conditions that must be met in order to qualify.

The Stark Law Exceptions

Permitted Ownership and Compensation Arrangements

• Physician services
• In-office ancillary services
• Services to members of prepaid health plans
• Academic medical centers
• Implants furnished by ASC
• Dialysis-related drugs furnished by end stage renal disease facility
• Preventive screening tests, immunizations and vaccines
• Eyeglasses and contact lenses following cataract surgery
• Intra-family rural referrals

Permitted Compensation Arrangements

• Rental of office space
• Rental of equipment
• Employment relationships
• Personal service arrangement
• Physician recruitment
• Isolated transactions
• Services unrelated to provision of designated health services
• Hospital-affiliated group practice arrangements
• Fair market value (FMV) payments made by physicians for items and services (i.e., clinical laboratory services)
• Charitable donations by physician
• Non-monetary compensation (benefits) up to $385 per year
• Fair market value compensation
• Medical staff incidental benefits
• Risk-sharing arrangements (i.e., withholds, bonuses, risk pools)
• Compliance training
• Indirect compensation arrangements
• Referral services
• Obstetrical malpractice insurance subsidies
• Professional courtesy
• Retention payments in underserved areas
• Community-wide health information systems
• Electronic prescribing items and services
• Electronic health records items and services

**Permitted Ownership Interests**

• Publicly traded securities
• Mutual fund investment
• Rural provider (75% of DHS to rural residents)
• Hospitals in Puerto Rico
• Hospital ownership (whole, not department or floor). Applies only to physician-owned hospitals up to Dec. 31, 2010 – such hospitals cannot (i) expand physician ownership percentage, or (ii) expand capacity such as patient rooms, procedure rooms, etc. without a waiver from CMS.

For physician services, three of the most useful compensation exceptions are the ones for personal services, fair market value and *bona fide* employment.
Personal Service Arrangements Exception — Compensation

The personal service arrangements exception (§411.357(d)) is used with physicians who are independent contractors, not employees. For example, an arrangement with a physician to serve as medical director would need to meet the elements of the personal service arrangements exception to comply with Stark. Remuneration paid under the personal service arrangement is not a prohibited compensation arrangement if:

◆ The arrangement is set out in writing, signed by both parties and specifies services covered by the arrangement.

◆ The arrangement covers all services to be provided by the physician to the entity. This second condition is met if the agreement:
  — References all other arrangements, or
  — References a master list of contracts that is maintained with the historical record of all arrangements. The contract management database may serve as the master list.

◆ The term of the contract is for at least one year. The Centers for Medicare and Medicaid Services (CMS) does not want the hospitals to continue to increase the compensation to the physician during the 12-month term; it wants to make sure that the compensation is locked in for one year.

◆ The services that are being rendered must be reasonable and necessary.

◆ The compensation must be set in advance.

“Set in advance” under Stark is different than “set in advance” under the Anti-Kickback Statute. Under the Anti-Kickback Statute, “set in advance” means that the aggregate compensation paid to the physician during that year must be set in advance. By way of example, the hospital will pay the physician $15,000 for medical director services during the year. Under the Stark law, “set in advance” only requires setting the methodology of the compensation arrangement in advance, so there may be an arrangement where the facility is going to pay the doctor $100 per hour worked, but it does not establish an aggregate cap.

◆ The compensation must be fair market value and determined through arm’s length negotiations.

◆ The compensation must not take into account the volume or value of referrals or other business generated between the parties. The volume or value of referrals requirement is common to many exceptions and has been the Achilles’ heel in many physician contracts from a Stark perspective.

◆ Stark also permits a month-to-month holdover at expiration of the arrangement for up to six months. The contract does not need to even reference the six-month holdover period because it is automatic under the Stark law for the personal services arrangement exception.
Note that the regulations do not say “legal contract,” just “arrangement.” A series of emails that have electronic signatures on them discussing the terms and conditions of the financial arrangement, as well as the compensation, could, taken as a whole, represent the arrangement. Nevertheless, a legal contract is the best way to comply.

**Fair Market Value Exception**

The fair market value exception is the same as the personal service arrangements exception, but it does not require a one-year term. If the term is for less than one year, it may be renewed, but the compensation and terms may not change.

This exception will be useful in the following circumstances:
- Personal service arrangements with a term of less than one year;
- Personal service arrangements between a DHS Entity and a physician group that does not qualify as a “group practice” under the Stark law;
- Commercially reasonable loan arrangements between DHS Entities and physicians;
- Fair market value remuneration paid by a hospital to a physician that does not qualify for the “unrelated remuneration” exception; and
- Equipment leases with a term of less than one year, as long as they do not set payment based on a percentage of revenue or unit-of-service formula.

**Bona Fide Employment Exception**

The *bona fide* employment exception also is very similar to the personal services arrangement exception, except that it does not require the arrangement to be in writing with one caveat: if the arrangement requires referrals, the referral provision must be in writing.

The employment exception requires the following:
- The compensation must be fair market value;
- It cannot be determined in a manner that takes into account the volume or value of referrals; and
- It must be commercially reasonable even if no referrals are made to the employer.

*Productivity Bonuses.* A hospital may pay an employed physician a productivity bonus, but the bonus must be based only on personally performed services; the bonus may not take into account ancillary services or services performed by non-physician practitioners. To clarify, a hospital can pay a physician for supervision of a non-physician practitioner, but it cannot give the physician credit for all of the services performed by the non-physician practitioner.

*Referrals.* Under Stark, the hospital can require the employed physician to refer to a particular provider, as long as the compensation is set in advance and fair market
value; however, unlike the arrangement as a whole, the referral requirement must be in writing, and it may only be for the services for which the hospital has contracted.

There are three exceptions to this mandated referral:

(1) If the patient expresses a preference for a different provider.

(2) If the patient’s insurance does not cover the services at the required provider.

(3) If the physician truly believes that the required referral is not in the patient’s best medical interest.

**Volume or Value of Referrals**

A common element in all of the above exceptions is that the compensation may not be based on or vary with the volume or value of referrals or other business generated between the parties. “Based on” means the volume or value of referrals was taken into account when the compensation was set. For example, if the fair market value for the physician services ranges from $100 to $150, and the hospital decides to pay the physician $150 because of his high referral rate, clearly the volume and value of referrals has been taken into account.

“Varies with the volume or value of referrals” means that the compensation changes as the referrals change. The lawsuit against, and eventual settlement with, Halifax Hospital in Volusia County, Fla., focused on the question of whether a bonus incentive pool varied with the volume and value of referrals. In contracts with six oncologists, the hospital offered an incentive bonus. The government alleged that under the agreements, the pool on which the incentive bonus was based included revenue from fees for DHS not personally performed by the physicians. Thus revenue from referrals made by the medical oncologists would flow into the incentive bonus pool, and additional referrals would be expected to increase the size of the pool. As the court observed, “All other things being equal, this would in turn increase the size of the incentive bonus received by the referring medical oncologist.” Halifax argued that the bonus structure satisfied the *bona fide* employment exception because the bonus pool was divided based on each physician’s personally performed services, but the court pointed out that the bonus was not “based on services personally performed,” but was only “divided up based on services personally performed....The bonus itself was based on factors in addition to personally performed services — including revenue from referrals made by the Medical Oncologists for DHS.” *U.S. ex. rel. Baklid-Kunz v. Halifax Hospital Medical Center and Halifax Staffing, Inc.*, No. 6:09-CV-1002 (M.D. Fla., Nov. 13, 2013). The *Halifax* case exemplifies the importance of understanding exactly what a physician’s compensation is based on and representing it correctly in the agreement.

The crux of the *Tuomey* case focused on the fair market value and commercial reasonableness of part-time employment agreements with 19 physicians in various specialties. The contracts had 10 year terms, included requirements for only outpatient
procedures and required the physicians to perform these procedures only at Tuomey. The annual salary was based on the previous year’s collections and included a bonus equal to 80% of net collections of professional fees and an additional 7% productivity bonus for other factors. The contracts included a noncompete within 30 miles of the hospital while the physicians were under contract and for two years following expiration. The physicians also received generous benefits. An outside evaluation firm indicated that for purposes of fair market value, the productivity levels of the physicians were between the 50th and 75th percentiles, but it did not include the benefits in the evaluation. The actual compensation level Tuomey paid to the physicians was above the 90th percentile.

At trial, a government expert analyzed the contracts and concluded the following:

◆ It would be impossible to ever make a profit on these contracts, and thus the contracts were not commercially reasonable.
◆ The physicians were receiving full-time benefits for minimal hours per week.
◆ The outside evaluator showed that certain physicians across the country received between 49% and 63% of net collections, but Tuomey paid, on average, 131% of net collections.
◆ The non-compete agreement locked in referrals.

Based on these and other findings, the government alleged that Tuomey’s contracts with the physicians were in reaction to a competing ASC and the fact that physician groups had told the hospital that they may perform surgeries in their own offices rather than at Tuomey. U.S. ex rel. Drakeford v. Tuomey Healthcare System, No. 10-1819 (4th Cir.)

The Volume or Value of Referrals Condition

Clear Violations

• The physician is paid a fixed amount or percentage for each ancillary service referred to the hospital.

• The physician is paid at the upper end of the compensation range, recognizing that he/she is a high-volume referral source.

• The physician is paid a percentage of the reimbursement received by the hospital for every ancillary service referred by the physician.

Unclear Violations

• The compensation pool increases based upon the volume of ancillary referrals or profit/margin generated from ancillary referrals, even if the compensation pool is divided based upon personally performed services. (This was the problem in the Halifax case, and the court said it was the composition of the pool, not how it was divided.)
• The bonus/compensation pool is fixed but is based upon quality, expense containment and efficiencies based upon service line or medical department.
• A fixed bonus pool, divided based upon each physician’s productivity, paid based upon financial success of hospital or health system.

## What Is Commercially Reasonable?

Many of the exceptions under the Stark law require the payment to be “commercially reasonable even if no referrals were made” between the parties. “Commercially reasonable” applies to both the services and the payment. Commercial reasonableness is starting to take center stage in any investigations by the government. Even if an arrangement is fair market value, if it is not commercially reasonable, the government is likely to view it as noncompliant with Stark.

While most hospitals have a fair market value process, including documentation, a memo, and a questionnaire, many do not have a formalized process for reviewing a compensation arrangement from a commercial reasonableness perspective.

Here’s the analysis to assess the commercial reasonableness of the arrangement.

First, determine what the business purpose of the arrangement is.

♦ Does the arrangement further the hospital’s mission or pursuit of strategic goals?
♦ Is the amount of services necessary? Justify the amount of services, not only the type of services. How much time does the service demand to meet the hospital’s needs? For example, does the facility really need 100 hours a month from a medical director or are 50 hours acceptable? If the hospital pays the medical director for 100 hours and 50 is all that is really needed, then the amount of services may not be commercially reasonable.

## What Is Not Commercially Reasonable

The following services may not be commercially reasonable:

• Two medical directors over a department when only one is needed.
• Paying the physician for questionable consulting services.
• Renting a piece of equipment full-time when it is used only once a month (assuming rental for one day is less than full-time rental).
• Purchasing a physician’s medical office building with no intention of using the building.

Next, a hospital should assess its internal needs for the arrangement. To assess the commercial reasonableness of an arrangement from an internal perspective, answer the following questions:
(1) Does the hospital require a physician of a particular specialty?

(2) Does the physician have sufficient knowledge, experience, and training for the position (i.e., medical informatics)?

(3) Are the duties and responsibilities necessary from both a medical and business perspective?

(4) Can the service be performed by a non-physician provider? If the answer is yes, that it’s possible that it can be performed by a non-physician, but for quality or other reasons, you want to engage a physician, then you need to state why.

(5) If the services are rendered on an hourly or part-time basis, are there mechanisms in place to ensure that the services are actually performed by the physician? If yes, describe the mechanisms. If it is a full-time arrangement, just write, “full-time.”

(6) Is there a continued need for the services?

(7) Are these services duplicated elsewhere, not only within the organization but possibly with other providers within the community?

Next the hospital should assess the following external factors that affect commercial reasonableness:

(1) Do the specific market conditions support the level of compensation to be paid (i.e., high demand but low supply for specialty, trauma center versus non-trauma center)?

(2) Is the compensation paid consistent with other similarly situated hospitals (i.e., call compensation, payment for indigent care)? For example, if the hospital’s competitors are paying call compensation, it’s probably commercially reasonable for it to pay call compensation.

**Fair Market Value**

Many of the exceptions also require that the compensation be “fair market value” (FMV). In the health care context, there are essentially three basic views on the meaning of FMV:

(1) “Person on the street” perspective.

(2) Professional appraisal perspective.

(3) Legal/regulatory perspective.

Unfortunately, these views frequently conflict.

**1 The “Street” view:**

◆ What everyone is getting paid in the market.

◆ What the hospital down the street is paying.
Incremental cost plus a profit margin.
What’s in a survey book.
What it’s worth to one party to the transaction.

(2) Professional appraisal perspective:

Business evaluations often take three approaches; cost, income, and market, and typically the FMV is the average of these three. If an appraisal is based on only one of these factors, it is much riskier than if it is based on all three.

Under the income approach, the hospital is evaluating the potential of future referrals probably from the physician involved in the arrangement; thus, it is based upon the volume or value of referrals. While it is okay to include income, it is not advisable to use it as the sole indicator. In fact, from a Stark perspective, it’s safer to use just cost and market, but most business evaluations do include income.

Note that there is no body of knowledge or standards for compensation valuation (CV).

(3) Legal/regulatory perspective:

The Stark law addresses fair market value in the context of services and in the context of equipment and space. The definition of fair market value is “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 a 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 a 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 service agreement.” 42 CFR §411.351. The phrase, “on the date of acquisition of the asset or at the time of the service agreement” is important because an arrangement will be viewed for commercial reasonableness in relation to when it was made, not based on the time an investigation is underway, as long as the term is reasonable. As a general rule, three years is a reasonable term.

For real estate and equipment, Stark defines fair market value as the market price at which bona fide sales have been consummated for like-type assets in a particular market. For real estate, the Stark law states that fair market value is “the value of rental property for general commercial purposes (not taking into account its intended use). In the case of a lease of space, this value may not be adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor when the lessor is a potential source of patient referrals to the lessee.”

HHS has consistently said it will accept any method that is commercially reasonable and that the appropriate method to determine fair market value depends on the

For compensation, Stark Phase II included a FMV safe harbor based on hourly rates presented in six surveys. While this safe harbor was deleted in Phase III because some of the surveys were no longer available or were not accessible to all providers, HHS still says the elements of the safe harbor represent a prudent documentation process.

Under the safe harbor, an hourly rate is deemed to be FMV if it meets one of the following two tests:

(1) The hourly rate is less than or equal to the average hourly rate for emergency room physician services in the market, provided there are at least three hospitals providing emergency room services in the market.

(2) The hourly rate is determined by averaging the 50th percentile national compensation level with the same physician specialty in at least four of the following surveys and dividing by 2000:

- Hay Group - Physician’s Compensation Survey
- Hospital and Health Care Compensation Services - Physician Salary Survey Report
- Medical Group Management Association (MGMA) - Physician Compensation and Productivity Survey
- ECS Watson Wyatt - Hospital and Health Care Compensation Report
- William M. Mercer - Integrated Health Networks Compensation Survey

As of Phase III, providers are no longer limited to these surveys but may reference “multiple, objective, independently published surveys.”

As long as the compensation is at the 50th percentile or less, it is deemed safe.

The Phase II preamble to the Stark regulations states that the definition of FMV “is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies. For example, the methodology must exclude valuations where the parties to the transaction, while at arm’s length, also are in a position to refer to each other.” Phase II, 69 Fed. Reg. 16107 (March 26, 2004).

In Phase I, CMS’s predecessor, the Health Care Financing Administration, said FMV can be established by “any method that is commercially reasonable”; however, if the volume and value of referrals or other business generated may not be taken into account, market comparables, such as in the case of real estate, should not include arrangements between parties in a position to refer. Phase I, 66 Fed. Reg. 944 (Jan. 4, 2001).

For compensation, one method is to align the compensation with physician productivity. As a general rule, compensation benchmarking should not be more than 10 percentage points above where the physician’s work RVUs (wRVUs) or productiv-
ity is. The most commonly used productivity measures, in order, are the following: wRVUs, collections, net income, and patient visits, according to the 2011 Physician Compensation and Productivity Survey by Sullivan, Cotter & Associates, Inc. Of those that use productivity-based incentive measures, 74% use wRVUs. For most specialties, compensation per wRVU should remain approximately at the 50th percentile.

However, as more and more hospitals look for other ways to set compensation, they are increasingly relying on non-productivity-based models that are solely wedded to the wRVUs. For example, a single tier model may benchmark the package at the 50th percentile, as described in one of the surveys, and offer a guaranteed base cash compensation of $175,000 with additional incentive compensation of $40 per relative value unit (RVU) above 4,500 RVUs worked.

Another model is tiered productivity where compensation is based upon the number of work RVUs that the physician generates. For example, assume the RVU tiers look like this:

<table>
<thead>
<tr>
<th>RVUs worked</th>
<th>Compensation per RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,500 and below</td>
<td>$30</td>
</tr>
<tr>
<td>4,501 – 5,500</td>
<td>$35</td>
</tr>
<tr>
<td>5,501 – 6,500</td>
<td>$40</td>
</tr>
<tr>
<td>6,501 and above</td>
<td>$42</td>
</tr>
</tbody>
</table>

In these types of models, you should test the high productivity to be sure the compensation stays within the benchmark data. For example, as shown in the table below, if the wRVUs for the 90th percentile were 13,795 and the 50th percentile benchmark data were $63.54, the compensation would be $876,534. However, if the physician were paid at the 90th percentile benchmark of $105.18 to align with the 90th percentile wRVU, the compensation would be $1.4 million. But the benchmark range at the 90th percentile is $943,059, so the hospital would be paying the physician 153% of the benchmark, which would catch a regulator’s eye.

<table>
<thead>
<tr>
<th>Calculation to Test Whether Compensation Is Within the Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVUs</td>
</tr>
<tr>
<td>7,981</td>
</tr>
<tr>
<td>10,723</td>
</tr>
<tr>
<td>13,795</td>
</tr>
</tbody>
</table>

Based upon 2012 Physician Compensation and Production Survey from the Medical Group Management Association
Fair market value is based upon the specific financial arrangement being entered into by the parties. Factors that can legitimately cause compensation to exceed the 90th percentile include:

- Extremely high productivity;
- High demand or low supply for the specialty;
- A thought leader in the specialty;
- Historic compensation above the 90th percentile for personally performed services (do not include revenue from ancillary services or mid-level providers);
- Super sub-specialization or multi-specialty; or
- A nationally renowned program.

When analyzing fair market value compensation, understand all sources of compensation. First, analyze every component of compensation being paid, including benefits. The gold standard here is if each component of compensation is fair market value, then the aggregate compensation should be fair market value. If you say, yes, the employment is fair market value, yes, the research is fair market value, etc., then the aggregate should be fair market value.

Another factor to take into account is whether the hospital is dealing with a physician in an employment capacity or an independent contractor capacity. Under the employment exception, compensation cannot vary based upon the volume or value of referrals, and bonuses are limited to personally performed services. Under the in-office ancillary services exception, the hospital has greater flexibility because profits from DHS can be divided among the physicians in the group practice.

A cautionary note: if a physician is on a productivity model, and the hospital determines that there is a coding error for which the hospital will have to make any repayment, then those wRVUs that are subject to the repayment have to be backed out of the compensation model. If the hospital allows the physician to retain the wRVUs and the compensation from those wRVUs that it has repaid, it is arguable whether that’s fair market value and commercially reasonable because the physician has been credited for wRVU credit that the hospital had to pay back. Hospitals could conduct periodic audits of any physician that it believes is high risk because of the compensation level or because of a high coding error rate and seek repayment from the physician for any wRVUs that have been repaid.

**Medical Directors**

Contracts for medical director services are prime candidates for Stark law issues. Medical directorships are for administrative services, not clinical services, although they do provide clinical oversight. There is medical director benchmark data in the surveys, for example, Sullivan Cotter and the Medical Group Management Association surveys.
Medical Director

- Medical directorships are for administrative services, not clinical services.
- Medical director benchmark data exist.
- Clinical benchmark data can be used if the administrative services require
  (a) a physician, and
  (b) a physician of a specific specialty.
- Structure of compensation (and underlying FMV documentation) may depend upon legal status: employee vs. independent contractor.

An independent contractor may receive an hourly payment with a maximum number of hours specified in the contract or an annual payment determined by a projected number of hours multiplied by the FMV hourly rate.

Hospitals can use clinical benchmark data for an administrative service if this service requires a doctor or a doctor of a specific specialty. For example, if the hospital needs an orthopedic surgeon to be a medical director of its orthopedic departments, experts believe it is commercially reasonable to use the clinical benchmark data in order to justify the compensation.

Hospitals also must decide whether to have an hourly compensation or an annual payment for medical directors. Hourly payments for services actually rendered and documented, from a compliance perspective, are a good conservative approach.

If the facility wants to pay some type of monthly stipend or annual payment, it’s going to have to monitor the services and the number of hours rendered to make sure that they are consistent with the projections on which the annual payment was based.

The monitoring method is the timesheet. Timesheets are necessary for two reasons. While they are not legally required, from a compliance and legal perspective, if the hospital has a timesheet filled out by a referring physician, then it serves as documentation of the services rendered. Second, especially for hospitals, if the medical director compensation is going on the cost report, there is a cost report requirement that a periodic time allocation or calculation of the services that are rendered hit the cost report. Appendix A presents an example of a tool used to track the time of a medical director.

One common problem is that the documentation based upon the services rendered by the physicians does not align with the amount of compensation in the annual payment. Hospitals need to monitor this on a daily basis to ensure compliance. Many hospitals believe Stark law compliance starts at the commencement of the contract. While it does, it’s during the term of the arrangement where compliance issues related to Stark arise. Lack of management during the term of the agreement can cause the arrangement to fall out of fair market value and not be commercially reasonable.
Real Estate

Real estate transactions have been a major and expensive contributor to Stark violations. From a compliance perspective, they have both fair market value and commercially reasonable elements.

The fair market value query asks, “Is the physician paying occupancy costs that are consistent with arm’s length relationships in comparable properties in the local market?”

For commercial reasonableness, the query is, “Is the hospital establishing rental rates in amounts sufficient to generate positive cash flows and a rate of return consistent with (1) risk and (2) other local real estate investors? Is this space an amount that is needed by the physician?” For example, let’s assume that all of the other real estate owners that are renting office buildings are generating a 10% margin on average in your community. But when you look at your medical office buildings, you’re losing 10%. This could be attributed to a number of factors, one of which would be rents that are less than fair market value, which violates Stark.

Calculating a Reasonable Rate of Return. To be commercially reasonable, unless extenuating circumstances exist, real estate should generate a reasonable rate of return. A commercially reasonable rate of return is calculated as follows:

\[
\text{(Amortized Cost of Building + interest + expenses) - rent receipts} = 10\% + (\text{Market reasonable rate of return})
\]

Other factors to take into account when assessing the commercial reasonableness of a rate include the following:

◆ Whether tenant improvements (TIs) are consistent with the market and whether the charge for improvements that are not market standard are likewise consistent.
◆ New space (higher TIs)
◆ Rehab (presumption — lower TIs)
◆ Standard TIs
◆ Enhanced TIs
◆ Prorate with lease payments with interest
◆ Pay up front
◆ Leasing costs
◆ Amenities (parking, security, Internet, etc.)
◆ Total cost (design, construction, land, financing, HVAC, taxes, janitorial, legal, etc.)
◆ Quality of building — Is it a Class A, B or C building?
Real Estate Complexities: Office Space Rates

- Square foot measurement
- Real estate appraisals
- Gross lease vs. triple net lease
- Payment of increases in operating expenses
- Tenant improvements
- Holdover rent
- Exclusive use
- No percentage-based leasing arrangement
- No per-click rental for referrals from lessor

Time Share Arrangements

These types of real estate transactions pose the most problems when evaluating for compliance, primarily due to the complexity of allocating costs to establish a fair market value rental rate. To set the FMV rental rate, all costs must be allocated:

- Rental of space (half- or full-day slots)
- Vacancy rate (project 30% vacancy?)
- Supplies
- Utilities
- Staff (registration, nursing, etc.)
- Equipment

Let’s look at an example. Assume the following:

- $18 gross per square foot rental (exclusive use)
- 30% projected vacancy
- 1,000 square feet in suite
- Building has 6,000 square feet, with 1,000 square feet for common area (5,000 square feet usable space)
- Suite capable of being leased in half-day increments (8:00 A.M. – Noon; 1:00 P.M. – 5:00 P.M.)
- Furniture and equipment in suite determined to be leasable at $2,000 per year using independent third-party leasing company.
- Miscellaneous medical/office supplies projected to be used in suite is approximately $5,000 annually if suite is leased 70% of the time.
Here’s the calculation:

$18 (exclusive use rate) (30% vacancy) = $25.71 per square foot ($18 \div .7 = $25.71)

1,000 square feet (suite) ÷ 5,000 square feet (total in building not including common area) = 20% (percentage of suite’s usable space in building’s usable space)

1,000 square feet (common area) x 20% (suite to building) = 200 square feet (common area allocated to suite)

1,200 square feet (suite plus allocated common area) x $25.71 = $30,852

$30,852 + $2,000 (furniture and equipment) + $5,000 (medical/office supplies) = $37,852

$37,852 ÷ 52 (weeks) = $728 (weekly rate)

$728 ÷ 5 (business days in week) = $146 (daily rate)

$146 ÷ 2 = $73 (half-day rate)

The example becomes more complicated if:

◆ Part of suite is leased (as opposed to full suite).
◆ Staff is provided by landlord/hospital.
◆ Specialized equipment is used.
◆ Non-standardized supplies are used by a tenant.

<table>
<thead>
<tr>
<th>Time Share Lease Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Specific days, # of days</td>
</tr>
<tr>
<td>• What is exclusive use? What must be used exclusively?</td>
</tr>
<tr>
<td>• Is a lease required?</td>
</tr>
<tr>
<td>• Hospital patients – Can the hospital arrange for specialists to see the hospital’s patients in hospital space?</td>
</tr>
<tr>
<td>• If the hospital schedules the patient but does not bill provider-based, can the hospital charge the physician the technical fee?</td>
</tr>
</tbody>
</table>

**Operationalizing the Contract Process**

All of the above concerns must be taken into consideration when negotiating contracts with physicians, and facilities want to make sure that they operationalize all of their contractual arrangements appropriately. How is this done?

First, have a formal process with respect to the development of the contract and also the approval of the contract. Ideally it would be better to evaluate to the financial terms before the financial terms are discussed with the physicians. But if that is not
feasible, then the CEO should turn to legal counsel or the compliance officer for the development of the contract. As the terms of the contract are being worked out, someone internally should evaluate each provision both from a fair market value and a commercial reasonableness perspective and document why the terms are compliant.

Once the contract is developed, it should be vetted before an independent committee. Sometimes the committee comprises high level executives within the organization. One approach is to have the person recommending the contract come before the committee and explain why the arrangement is commercially reasonable, why it’s needed from business perspective and why they believe it to be fair market value.

From a fair market value perspective, as long as the compensation is benchmarking at the 50th percentile or less, going back to that fair market value safe harbor under the Phase II regulations, you’re probably safe. But between the 50th and 75th percentile, the compensation is higher than average and will need more vibrant documentation as to why this particular physician warrants compensation above the median.

Once you get above the 75th percentile, it is recommended that the hospital send that contract out to an independent third party, again either a lawyer or a third-party evaluation company that can analyze everything. Compensation in the top quartile increases the risk, so all the documentation should go before the review committee, and the committee should vote on whether they believe the contract meets the necessary standards.

Once the contract makes it out of the approval process, then it moves towards execution. Someone — a paralegal, a lawyer, a contract manager — needs to be responsible for ensuring that the contract is appropriately executed with signatures of both parties and date of execution. Then it needs to be validated once again before the commencement of the financial arrangement.

If the hospital begins to honor the financial arrangement before the contract is properly executed, it may fall out of Stark compliance. There is an exception in §411.353(g) (1) that allows an arrangement to begin without a signed contract as long as the contract is signed 30 consecutive calendar days immediately following the date on which the compensation arrangement commenced, which would be the date the arrangement began without the signed contract. If the lack of signatures on the contract was inadvertent, the contract must be signed within 90 days of the date it became noncompliant to avoid Stark liability.

When the financial arrangement begins, the contract should be entered into a contract management database. This database should be populated with key fields like the compensation amount, the commencement date, the termination date and the services or items. When the request for approval comes into the finance office, they can go into the contract management database and make sure that the request for payment is consistent with the terms that are in the database. And if they’re not, then they need to contact somebody either in the compliance department or the legal department to validate whether this payment is permissible under the written contract.
For example, a physician attends a continuing medical education event and submits expenses of $2,000 to the hospital. Finance reviews the terms in the contract database and discovers that the contract does not say that the hospital will reimburse for that CME. This means that there has to be good connection and communication between the three departments — the finance department, the compliance department, and the legal department — and when issues arise when payment happens, they need to go back to the actual contract with the assistance of compliance or legal that validates that the payments that are being requested. In addition, the CEO and COO usually are involved with contract negotiations and approval.

At the end of the contract term, somebody again should be responsible — most likely in the legal department — to notify the appropriate person in the hospital that the contract is about to expire and ask whether the contract will be renewed, renegotiated, or allowed to expire.

**Conclusion**

A well-managed physician contract process is crucial to avoiding Stark law problems that may arise and keeping investigators at bay. The majority of situations disclosed to CMS under the Self-Referral Disclosure Protocol involve “arrangements” that do not comply with the Stark rules, and the big cases, such as Halifax and Tuomey, always seem to involve noncompliant contracts.

Hospitals not only should have a process to ensure that the contract itself meets all the Stark requirements for the types of services rendered but must monitor the performance of the contract to ensure that, for example, that the time spent is equal to that specified in the contract on which compensation is based. It is too easy to have an arrangement fall out of compliance because the physician did not log enough hours to justify the compensation. The hospital also must pay attention to expiring contracts and decide whether to renew them or let them expire. Without a new contract, the physicians may not continue to perform the services.
Question and Answer Session

QUESTION: Can you recommend a process for managing physician contracts to ensure Stark compliance? Who should be in charge? How often should they be pursued? And what do you do about old contracts still in effect?

Wade: Very good question. And it goes back to that operational issue; we want to make sure that we operationalize all of our contractual arrangements appropriately.

First, you need to have a formal process with respect to the development of the contract and also the approval of the contract. Ideally it would be better to evaluate to the financial terms before the financial terms are discussed with the physicians. But I understand that a lot of times that doesn’t happen; usually the CEO will meet with the physician and they say, ‘Okay, let’s talk about a financial arrangement.’ And then typically the CEO will then turn to legal counsel or the compliance officer for the development of the contract. And I think that’s an okay process. While the development of the contract is occurring, then, either internally or externally, someone should be the evaluating the proposed terms both from a fair market value perspective and also a commercial reasonableness perspective and documenting that.

Once the contract is developed, then the best process is to have the contract vetted before an independent committee. What I’ve seen most frequently is high level executives within the organization serving on the committee. By way of example, Halifax Health calls their committee PARC, which stands for Physician Arrangement Review Committee. The person who is recommending the contract comes before the PARC committee and explains why the arrangement is commercially reasonable, why it’s needed from business perspective, and why he or she believes it to be fair market value. With the fair market value you can either develop that documentation internally or turn to external resources to assist you.

I believe from a fair market value perspective as long as the compensation is benchmarking at the 50th percentile or less, going back to that fair market value safe harbor under the Phase II regulations, you’re probably going to have to have a lot of documentation on the fair market value side. But between the 50th and 75th percentile, obviously we’ve got compensation that’s greater than average, and you’ll need more vibrant documentation as to why this particular physician is warranted to have compensation above the median.

Once you get above the 75th percentile it’s my recommendation that you send that contract out to an independent third party, again either a lawyer who knows the Stark rules and understands fair market value, or a third party evaluation company that does fair market value assessments. Once you get above the 75th percentile, you have something in the top quartile, and it increases the risk. All the documentation should go before your review committee, and your committee should vote on the compensation.
What is unique about Halifax is every member of their review committee has a veto power. Typically when I have these type of committees, it is majority rule, but Halifax has said they really strongly believe that anybody should have the ability to speak up and stop the speeding train. Thus in their review committee, anybody possesses the veto power. If the arrangement is vetoed during a meeting, the sponsor can try to bring it back if there’s additional documentation.

Once it makes it out of the approval process then it goes towards execution. You need somebody — a paralegal, the lawyer, a contract manager — who is responsible for ensuring that the contract is appropriately executed. It then needs to be validated before the commencement of the financial arrangement. If the contract is not signed when the financial arrangement begins, you are going to fall outside of compliance with Stark. There is a signature leniency exception that exists, under which there’s a possibility that you can start the financial arrangement as long as the written arrangement exists at either 30 or 90 days before the commencement of the financial arrangement. But for general purposes somebody’s got to be in charge to make sure the contract is signed by both parties.

Now the commencement of the financial arrangement can begin. The contract, however, should then be put in to a contract management database. This database should be populated with key fields like what is the compensation amount, what is the commencement date, what is the termination date. With this information, people from finance can go into the contract management database and make sure the request for payment is consistent with the terms in the database before they approve it. And if they’re not, then finance needs to contact somebody either in the compliance department or the legal department to validate whether or not this payment is permissible under the written contract.

I’ve seen this before. A physician goes off on a continuing medical education trip and wants to be reimbursed for $2,000 for that CME. You look at the contract, and it doesn’t say that the hospital will reimburse for that CME. There’s got to be a good connection between the three departments; the finance department, the compliance department and the legal department. Use the database to communicate between the three departments, but when issues arise, before payment happens, they need to go back to the actual contract with the assistance of compliance or legal to validate that the payments are authorized by the contract.

Again, I’ll use Halifax as an example. Halifax is hiring a Payment Officer. And before any payment is made to a referring physician, this payment officer has to approve it. He is going to look over the accounts payable documentation, the contract management database, look over the contract itself to make sure that the payment is warranted. Now, that’s not required by their corporate integrity agreement; it’s just an extra layer for safety the hospital decided to add. I doubt if very many hospitals have that type of person around the country. It’s the first time I have heard of a hospital hir-
ing for this purpose, but it helps ensure compliance at the time of payment because the train can fall off the tracks if you make an inappropriate payment.

At the end of the contract term, somebody should be responsible for notifying the contract sponsor that the contract is about to expire and ask that what he wants to do with the expiring contract. And hopefully if he wants the contract arrangement to continue, he’ll modify the arrangement, draft a new arrangement, and then the whole life cycle begins again.

So you can see you’ve got a lot of moving parts involving the three primary departments: legal, compliance and finance. A fourth player probably is the CEO, COO and CFO who are out there negotiating those contracts. They play a key part in the approval process probably through the approval committee. That’s how I’ve seen it work most effectively.

**QUESTION:** Who does the payment control officer report to and what are his qualifications?

**Wade:** Well, it’s interesting because we debated inside Halifax as to the type of credentials the person should have — finance, compliance, legal — and we ultimately decided it was going to be a lawyer. They, however, were in a unique position: they had an attorney who was a general counsel at a hospital system who was retiring and wanted to have a part-time position in Daytona Beach, so he decided that this would be a good role for him. There was some debate also as to whether or not he would report to compliance and legal or to the CEO. At least at this point he’s going to report to the CEO, but this may change.

**QUESTION:** My organization installs pharmacies in group practices under the in-office ancillary services exception, and this question that has often come up. Assume there are 10 physicians in the group practice, but there are only two physicians that own the practice. We are asked whether we can compensate the other employed physicians for referring to the pharmacy and we say no. Is there any other way that those employed physicians can be compensated or bonused in some way?

**Wade:** Under the group practice definition, you either can provide a bonus program for personally performed services, which is not your question I understand; I just wanted to make sure people understood that there are two ways; or through a profit sharing of DHS. So my answer would be yes. You can provide financial sharing of the profit that’s being generated through these outpatient prescription drugs as long as the methodology is set in advance, and there is not a direct tie-in. Typically you share it on a per capita basis; if there are ten physicians, you take the profit generated and divide that by ten, and then everybody shares equally, that’s very safe.

What you don’t want to do is say to the doctor, you ordered 10% of the pharmaceuticals that are generating the profit; therefore we’re going to give you 10% of the profit.
There can be no direct link between the distribution of the profit and the physician’s ordering. There can be an indirect link through the group practice definition.

**QUESTION:** For productivity bonuses, is it correct that a physician should not be bonus on RVUs produced by non-physician providers under their oversight?

**Wade:** It depends on which exception a practice or facility is working under; if you’re under the in-office ancillary services exception you can; the doctor can receive a direct benefit from the work RVUs that are being generated by the midlevel provider. If, however, you’re using the employment exception you cannot, because you’re limited there to only the personally performed services.

However, I have generated compensation arrangements using what I would call “phantom work RVUs.” For example, if I believe that the supervision services of that physician is worth about $10,000, then I can allocate a percentage of the work RVUs generated by the non-physician provider and give the supervising physician a limited amount of credit, let’s say 10% credit for every work RVU with the assumption that through that 10% credit, the physician will earn $10,000.

Now I’m not paying the physician directly for the services performed by that non-physician provider; what I am doing is I’m giving credit to that physician for the supervision services through the allocation of phantom work RVUs. There’s a way that you can do it, but it’s not, if you’re living under an employment exception you can’t give a 100% full credit to the physician as a bonus.

**QUESTION:** Can you explain a more about the use of the “master list” you can reference in the contract?

**Wade:** The master list is a requirement in the personal services arrangement exception. Often when I draft a contract and give it to a non-healthcare lawyer, he always wants to delete the master list reference. Going back to the personal services arrangement exception, one of the requirements is that in the contract you either have to cross reference all of the other services that the physician is providing to the DHS provider, or you have to state in the contract that the DHS entity maintains a master list of all of the arrangements that the hospital has with the referring physician. If the Department of Health and Human Services, OIG, or CMS ever wanted to come in and find out all the other contractual arrangements, that master list has to be available for discovery for the cross reference. The contract management database we’ve discussed, that’s your master list.

If you’re dealing with a lawyer who wants to delete that section and you agree, you’re not cross referencing everything, and you won’t comply with all of the components of the personal services arrangement exception. You still may comply with the fair market value exception, because the fair market value exception does not require a cross reference to the master list, it’s only in the personal services arrangement exception.
tion. If my client has a contract management database, I always put in a cross reference to the master list. But that’s the purpose.

**QUESTION:** What should compliance professionals do to ensure physician accountability from employed physicians who are compensated at the higher end of the fair market value range, but have a high coding error rate for evaluation and management services, as well as for procedures?

**Wade:** Any time an employee physician is above the 75th percentile, then I would say from a compliance perspective those physicians should be in a higher risk category. A lot of times with my clients, we categorized a physician from a compensation and also a coding perspective either high risk, medium risk or low risk. I would always classify somebody that’s producing work RVUs above the 75th percentile as a potential high risk.

I would go through a periodic auditing or review of that physician’s claims, preferably on a pre-bill basis — they call it prospective review versus retrospective review. I also would audit a few other claims to determine whether or not there are coding errors and use the findings to educate the physician regarding correct coding standards.

Another thing I do with all my clients is that if they have a physician on a productivity compensation model, and its later determined that there is a coding error for which the hospital will have to make any repayment, then those work RVU’s that are subject to the repayment have to be backed out of the compensation model. If you allow the physician to retain the work RVUs and the compensation from those work RVUs that you repaid, it’s arguable whether or not that’s fair market value and commercially reasonable because now you know that you’ve compensated a physician for a work RVU credit that you had to pay back.

I would cover this through classification of a physician being high risk because they’re high productivity and compensation. I would protect yourself through the use of periodic audits, probably at least twice a year. Then in the contract have a mechanism whereby you can seek repayment from the physician for any work RVUs that are subject to a repayment.

**QUESTION:** What about a captive insurance program for physicians if the captive is owned by the hospital?

**Wade:** Well the captive insurance must either be billing for DHS performed or they must be actually performing DHS. I don’t believe that a captive insurance with the assumption that they’re a wholly owned subsidiary of the hospital is a DHS entity.

However, you could have an indirect compensation arrangement that needs to be analyzed. If the physicians are receiving payment from the captive insurer, then obviously that’s compensation, and you also have ownership between the captive insurance and the hospital. Then you have to analyze the overall arrangement to determine
whether or not you meet the indirect compensation arrangement definition. Just thinking out loud — you probably do. You have to look at the closest compensation arrangement with the referring physician, which is the arrangement between the captive and the physician and determine whether or not the compensation paid varies based on the volume of value of referrals.

Since it is probably based upon services rendered, yes, it does vary. So the next question is do we still fall within the indirect compensation exception.

The next question is that within the exception then the captive has to have a contract with the referring physician and the compensation has to be fair market value. So Stark is implicated, but it’s implicated through the application of the indirect compensation arrangement definition. You still should be able to meet the indirect compensation arrangement exception.

**QUESTION:** If an employed physician is making charitable donations, can he or she allocate funds back to the practice?

**Wade:** Does that mean if I’m a doctor I’m making a charitable donation to the hospital, but I’m going to earmark that charitable donation for the benefit of my practice? If that’s the nature of the question, then first there is a charitable donation exception under Stark. If the physician making the charitable donation, which can be either time or money, to the hospital that meets the exception, you’re fine.

One common example would be a charity clinic where the medical staff donates hours without any compensation.

I’m thinking we probably have a potential indirect compensation arrangement between the physician and the practice, which I am assuming is a subsidiary of the hospital. But I don’t think in this context we’re going to meet the indirect compensation arrangement exception. So, I think it’s all doable but I would need to know more facts because you’d have to use the application of the indirect compensation arrangement definition and exception and that gets very fact specific and detailed. So I just generally I’d say that that would be acceptable, but I would need more facts.
# Appendix A: Medical Director Tracking Tool

## Name of Hospital A

Please complete this timesheet by the X day of the month and return it to X.

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Medical Director of [Title]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Period from [Mo., Day, Yr.] through [Mo., Day, Yr.]</td>
<td></td>
</tr>
</tbody>
</table>

*For a full description of duties, refer to the Medical Director Agreement between [Hospital A and Physician X]*

<table>
<thead>
<tr>
<th>Duties/date and No. of hours in half-hour increments</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Provide program assistance, guidance, and recommendations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Provide medical guidance and direction.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Provide educational inservices and/or conferences.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Administrative duties.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Be available to discuss and review treatment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Be a physician liaison.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Meet regularly with clinic staff. Attend meetings as requested.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

<table>
<thead>
<tr>
<th>Signature of Physician:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

In addition to the hours performed, please describe the services performed during this pay period.

Created by Bob Wade, Esq., Krieg DeVault LLP, Mishawaka, Indiana
### MEDICAL DIRECTOR TRACKING TOOL

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Current Hourly Pay</th>
<th>Contract Hourly Pay</th>
<th>Contract Weeks</th>
<th>Actual Total Hrs. Wrk</th>
<th>Prorated Hrs.</th>
<th>Contract Annual Hrs.</th>
<th>Contract Start Date</th>
<th>Contract Expire Date</th>
<th>Total Annual Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td>$102.42</td>
<td>$114.00</td>
<td>17</td>
<td>65.5</td>
<td>59</td>
<td>180</td>
<td>09/01/10</td>
<td>08/31/11</td>
<td>$20,520.00</td>
</tr>
<tr>
<td>Dr. B</td>
<td>$117.65</td>
<td>$102.56</td>
<td>26</td>
<td>68</td>
<td>78</td>
<td>156</td>
<td>07/01/10</td>
<td>06/30/11</td>
<td>$16,000.00</td>
</tr>
<tr>
<td>Dr. C</td>
<td>$142.12</td>
<td>$111.00</td>
<td>43</td>
<td>201.5</td>
<td>258</td>
<td>312</td>
<td>08/01/10</td>
<td>07/31/11</td>
<td>$34,632.00</td>
</tr>
<tr>
<td>Dr. D</td>
<td>$139.54</td>
<td>$137.80</td>
<td>4</td>
<td>79</td>
<td>80</td>
<td>1040</td>
<td>08/01/10</td>
<td>07/31/11</td>
<td>$143,310.40</td>
</tr>
<tr>
<td>Dr. E</td>
<td>$134.77</td>
<td>$97.87</td>
<td>26</td>
<td>321</td>
<td>442</td>
<td>884</td>
<td>07/01/10</td>
<td>06/30/11</td>
<td>$86,520.00</td>
</tr>
</tbody>
</table>

- **Current Hourly Pay**: Current hourly rate based upon total hours documented (Total Annual Compensation/(52 X Contract Weeks)/Actual Total Hours Worked)
- **Contracted Hourly Pay**: (Total Annual Compensation)/(Contracted Annually Hours)
- **Contract Weeks**: Number of weeks into current annual contract cycle
- **Total Hours Worked**: Number of hours of services documented by physician during current term based upon time sheets approved (cumulative number)
- **Prorated Hours**: Average hours physician would have worked if hours evenly distributed throughout contract term
- **Contracted Annual Hours**: Number of hours required by contract on annual basis
- **Contract Start**: Effective date of current annual term
- **Contract Expiration**: Expiration date of current annual term
- **Total Annual Compensation**: Total amount of annual compensation per contract

Created by Bob Wade, Esq., Krieg Devault LLP, Mishawaka, Indiana
Appendix B: Excerpts from AIS’S A Guide to Complying with Stark Physician Self-Referral Rules

Key Elements of the Compensation Exceptions

The compensation exceptions have a number of common elements, and the correct understanding of compensation exceptions revolves around the understanding of the following terms:

- Fair market value
- Commercially reasonable
- Volume or value of referrals
- Other business generated
- Set-in-advance

In addition, many of the exceptions require a signed, written agreement.

‘Fair Market Value’

Virtually all of the compensation arrangement exceptions require that the remuneration paid be consistent with “fair market value.” The Stark law and regulations define “fair market value” as “the value in arm’s-length transactions, consistent with the general market value.”

CMS made it clear that it will accept any method that is commercially reasonable and provides the agency with evidence that the compensation is comparable to what is ordinarily paid for an item or service in the relevant location by parties in arm’s length transactions who are not in a position to refer to each other. In other, words, the characteristics of each transaction, such as the type and the location, will dictate the acceptable valuation methods. CMS cautions that an independent valuation does not in and of itself assure the accuracy of the figure. Phase II, 69 Fed. Reg. 16107.

In most of the exceptions, the fair market value standard also is coupled with the prohibition on taking into account the volume or value of referrals or other business generated by the parties. This condition affects fair market value and the comparables that may be used to establish its value.

TIP

In the Phase I preamble, CMS points out that fair market value for physician compensation probably precludes relying on comparables that involve entities and physicians in a position to generate business or referrals. Phase I, 66 Fed. Reg. 944.
The definition of “fair market value” in §411.351 defines “general market value” for compensation, assets, and rental property and equipment. The definitions are similar but with unique features for each one.

With regard to compensation, “general market value” is “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 service agreement.” The fair market price, according to the definition, is “the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.” SSA §1877(h)(3); 42 U.S.C. §1395nn(h)(3); §411.351.

CMS, in the Phase III preamble, also notes the hospitals must use the fair market value for administrative services. Contracts for physician services also may include an annual adjustment, including a cost-of-living adjustment, as long as the resulting compensation is fair market value. Phase III, 72 Fed. Reg. 51016.

For an asset transaction, “general market value” is defined as “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 . . .” on the date of acquisition of the asset; the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity, and quantity in a particular market at the time of acquisition. §411.351.

For purposes of rental property, “fair market value” means “the value of rental property for general commercial purposes (not taking into account its intended use).” SSA §1877(h)(3); 42 U.S.C. §1395nn(h)(3); §411.351. The phrase “not taking account its intended use” is unique to the office space and equipment exceptions. It means that comparables may be any commercial property, not simply those with medical purposes, such as medical office space. As CMS stated in the Phase I preamble, the payment for a rental property will reflect the

“value of property for general commercial purposes, not taking into account its intended use” when it takes into account any costs that were incurred by the lessor in developing or upgrading the property, or maintaining the property or its improvements, regardless of why the improvements were added. That is, the rental payment can reflect the value of any similar commercial property with improvements or amenities of a similar value, regardless of why the property was improved. On the other hand, we also believe that rental payments would specifically take into account the intended use of the property if the lessee paid inflated amounts solely to enhance his or her medical practice. For example, rental payments by a physical therapist would not be fair market value for purposes of section 1877 of the Act if the physical therapist agreed to pay an inflated rate that was not justified by improvements or other amenities and was higher than the rate paid by other, similarly situated medical practitioners in the same building just because the building was occupied by several orthopedic practices.”

However, if the location of a medical practice in a medical building has a fair market value that is higher than offices in buildings without other medical practices and the payment is
comparable to that paid by the other practices in the building, the payment would meet the

This definition is not intended to prevent the parties from taking into account the cost of
leasehold improvements or maintenance of the particular property. This is made clear by the
following sentence in the regulatory definition of “fair market value”:

For purposes of this definition, a rental payment does not take into account intended
use if it takes into account costs incurred by the lessor in developing or upgrading the
property or maintaining the property or its improvements. §411.351.

In the Phase III rule, CMS addressed the treatment of improvements made to office space at
the request of the lessee. For the purpose of fair market value, if a lessor provides improve-
ments at the request of the lessee that benefits only the lessee and will not be chargeable to any
subsequent tenant, the lessor should allocate the entire cost of the improvements to the lessee.
If the lessor reasonably believes the improvements will benefit subsequent tenants, the costs
may be allocated over their expected useful life. Phase III, 72 Fed Reg. 51045.

In the case of a lease of space, the prohibition on additional value either party would attribute
to the proximity or convenience to the lessor is restricted to physician lessors who are potential
sources of referrals to the lessee. 66 Fed. Reg. 945. With regard to the application of the limita-
tion to hospitals, CMS states:

That limitation does not appear to us to apply when an entity, such as a hospital, refer-
to the physicians. As a result, we believe a hospital should factor in the value of prox-

Contractual joint ventures, related party transactions, and other arrangements that may not be
at arm’s-length raise compliance questions under these fair market value definitions. It, there-
fore, is advisable, particularly for these types of transactions, to obtain a fair market valuation
from a reputable, independent appraiser with the qualifications to appraise the particular type
of arrangement. CMS also cautions that an independent valuation does not in and of itself as-

Alternatively, the parties may benchmark remuneration against market-comparable transac-
tions to evidence that the arrangement is at fair market value.

‘Commercially Reasonable’

Seven compensation arrangement exceptions explicitly require that the remuneration must
be paid under an agreement that would be “commercially reasonable” even if there were no
referrals between the parties.1 [1 The exceptions are rentals of office space and equipment
(§411.357(a) and (b)); bona fide employment relationships ((§411.357(c)); isolated transactions
(§411.357(f)); group practice arrangements with a hospital (§411.357(h)); fair market value
compensation (§411.357(l)); and the indirect compensation exception (§411.357(p)). The excep-
tion for personal service arrangements does not use the term “commercially reasonable” but
does require “the aggregate services contracted for do not exceed those that are reasonable and
necessary for the legitimate business purposes of the arrangement(s).” §411.357(d)(1) (iii).] In
the proposed Stark II rule, CMS explained that a commercially reasonable arrangement was
one that appears to be a “sensible, prudent business agreement, from the perspective of the
particular parties involved, even in the absence of any potential referrals.” Prop. Stark II, 63 Fed. Reg. 1700. In the Phase III rule, CMS elaborated on this statement, saying “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 (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals.” Phase II, 69 Fed. Reg. 16093.

In the preamble to the FY 2009 Inpatient Prospective Payment Final Rule, CMS again elaborated on its view of commercially reasonable:

[W]e would … have a serious question as to whether an agreement is commercially reasonable if the lessee is performing a sufficiently high volume of procedures, such that it would be economically feasible to purchase the equipment rather than continuing to lease it from a physician or physician entity that refers patients to the lessee for DHS. 73 Fed. Reg. 48714 (Aug. 19, 2008).

In short, an arrangement must be commercially reasonable for both the services and the payment.

Whether an arrangement is “commercially reasonable” has been an issue in a number of settlements and court cases. The Department of Justice alleged that Marion County Medical Center in South Carolina, among other things, paid two physicians compensation that was not commercially reasonable because the monthly compensation was more than 100% in excess of fair market value. The settlement was announced on July 18, 2006. In the Memorial Health University Medical Center, Savannah Ga., (settled April 24, 2008) case, the government alleged that the medical center paid employee-ophthalmologists at a level that exceeded the fair market value of their services, and thus the compensation was not commercially reasonable. In the HCA/Parkridge Medical Center case (Chattanooga, Tenn.) (settled Sept. 19, 2012), the government allegations included a claim that HCA rented more space that was commercially reasonable for its business needs. Each of these settlements cost the hospital millions of dollars.

Recently, the most visible case of government allegations of commercially unreasonable arrangements is the whistleblower case against Tuomey Healthcare System (Sumter, S.C.). Here the government alleged that arrangements between Tuomey and employed physicians were not commercially reasonable because, although the compensation was based on legal opinions and a professional assessment of fair market value, the hospital was compensating the physicians at a level that far exceeded the revenue their services were bringing in for the hospital. Such an arrangement, the government contended, was not “commercially reasonable” and, instead, evidenced that the compensation was based on the volume or value of referrals and other business generated by the physicians. The proceeding, which went through several iterations, finally resulted in a verdict against Tuomey for violations of the Stark law. U.S. ex rel. Drakeford v. Tuomey Healthcare System, Inc., No. 3:05-cv-2858 (D.S.C.).

A hospital should weigh a number of factors when it assesses an arrangement for its commercial reasonableness. Internal factors include the following:

- What is the business purpose of the arrangement? Does it further the strategic goals of the facility?
- Why does the facility need these particular services?
Does the hospital require a physician of a particular specialty?

- Can the service be performed by a non-physician provider?

- Does the physician have sufficient knowledge, experience, and training for the position (i.e., Medical Informatics)?

- Are the duties and responsibilities necessary from both a medical and business perspective?

External factors to consider are the following:

- Do the specific market conditions support the level of compensation to be paid (i.e., high demand but low supply for specialty, trauma center versus non-trauma center)?

- Is the compensation paid consistent with other similarly situated hospitals (i.e., call compensation, payment for indigent care)?

As commercial reasonableness continues to emerge as a basis for finding a Stark violation, hospitals and physicians should thoroughly document the reason for the arrangement.

‘Volume or Value of Referrals’

Virtually all of the compensation arrangement exceptions, including the office space rental, equipment rental, employment, personal service arrangements, fair market value, as well as the academic medical center exceptions, prohibit compensation that takes into account the volume or value of referrals to the DHS Entity by the referring physician. CMS has clarified that “referrals” in the phrase means referrals for Medicare-covered DHS. This clears up an ambiguity in the definition of “referral” about whether referrals also include referrals for non-Medicare-covered services. Prop. Stark II, 63 Fed. Reg. 1692.

In §411.354(d)(2), CMS specifies that unit-based compensation (whether time- or service-based) does not vary with the volume or value of referrals (although aggregate compensation based on such methodologies does so vary), as long as the compensation is set in advance and does not vary during the term of the agreement in any way that takes DHS referrals into account. CMS further clarifies that referrals for purposes of the volume or value test do not include referrals for the professional component of DHS personally performed by the referring physician. §411.351(1)(i) (definition of “referral”).

In the final 2010 Physician Fee Schedule Rule, CMS made clear that for purposes of determining whether compensation is based on the volume or value of referrals, it looks to all the members, physicians, and independent contractors in the physician organization, not just the physician owners who stand in the shoes of the organization. 74 Fed. Reg. 61932.

A U.S. district court in U.S. v. Bradford Regional Medical Center, Civil No. 04-86 Erie (W.D. Pa. Nov. 10, 2010) added its view of the meaning of the term “referral.” The court, after citing the definition of “fair market value” in §411.351 and language in the Stark rule preambles addressing the physician recruitment provision and the physician compensation exception (Phase III, 72 Fed. Reg. 51048) and a discussion of the value or volume standard (Phase I, 66 Fed. Reg. 877), concluded that CMS intended the term “referral” to encompass both actual and anticipated referrals. This interpretation is significant when analyzing whether the volume and value of referrals were taken into account when determining fair market value for compensation.
In U.S. ex rel. Drakeford v. Tuomey Healthcare System, Inc., No. 3:05-cv-2858 (4th Cir., March 30, 2012), the U.S. District Court for South Carolina looked to the regulations and the Stark preambles to determine “whether anticipated referrals constitute a proper basis for finding that a physician’s compensation takes into account the volume and value of referrals.” The court cites language in the Phase I preamble (66 Fed. Reg. 877), which says that the volume or value standard is not implicated where the physician must refer to a particular provider as a condition of payment, as long as “the payment is fixed in advance for the term of the agreement, is consistent with fair market value for the services performed (that is, the payment does not take into account the volume or value of the anticipated or required referrals), and otherwise complies with the requirements of the applicable exception…” Based on the preamble and the regulatory definition of fair market value, the court concluded “that compensation based on the volume or value of anticipated referrals implicates the volume or value standard.”

The U.S. District Court, Middle District of Florida, in U.S. ex rel. Baklid-Kunz v. Halifax Hospital Medical Center and Halifax Staffing, Inc., found that the hospital violated Stark by distributing bonuses to employee-oncologists that were not restricted to the physicians’ personally performed services. Halifax had argued that because the bonuses were distributed based on the physicians’ personally performed services, they did not take into account the volume and value of referrals; however, the bonus pool itself included revenues from DHS such as outpatient services not personally performed by the physicians, and because of the composition of the bonus pool, the bonuses did take into account the volume and value of referrals.

Whether compensation takes into account the volume or value of arrangements can be a tricky matter. Even if compensation is based on fair market value and services are arguably medically necessary, the government may find a Stark violation if it believes physicians were paid, in some form or fashion, on the volume or value of referrals. The more that compensation arrangements are aligned with financial success, the greater risk the hospital has that the government can say it takes into account the volume or value of referrals — perhaps even when compensation is fixed in advance.

The following are four hospital compensation scenarios that are hazardous in terms of the volume or value of referrals under the Stark law, from the most risky (1) to the least risky (4):

(1) Paying physicians a certain amount for every referral or technical service obviously takes into account the volume or value of services and therefore runs afoul of Stark.

(2) Paying physicians a percentage of profits generated. Compensation is not technically tied to each referral, but the pool of money from which bonuses are paid is generated from the referrals of those physicians.

(3) Paying physicians fixed fees based on the operation of a department. Suppose the hospital rewarded them for meeting certain indicators. Maybe physicians were paid $500,000 if they met quality, efficiency and utilization goals. Because the bonus is fixed, this arrangement is safer than the first two, but there is still risk. When the hospital projects the success of the department from a budgetary perspective, it may take into account the volume or value of referrals.

(4) Paying physicians based on the financial success of the hospital as a whole. While this appear the safest option of the four, it is still not safe from government scrutiny. Suppose the fair-market value compensation range for a physician is $40 to $50 per work relative value unit.
If the hospital decides to pay the physician the high end of the FMV range, the government might argue it was influenced by the volume or value of the physician’s referrals and was not commercially reasonable — especially if there is a memo or email to that effect.

‘Other Business Generated’

The compensation arrangement exceptions, except for the *bona fide* employment exception, provide that compensation may not vary with the volume or value of “other business generated” by the referring physician for the DHS Entity. Other business includes private pay business as well as Medicare-covered DHS and other Medicare-covered items and services. Unit-based compensation (whether time- or unit-of-service-based compensation) is deemed not to take into account “other business generated between the parties” so long as the unit-based compensation is fair market value and is not adjusted during the course of the compensation arrangement on a prohibited basis. §411.354(d)(3).

As it did for the volume or value of referrals, in the final 2010 Physician Fee Schedule Rule, CMS made clear that for purposes of determining whether compensation is based on the volume or value of “other business generated,” it looks to all the members, physicians, and independent contractors in the physician organization, not just the physician owners who stand in the shoes of the organization.

Other arrangements, such as percentage arrangements, that provide incentive compensation based on the extent of business dealings between the parties, generally do vary with the volume or volume of referrals for purposes of the applicable Stark law exceptions.

**TIP: PERSONALLY PERFORMED SERVICES**

Note that a percentage arrangement based solely on collections or profits generated by services, including the professional component of DHS personally performed by the referring physician, and that does not involve any “incident to” revenue or DHS technical component revenue, is outside the scope of the Stark law. This is because such personally performed services do not involve any referral within the meaning of the Stark law and, thus, do not constitute other business generated by the referring physician.

‘Set-in-Advance’ Requirement

Hospitals and other DHS entities contracting with, but not employing, a referring physician for professional services must rely on the personal service arrangements, fair market value, or academic medical center exceptions. These exceptions, among other conditions, require that compensation to the referring physician be “set in advance.”

As originally proposed in the Phase I regulations, compensation to a referring physician structured as a percentage of revenues or profits, even non-DHS revenues or profits, could not satisfy the set-in-advance requirement. However, in response to numerous public comments, CMS, in the Phase II regulations, amended the definition of “set in advance” to include any compensation arrangement, including percentage-based compensation arrangements, calculated in accordance with any specific formula that is set forth in sufficient detail so that it can be objectively verified. The compensation amount, rate, or formula must be set out in an agree-
ment between the parties before the furnishing of the items or services for which the compensation is paid and may not be changed during the course of the agreement in a manner that reflects the volume or value of referrals or other business generated by the referring physician. Phase II, 69 Fed. Reg. 16092; §411.354(d)(1).

In the Phase III preamble, CMS confirmed that percentage-based compensation arrangements, such as percentage of collections or percentage of revenues compensation methodologies, may meet the set-in-advance standard, but only if the arrangements meet all other terms of a relevant exception. Phase III, 72 Fed. Reg. 51031.

CMS clarified in the FY 2009 Inpatient Prospective Payment System (IPPS) rulemaking that signatures do not need to be present to satisfy the set-in-advance requirement. IPPS, 73 Fed. Reg. 48697 (Aug. 19, 2008).

The definition of “set in advance” clears the way for hospitals and other DHS entities that rely on the personal service arrangements, fair market value, and academic medical center exceptions to compensate independent contractor physicians on a pre-agreed percentage or other productivity basis. To comply with applicable exceptions, however, the percentage arrangements may not vary with the volume or value of referrals or other business generated by the referring physician. This means that the productivity formula may not take into account revenues from “incident to” services or from the technical component of DHS services performed by the referring physician, unless the compensation arrangement is between a group practice and an independent contractor physician who is in the group practice. A percentage or productivity arrangement based solely on the professional component of services, including DHS services, personally performed by the referring physician will satisfy these requirements.

CMS, in the FY 2009 IPPS rule, made it clear that a DHS Entity and a physician or physician organization could amend their agreement and still satisfy the set-in-advance requirement if the amendment, like the original agreement, sets out the compensation or formula in sufficient detail before the amendment is implemented, does not take the volume or value of referrals or other business generated into account, and leaves the amended compensation or formula in place for at least one year from the date of the amendment. 73 Fed. Reg. 48697 (Aug. 19, 2008).

**Signature Requirements**

A number of important Stark compensation exceptions include a signature requirement. This has created significant exposure for hospitals, in particular, because they usually have many agreements with physicians that, if not signed, do not fall within a Stark exception. The final FY 2009 Inpatient Prospective Payment System rule added a new paragraph to the Stark regulations (§411.353(g)) that effectively forgives a failure to meet the signature requirement of a compensation exception if the other requirements of the exception are met and the failure to comply with the signature requirement was

(1) inadvertent, and the parties obtain the signature(s) within 90 days following the date on which the compensation arrangement becomes noncompliant (without regard to whether any referrals have occurred or compensation has been paid during such 90-day period); or

(2) not inadvertent, and the parties obtain the required signature(s) within 30 days following the date on which the compensation arrangement becomes noncompliant (without regard
to whether any referrals have occurred or compensation has been paid during such 30-day period).

This accommodation for temporary noncompliance with the signature requirements of a compensation exception may only be used once every three years with respect to a particular referring physician. 73 Fed. Reg. 43705–09 (Aug. 19, 2008).

CMS also has made clear that for purposes of the signature requirement, the signature of the authorized representative of a physician organization satisfies the requirement. 74 Fed. Reg. 61932 (Nov. 25, 2009).

**Conditioning Compensation on Referrals**

Prior to the Phase I regulations, CMS took the position that employment and independent contractor arrangements with physicians that required them to refer to particular health care providers were inconsistent with the prohibition on taking into account the volume or value of referrals. Prop. Stark II, 63 Fed. Reg. 1700. In the Phase I regulations, CMS permitted referrals in a compensation arrangement, if certain conditions were met. Phase I, 66 Fed. Reg. 878. In the Phase II regulations, CMS narrowed the exception by limiting the types or arrangements under which compensation conditioned on referrals would be permitted to a *bona fide* employment contract, a managed care contract, or “other contract.” In Phase III, CMS narrowed the “other contract” to explicitly state “a contract for personal services.” Thus, a *bona fide* employment contract, a managed care contract, or a contract for personal services between the DHS Entity and the physician may condition compensation on referrals from the referring physician as long as specific conditions are met. §411.354(d)(4).

The required referrals must relate solely to services that come within the scope of the physician’s employment or contract and be reasonably necessary for the legitimate business purposes of the compensation relationship. CMS explains that it would not be related to the scope of employment if a hospital requires a physician employed by the hospital on a part-time basis to refer his off-hours private practice patients to the hospital. Phase II, 69 Fed. Reg. 16069–070.

To qualify for the exception, the compensation arrangement also must otherwise comply with an applicable general Stark law exception (under §411.355) or one of the compensation arrangement exceptions under §411.357. The compensation arrangement must

- be set forth in a written agreement signed by the parties;
- be set in advance for the term of the agreement; and
- be consistent with fair market value for services performed; that is, the payment may not take into account the volume or value of anticipated or required referrals.

**Personal Service Arrangements**

Hospitals often contract with physicians to provide professional services, such as staffing an emergency room, reading diagnostic test results, or serving as medical director. Whenever a physician or a physician group receives remuneration in return for furnishing such professional services to or on behalf of a hospital, the physician is deemed to have a “financial
relationship” with the hospital under the Stark law in the form of a “compensation arrangement.” SSA §1877(h)(1); 42 U.S.C. §1395nn(h)(1); §§411.354(a), 411.354(c). (A physician and his or her wholly owned professional corporation are treated as one person for purposes of this analysis.)

**Personal Service Arrangements Between a Physician and a Hospital**

Importantly, the Stark law includes an exception protecting compensation paid in connection with personal service arrangements between a physician and a hospital. SSA §1877(e)(3); 42 U.S.C. §1395nn(e)(3); §411.357(d). In order for a compensation arrangement to qualify under this exception, the arrangement must satisfy the following requirements:

- The arrangement must be memorialized in a writing, signed by the parties, and specify the services to be covered by the arrangement.
- The arrangement must cover all services to be furnished by the physician to the hospital; and cross-reference any other arrangements between the hospital and the physician; or cross-reference a master list of such contracts maintained and updated and available to the secretary of the Department of Health and Human Services upon request.
- The aggregate services to be provided by the physician under the contract must not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement(s).
- The term of each arrangement must be for at least one year. Termination with or without cause is permitted during the first year of the agreement, but the parties may not enter into the same or a “substantially the same” arrangement during the remainder of the first year of the original term of the agreement. However, the parties may amend the agreement under the same terms and conditions as for the office space and equipment rentals exceptions.
- The compensation to be paid to the physician over the term of each arrangement must be “set in advance,” must not exceed fair market value, and must not be determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.
- The services to be furnished in connection with each arrangement must not involve the counseling or promotion of a business arrangement or other activity that violates federal or state law.

Under the regulations, the arrangement may hold over for up to six months following the expiration of an agreement of at least one year that met the requirements for the personal services arrangement exception, as long as the holdover arrangement is on the same terms and conditions as the immediately preceding agreement. §411.357(d)(1)(vii).

Compensation will be deemed “set in advance” if it is established in the agreement between the parties before services are furnished even if it takes the form of a time-based fee, per-unit-of-service fee, percentage-based fee, or a fee calculated through any other formula specified in sufficient detail that it can be “objectively verified,” and
is not modified during the agreement in a manner reflecting the volume or value of referrals or other business generated by the physician for the hospital. §411.354(d)(1). Moreover, time-based and per-unit-of-service-based compensation will be deemed not to account for the volume or value of referrals or other business generated by the physician for the hospital so long as it is fair market value for services actually furnished and does not vary in a manner that accounts for business generated by the physician for the hospital (other than for services personally performed by the physician). §§411.353(d)(2) and (3).

**EXAMPLE**

A hospital could contract to compensate an emergency room physician $X per hour or $Y per patient encounter, assuming those rates were fair market value. It could not, however, compensate the physician $Y per patient encounter resulting in no hospital admission and $Y+$5 per encounter once the physician has generated a certain number of inpatient admissions for the hospital during the calendar year. In this example, $Y+$5 compensation would take into account the volume or value of referrals from the emergency room physician.

Fair market value is the compensation level that would result from well-informed parties who are acting at arm’s-length and are not otherwise in a position to generate business for the other party. In general, determination will be made as to whether compensation for services is fair market on a case-by-case basis by contrasting payment rates in similar transactions between parties meeting the foregoing requirements. Compensation benchmark data is one resource or tool that can be used to determine whether the compensation paid to the physician is fair market value depending upon whether the proposed compensation appropriately aligns with such benchmark data.

Before December 4, 2007, the regulations included a safe harbor definition of fair market value with two alternative methodologies. First, the hospital and physician were permitted to base payment on an hourly rate for time actually worked and set the hourly rate as equal or less than the average hourly rate for emergency room physician services in the relevant physician market (provided there were at least three hospitals providing emergency room services in the relevant market). The second methodology relied on the average of the 50th percentile national annual compensation level for physicians within the same specialty (or, if the specialty was not identified in the survey, for general practice) in at least four of specified surveys, divided by 2,000 hours. Because the data required for each of these calculations were difficult to find or no longer existed, CMS removed the safe harbor definition of fair market value. According to CMS,

Ultimately, the appropriate method for determining fair market value for purposes of the physician self-referral law will depend on the nature of the transaction, its location, and other factors. As we explained in Phase II, although a good faith reliance on an independent valuation (such as an appraisal) may be relevant to a party’s intent, it does not establish the ultimate issue of the accuracy of the valuation figure itself (69 FR 16107). Our views regarding fair market value are discussed further in Phase I (66 FR 944) and Phase II (69 FR 16107). Phase III, 72 Fed. Reg. 51015 (Sept. 7, 2007).
Even though CMS removed the fair market value safe harbor definition, it stated that the process set forth in the definition is a reasonable and prudent process for the establishment of fair market value compensation.

As part of a personal services arrangement, a hospital may mandate that the physician refer patients requiring inpatient or outpatient services to the contracting hospital (as opposed to another provider) as long as each of the following requirements is met:

- The arrangement between the physician and the hospital is for clinical services (not administrative or other services).
- The referral requirement relates solely to the physician’s services covered by the scope of the agreement and is reasonably necessary to effectuate the business purposes of the relationship.
- The referral requirement is specified in the written agreement with the physician.
- The referral requirement does not apply when
  - the patient expresses a preference for a different provider;
  - the patient’s insurer determines the provider or the contracting hospital is not a participating provider; or
  - the physician concludes that referral to the contracting hospital is not in the patient’s best medical interests.
- The compensation is set in advance, is fair market value, and conforms to another Stark law exception. §411.354(d)(4).

In the unusual circumstance that the compensation paid for personal services is unsolicited by the physician, nonmonetary in nature, and approximately $392 or less in value (as of 2015), the parties might be able to protect the arrangement under the terms of the nonmonetary compensation exception in lieu of complying with the foregoing requirements.

**Personal Service Arrangements Between a Physician Organization and a Hospital**

Before the Phase III regulations, an arrangement between a hospital and a physician organization that received remuneration in return for furnishing services collectively to, or on behalf of, a hospital constituted a direct compensation arrangement between the hospital and the physician organization, but the relationship between the hospital and the members, employees, and contractors of the physician organization could only have been an “indirect compensation arrangement” if the arrangement met the strict definition of an indirect compensation arrangement. SSA §1877(h)(1); 42 U.S.C. §1395nn(h)(1); §§411.354(a), 411.354(c). A “physician organization” includes group practices, physician practices that do not meet the definition of “group practice,” and solo physicians, as well as their wholly owned corporations as long as physician services are provided through such organization.

Due to the introduction of the stand-in-the-shoes concept, all relationships between hospitals and physicians are treated as direct compensation arrangements with regard to those members of the “physician organization” with an investment or ownership interest. (Those without such an interest may have an indirect compensation arrangement if the strict definition is met.)
The primary differences between the personal services exception and the indirect compensation arrangements exception are the one-year term of the agreement and the set-in-advance requirement of the personal services arrangement. However, the arrangement between the hospital and the physician organization itself could fall under the personal services arrangements exception if it met all the requirements. If the arrangement between the physician organization and the hospital meets all the requirements of the personal services arrangements exception, the arrangement also should stand to protect the physicians affected by the stand-in-the-shoes provision. Note that the individual physicians do not need to sign the agreement between the physician organization and the hospital to be “parties” to the original agreement under the stand-in-the-shoes concept; an authorized representative of the physician organization will suffice. 74 Fed. Reg. 61932 (Nov. 25, 2009).

**Personal Service Arrangements Exception and Medical Director Services**

The personal service arrangements exception is the typical exception that will apply to independent contractor medical director services. Medical director services are administrative services, not clinical services. Therefore, from a fair market value perspective, hospitals and physicians must be careful to use correct fair market value documentation to support medical director arrangements. Medical director benchmark data, by specialty, can be used as support for medical director compensation. Further, if the medical directorship requires a physician of a particular specialty, it is possible to use clinical benchmark data to support the compensation paid under the medical directorship.

Medical director compensation is typically paid either by hour worked or through an annual payment typically paid each month, which is commonly referred to as a monthly stipend. It is important to have a mechanism to document the hours worked under either compensation methodology. Typically, medical directorships require the physician to complete a monthly time sheet specifying the administrative services rendered with a calculation of the number of hours worked. Although a time sheet is not legally required under the personal service arrangements exception, it is the most frequently used method of documenting time worked. However, other time recording mechanisms can be used as long as such mechanisms fairly account for the amount of time spent by the physician on the medical director duties and responsibilities.

If the hospital is paying the medical director per hour worked, the time recorded each month will be used by the hospital and multiplied by the agreed-upon fair market value hourly rate to establish the monthly payment. Alternatively, if a monthly stipend is paid, the hospital and physician should carefully watch the hours being worked by the physician to ensure that the hours worked are consistent with the estimation of the number of hours worked that formed the basis of the annual compensation agreed upon in the medical director arrangement. Under the annual payment methodology, if the physician performs less than the projected number of hours, the resulting compensation, which will be calculated on an hourly basis, could substantially exceed fair market value.

By way of example, assume that the hospital and physician believed that 120 hours was commercially reasonable and a $100 per hour was fair market value for the medical director services. With these assumptions, the hospital and physician entered into a medical director
arrangement with a $12,000 annual payment, or a $1,000 monthly stipend. However, instead of working 120 hours during the 12-month term, the physician only worked 50 hours. The resulting hourly rate, therefore, would be $240 per hour ($10,000 ÷ 50 hours = $240). Thus, in this example, $240 per hour, which is the calculated resulting hourly compensation paid, may be above fair market value. Thus, it is critically important that medical director compensation be monitored during the term of the arrangement to ensure that the resulting compensation, calculated on an hourly basis, remains at fair market value.

**Employment Arrangements Between a Physician and a Hospital**

Whenever a physician receives compensation for services furnished to a hospital pursuant to a *(bona fide)* employment arrangement with the hospital, the physician is deemed to have a “financial relationship” with the hospital under the Stark law in the form of a “compensation arrangement.” For example, a hospital-employed anesthesiologist or hospital-employed medical director would maintain such a financial relationship, irrespective of the amount of compensation he or she received or the manner in which it was calculated (hourly wage, per-encounter fee, annual salary). SSA §1877(h) (1); 42 U.S.C. §1395nn(h)(1); §§411.354(a), 411.354(c).

The Stark law includes an exception protecting compensation paid pursuant to such employment arrangements. SSA §1877(e)(2); 42 U.S.C. §1395nn(e)(2); §411.357(c). In order to qualify for protection under this exception, however, the arrangement must satisfy the following requirements:

- The employment must be for identifiable services, but unlike personal service arrangements, does not need to be memorialized in a writing signed by the parties.
- The amount of compensation paid to the physician must be consistent with fair market value of the services furnished and must not be determined in a manner that takes into account the volume or value of any Medicare referrals generated by the physician for the hospital (excluding referrals for professional services personally performed by the referring physician).
- The remuneration paid to the physician must be reasonable even if no Medicare referrals were made to the hospital.

As part of an employment relationship meeting the foregoing requirements, a hospital may mandate that the physician refer patients who require inpatient or outpatient services to the employer hospital (as opposed to another provider), as long as each of the following requirements is met:

- The arrangement between the physician and the hospital is for clinical services (not administrative or other services).
- The referral requirement relates solely to the physician’s services covered by the scope of the agreement and is reasonably necessary to effectuate the business purposes of the relationship.
- The referral requirement is specified in a written agreement with the physician and signed by the hospital and physician.
The referral requirement does not apply when the patient expresses a preference for a different provider, the hospital is not a contracting provider with the patient’s insurer, or the physician concludes that referral to the contracting hospital is not in the patient’s best medical interests. §411.354(d).

Because a written agreement signed by the parties is required to meet the mandated referral requirement, an employment arrangement that incorporates the referral requirement also must be in writing and signed by the parties even though the employment exception does not require a written agreement for the employment arrangement. However, while Stark permits a referral requirement for hospital-employed physicians, the anti-kickback statute does not, and for this reason, many attorneys advise clients not to incorporate the referral requirement into employment agreements.

Hospital Employment of Physicians

The following narrative is based on a 2014 interview with Bob Wade, Krieg DeVault, Mishawaka, Ind.

The lawsuit against Halifax Hospital in Volusia County, Fla. illustrates the risks and pitfalls associated with hospital employment arrangements with physicians.

In this case, Halifax had arrangements with nine employed physicians — three neurosurgeons and six oncologists. The hospital allegedly used bonus pools to reward physicians for referring patients to the hospital. The oncologists, for example, were paid 15% of the net profits of the medical oncology program at the hospital, which meant they were rewarded for the hospital services they referred, according to the government’s complaint.

In its Nov. 13 order on a motion for partial summary judgment filed by the United States, the court reviewed employment agreements with six medical oncologists to determine whether an incentive bonus provision made the agreements ineligible for the Stark bona fide employment exception, as the government alleged. The government alleged that under the agreements, the pool on which the incentive bonus was based included revenue from fees for DHS not personally performed by the physicians. Thus revenue from referrals made by the medical oncologists would flow into the incentive bonus pool, and additional referrals would be expected to increase the size of the pool. As the court observed, “All other things being equal, this would in turn increase the size of the incentive bonus received by the referring medical oncologist.”

Halifax argued that the bonus structure satisfied the bona fide employment exception because the bonus pool was divided based on each physician’s personally performed services. The U.S. district court disagreed. The incentive bonus itself, the court said was not a “bonus based on personally performed services,” but was only “divided up based on services personally performed.... The bonus itself was based on factors in addition to personally performed services — including revenue from referrals made by the Medical Oncologists for DHS.” The government, the court concluded, established that Halifax Hospital violated the Stark law. However, the court still had to rule on the scope of the violation, that is, the volume or value of the referrals that were noncompliant with Stark. In the end, just before it went to trial in March 2014, Halifax settled with the government for $85 million, substantially less than the amount the government was asking for. U.S. ex. rel. Baklid-Kunz v. Halifax Hospital Medical Center and Halifax Staffing, Inc., No. 6:09-CV-1002 (M.D. Fla., Nov. 13, 2013).
The settlement eliminated an opportunity to further clarify what constitutes taking the volume or value of referral into consideration when establishing physician compensation. The volume or value of referrals is tricky business because potentially the government could see them behind every compensation corner, says attorney Bob Wade, who is with Krieg DeVault in Mishawaka, Ind. “Where is the line? The Stark law was developed because there was a perception that when the doctor has a financial relationship there is the potential for overutilization, but now it’s come to the point where you may have an arrangement where you violate Stark even though compensation was fair market value and arguably services are medically necessary” because physicians were paid, in some form or fashion, on the volume or value of referrals. In this environment, “the more that compensation arrangements are aligned with financial success, the greater risk the hospital has that the government can say they take into account the volume or value of referrals” — perhaps even when compensation is fixed in advance.

Wade described four hospital compensation scenarios that he says are hazardous in terms of the volume or value of referrals under the Stark law, from the most risky (1) to the least risky (4):

(1) Paying physicians a certain amount for every referral or technical service obviously takes into account the volume or value of services and therefore runs afoul of Stark.

(2) Paying physicians a percentage of profits generated. “Compensation is not technically tied to each referral, but the pool of money from which bonuses are paid is generated from the referrals of those physicians,” Wade says. “The Halifax court concluded that, because the percentage was based on the profit generated from the referrals of those physicians and other physicians, it would take into account the volume or value of the referrals.”

(3) Paying physicians fixed fees based on the operation of a department. Suppose the hospital rewarded them for meeting certain indicators. Maybe physicians were paid $500,000 if they met quality, efficiency and utilization goals. “They will tie that to the services performed by the physicians or the anticipated success of the department to determine the fixed fees,” Wade says. Because the bonus is fixed, this arrangement is safer than the first two, but there is still risk. When hospital bean counters project the success of the department from a budgetary perspective, they may take into account the volume or value of referrals. Hopefully that’s not the case, he says, “but that hasn’t been tested yet.” The government may try to make this argument.

(4) Paying physicians based on the financial success of the hospital as a whole. “Is that diluted enough” to pass the volume-or-value-of-referrals test under Stark? It is unclear how far down the slippery Stark slope the government and whistleblowers will go in pursuing the connection between compensation and referrals. “The absurd thing is, in almost every compensation arrangement, when determining the amount, someone could allege hospitals were taking the volume or value of the business the physicians were generating into account,” Wade says. Suppose the fair-market value (FMV) compensation range for a physician is $40 to $50 per work relative value unit. If the hospital decides to pay the physician the high end of the FMV range, the government might argue it was influenced by the volume or value of the physician’s referrals and was not commercially reasonable — especially if there is a memo or email to that effect, he says.
As all of this plays out, Wade is advising clients to steer clear of compensation arrangements that are percentage based or incorporate the financial success of the department or entity they have influence over.

**Non-Productivity Compensation**

Some hospitals, health systems, and physician practices are trying to use compensation as a lever to improve quality of care and patient satisfaction, shape utilization, promote efficiency, and contain costs and practice expenses, paralleling many of the initiatives CMS has launched. They are attempting to compensate physicians, both contracted and employed, based upon patient and population wellness and other value-based factors and are emphasizing such wellness initiatives and directing patients to appropriate care environments and resources. These “non-productivity” models of compensation are gaining traction.

Compensation arrangements regarding non-productivity indicators can be developed but must conform to the Stark law restrictions regarding fair market value (FMV) and commercial reasonableness for services rendered. Today in almost every fair-market valuation, there is a higher percent of compensation going toward non-productivity factors; however, in this context, establishing FMV — the crux of compliance with the Stark self-referral law — is more of a challenge.

Suppose the fair-market-value salary for a certain specialist (according to the MGMA survey) is $300,000. The hospital might set a base salary of $200,000 and then dangle bonuses for a series of utilization/efficiency and quality improvement measures. These could include expanding office hours to reduce patients’ non-urgent trips to the emergency room and improving patient outcomes on Medicare core measures (e.g., controlling high blood pressure, treating heart attacks). The specialist has the potential to earn $400,000 if he or she hits a home run with every quality improvement measure but would earn the fair-market value amount if she just did very well. Because the specialist exceeded every measure, the additional hours and effort exerted to reach such measures accounts for the increased compensation.

Targets and thresholds can be developed around these non-productivity indicators to financially reward employed physicians for meeting or exceeding established thresholds. Such non-productivity compensation criteria include quality indicators, patient satisfaction, utilization of medical services at physician offices as opposed to emergency departments, reduction of practice expenses, utilization of non-physician providers, patient screening examinations (i.e., mammographies, colonoscopies, heart scans), and patient wellness education including exercise, smoking cessation, and nutritional counseling.

Hospitals have to monitor the targets and thresholds closely, however; if physicians are perfect all the time, the thresholds are probably too low, raising fair-market-value concerns. For example, a hospital wants to reward physicians who provide smoking cessation counseling to half of their patients. But at this point in time, the physicians are already counseling 75% of these patients, so the threshold is too low. The hospital increases the threshold to 90% and rewards the physicians who exceed the threshold with an increased work relative value unit (wRVU) amount or another established compensation amount.
Greater freedom in establishing nonproductive indicators exists if the physician is employed by a group practice using the in-office ancillary services exception. Such non-productivity compensation models are still limited by the fair market value and commercial reasonableness restrictions imposed by the Stark law exceptions unless the group practice definition and in-office ancillary services exception can be met. For example, if a physician is in a practice that meets the requirements of a group practice, then it would be possible to allocate profits based upon nonproductive indicators such as quality. Without meeting the definition of a group practice and the in-office ancillary services exception, it would not be permissible to allocate profits in this manner.

**Compliance Issues With Non-Productivity Compensation**

Hospitals should pay particular attention to three compliance issues that arise with non-productivity models of compensation:

1. **Setting Non-Productivity Indicators Too Low.** Setting these indicators too low can increase the risk that compensation is not fair market value. Further, if the indicators are set low then it could be construed as a kickback to a referral source. Ultimately, the indicators need to ensure that physicians must exert significant effort to receive additional benefits.

2. **Hospital Mechanisms Effectively Monitor Physician Performance.** A hospital needs to ensure it can monitor physician performance and those key non-productivity indicators. For example, if one indicator is the extent to which physicians reduce emergency-room use by their patients through appropriate methods (e.g., establish Saturday office hours), is there a way to track ER usage and count that back to the physician who receives incentives? One of the biggest issues is tracking the wRVUs that were actually personally performed by the physician. Often wRVUs tracked can include services personally performed by other practitioners, which increases Stark Law liability.

3. **Overall Compensation Must Be Commercially Reasonable and Fair Market Value.** MGMA data is still relevant in terms of the aggregate compensation. The hospital may have a physician so invested in improving overall patient health that his or her wRVUs drop and thus, it appears, productivity drops. The physician is performing in the 25th percentile based on wRVUs but, ultimately is paid in the aggregate in the 90th percentile because he or she is focused on overall health and utilization. However, he or she keeps patients out of the office because of quality initiatives and utilization.

Compliance officers and attorneys can take heart that the Stark law gives them some wiggle room as they recalibrate non-productivity compensation relationships. A non-productivity arrangement is probably Stark-acceptable as long as it was reasonable when the parties entered into it, but hospitals must have the ability to rebase the compensation package year to year rather than locking it in for three to five years.
Appendix C: Articles from AIS’s Report on Medicare Compliance


The Tuomey and Halifax Cases

Tuomey Faces Big Fines After Losing Stark, False Claims Trial

Tuomey Healthcare System in Sumter, S.C., violated the Stark law and submitted 21,000 false claims to Medicare, a federal jury decided on May 8, 2013, after a four-week trial. According to the verdict sheet, Tuomey’s false claims have a monetary value of $39,313,065, which are subject to treble damages.

“Tuomey is obviously disappointed with the verdict. We’re going to be looking at all our options in the upcoming days,” says one of its attorneys, Dan Mulholland of Horty, Springer and Mattern in Pittsburgh. “However it’s important to note that there were no allegations that Tuomey ever upcoded, overcharged or billed for medically unnecessary services or services not provided. Tuomey is a fine hospital and its board, management, employees and medical staff are among the finest people I’ve ever worked with.”

The closely watched trial sent shock waves through the legal community. One message from the case seems to be that “any time a hospital does not have a solid fair market value opinion supporting payments made to referring physicians, they are on thin ice,” says Pittsburgh attorney William Maruca, who is with Fox Rothschild.

The trial was the Department of Justice’s second attempt to prove that Tuomey’s compensation agreements with 18 physicians violated Stark and therefore the False Claims Act. In June 2010, the U.S. Attorney for South Carolina persuaded a jury that Tuomey’s compensation arrangements violated the Stark law, but not the False Claims Act. But the U.S. District Court judge who oversaw the trial set aside the false claims verdict — giving the government another bite at the apple — while granting the government’s request to recover $45 million from Tuomey in repayment stemming from the Stark noncompliance.

Appeals Court Triggered a Do-Over

Then the U.S. Court of Appeals for the Fourth Circuit sent both parties back to square one. In an April 2012 ruling, the appeals court said the trial judge had violated Tuomey’s 7th Amendment right to a jury trial and threw out the entire case, which prompted the retrial.

According to the government, Tuomey signed part-time employment agreements with 19 specialists when it seemed they would shift their outpatient procedures from the hospital to their private practices. Fearing a loss of revenue to the competition, Tuomey offered the physicians 10-year compensation deals, the government alleged. The specialists were required to
perform all outpatient procedures at Tuomey Hospital or its other facilities and were paid an annual base salary that varied according to the net cash collections for outpatient procedures and a productivity bonus equal to 80% of net collections, the court decision states. On top of that, the specialists could earn an incentive bonus worth up to 7% of their productivity bonus.

The contracts were brought to the government’s attention by orthopedic surgeon Michael Drakeford, who turned down Tuomey’s offer and became a whistleblower. The U.S. Attorney’s Office took over his false claims lawsuit in 2007.

The jury’s verdict and its financial implications have always been possible, but still “take your breath away,” says Macon, Ga., attorney Alan Rumph. “Tuomey’s Stark position, while aggressive, was not frivolous. This is a potential game changer in terms of the government’s negotiation power and strategy. Unless the Fourth Circuit reverses again, it’s going to be tough for hospitals to litigate another Stark case with this much at stake. Let’s all thank our lucky stars for the CMS self-referral disclosure protocol.”

“The Fourth Circuit’s decision was seen as the potential legacy of the case,” according to Philadelphia attorney Jeb White, who is with Nolan Auerbach. “This opinion closed the door on the argument that fixed compensation arrangements between hospitals and physicians do not run afoul of Stark, even when the fixed compensation is based on anticipated referrals to the hospital. Needless to say, in the wake of Tuomey, a lot of compensation arrangements should have been revised,” says White, former president of Taxpayers Against Fraud.

Contact Maruca at WMaruca@foxrothschild.com and White at Jeb@WhistleblowerFirm.com.

**Eleven Tips for Hospitals to Consider After the False Claims Verdict Against Tuomey**

Hospitals don’t necessarily have to run away from physician arrangements that aren’t ultra-conservative because of the May 8, 2013, false claims and Stark verdict against Tuomey Healthcare System. But they may want to reconsider the big picture of their financial arrangements as well as the Stark technicalities in light of the staggering penalties that face the South Carolina health system and other hospitals that run afoul of the law.

“If it smells bad, think again,” says Macon, Ga., attorney Alan Rumph, with Smith Hawkins.

After a four-week trial, a jury in Columbia, S.C., found that Tuomey’s compensation agreements with 18 physicians violated the Stark law, which caused the submission of 21,000 false Medicare claims to the tune of $39.3 million. If the judge imposes even minimum fines and penalties, Tuomey will have to fork over $240 million, although the Department of Justice could accept less.

“If you spend a lot of time with Tuomey, you could get spooked very quickly,” says Nashville attorney Thomas Bartrum, with Baker Donelson. Prosecutors may be emboldened by the Tuomey victory to pursue more Stark cases, and Bartrum fears some areas may be more vulnerable — including the uncharted waters of clinical care networks and other configurations developed in response to the pay-for-performance movement.
In the Tuomey case, the U.S. Attorney for South Carolina alleged that Tuomey entered into part-time employment agreements with 19 specialists when it seemed they would shift their outpatient procedures from the hospital to their private practices. Fearing a loss of revenue, Tuomey offered the specialists 10-year compensation deals as long as they performed all outpatient procedures at Tuomey Hospital surgery sites and signed noncompete clauses. The government alleged the compensation was above fair-market value and took into account the volume or value of the physicians’ referrals. The health system always disputed the allegations and fought them through two trials, which is rare considering the stakes of the False Claims Act, with its treble damages and $5,500 to $11,000 per-claim fines.

**Post-Tuomey Strategies for Hospitals**

Tuomey’s fate is one thing, but what is the verdict’s impact on its hospital brethren? Stark lawyers offer the following insights and suggestions to hospitals as they enter into new arrangements and rethink existing ones post-Tuomey:

1. **Don’t take valuations at face value,** says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind. An independent compensation valuation on an expert’s letterhead isn’t a get-out-of-jail-free card. “You need to evaluate the defensibility of any fair-market value valuation,” he says. Will the documentation really support the compensation if ever tested? Hospitals have to look both at the standard principles applied to business valuations and the regulatory definition of “fair-market value.” The Stark law doesn’t dictate how to determine fair-market value compensation — “you can use any methodology as long as it’s commercially reasonable” — but it better be convincing to a regulator, judge or jury, Wade says. For example, it wouldn’t pass muster to pay a physician compensation above the 95th percentile if his productivity were below the 25th percentile based on collections or work relative value units (assuming the work is purely clinical), he says.

2. **Re-evaluate the trend of moving ancillary services from physician practices to hospital outpatient departments,** where they can be reclassified as provider-based and billed to Medicare at a higher rate, Bartrum says. “We are seeing lots of these arrangements,” he notes. “We set them up to technically fit Stark exceptions, but Tuomey makes you go back and rethink ‘how safe are these arrangements?’ The government’s position in Tuomey can be read as essentially asserting that any uptick in physician’s compensation that can’t be accounted for should be characterized as compensation for future volume or value of referrals.”

3. **Don’t get spooked by “loss” arrangements, where hospitals pay employed physicians more than the hospital collects directly from the physician’s personally performed services,** Wade says. In light of Tuomey, “people may have a knee-jerk reaction and say loss arrangements are per se not fair-market value. But this is simply not the case as there are situations where loss arrangements are necessary and defensible,” he says. For example, a hospital may open a clinic in a remote area, where it serves mostly uninsured and Medicaid patients. The hospital pays a cardiologist $200 an hour to staff the clinic but collects only $100 an hour for her services. Wade thinks it’s still permissible because the hospital has a mission to serve the underserved.

4. **Consider taking financial arrangements into the CMS self-referral disclosure protocol if they seem aggressive through Tuomey-colored glasses,** Rumph says. “Hospitals need to be
more proactive in exploring places where the self-referral disclosure protocol is useful. Once
the government starts investigating or a whistleblower is involved, the matter is less likely to
be favorably resolved,” he notes.

(5) **Be on alert for the impact of the Tuomey verdict on the innovations in hospital-
physician arrangements emerging from new models of health care delivery**, Bartrum says.
“Right now, with pay-for-performance, the whole fear is that hospitals are paying physicians
for stuff that’s hard to value, such as changing care patterns, monitoring and collecting data
and reporting it to the hospital,” he says. Does it mean hospitals are in the crosshairs because
of Tuomey? And as hospitals, at the impetus of CMS, move from fee-for-service payments to
compensation for outcomes and value, there is a question whether the less-is-more model will
be perceived as above-fair-market compensation, Rumph adds. “It’s analytically difficult to fit
this into Stark,” he says. Bartrum notes that with clinically integrated networks and account-
able care organizations, physician referrals will generally increase to their hospital partners
within the network. Medicare ACOs have a Stark and kickback waiver, but more ACOs are
being set up in the commercial sector, and these arrangements don’t qualify for waivers.
Bartrum thinks these can be structured to comply with the Stark law’s risk-sharing exception,
but because of the lack of CMS commentary and guidance on that exception, some hospitals
are reluctant to rely solely upon that exception.

(6) **Steer clear of employment arrangements that are carved out for specific services**, Wade
says. “I’m not opposed to independent contractor arrangements” for discrete services, Wade
notes, but it seems suspicious when the hospital wants to employ physicians only when they
are performing specific services, especially if the arrangement is motivated by the desire to
expand or retain market share.

(7) **Don’t shop for regulatory opinions**, Bartrum says. If one lawyer says a financial ar-
rangeement violates Stark and/or the anti-kickback statute, there has to be a good justification
to run to another lawyer for a different answer.

(8) **Carefully consider non-compete clauses in physician contracts**. If the government
contends a hospital is paying physicians more than fair-market value, then the excess comp-
ensation could be tied to the covenant not to compete and construed as an inducement for
referrals, Wade says.

(9) **Avoid physician contracts of long duration**, Wade says. Whether they are with employ-
ees or independent contractors, service agreements generally should be no more than three
years long — or perhaps five years in the case of acquisitions. They can automatically renew
after the initial term, “which causes the parties to come back together to review the terms and
ensure that compensation remains fair-market value,” Wade says.

(10) **Remember that physicians on the hospital staff may become whistleblowers**, which
happened in the Tuomey and other false claims cases, Rumph says. “They are in a position
to see things that other people don’t see, particularly when negotiations with the hospital fall
through,” he says. And when there are big rewards for physician-whistleblowers, “it won’t
dissuade other doctors.”

(11) **Include all noncash compensation in the fair-market valuation**, Wade says. For
example, when the hospital adds physicians to its malpractice insurance coverage for their
hospital services and private practices, the value of the latter must be separately calculated
in the compensation. If the physician’s fair-market value compensation is $200 per hour and
the private-practice malpractice premium equates to $50 per hour, the hospital should pay the
physician only $150 per hour, he says.

Contact Wade at rwade@kdlegal.com, Rumph at alan@shhrlaw.com and Bartrum at tbar-
trum@bakerdonelson.com.

**As Tuomey Post-Mortem Continues, Judge Orders Health System to Pay $237 Million**

A federal judge on Sept. 30, 2013 ordered Tuomey Healthcare System to pay more than
$237 million for violating the Stark law and False Claims Act and declined to throw out the
jury’s verdict or grant a new trial. The Sumter, S.C., hospital filed its notice of appeal the fol-
lowing day, continuing a saga over physician compensation that has rocked the legal and
compliance world for three years.

On May 8, 2013, a federal jury found that the hospital’s compensation agreements with
18 employed physicians ran afoul of the Stark law, which turned the hospital’s claims for
Medicare services referred by the physicians into false claims.

In a statement, Tuomey said “it respectfully disagrees with the ruling” and will ask the
U.S. Court of Appeals for the Fourth Circuit for a stay of the judgment pending appeal.

“When you see the numbers, it makes you gasp — even though we knew this would fol-
low from the jury verdict,” says Atlanta attorney Alan Rumph, with Baker Donelson.

Meanwhile, former government officials, attorneys and compliance officers continue the
post-mortem on the Tuomey case. One bottom line: compliance officers should be at the table
for strategic planning. There is a perception they will be nay-sayers, but that isn’t the case.
“You can always get to a deal you are comfortable with to satisfy strategic objectives...if man-
gement is truly informed and willing to accept risks,” said Margaret Hambleton, senior vice
president of ministry integrity at St. Joseph Health System in California.

In the court order, U.S. District Judge Margaret Seymour in Columbia, S.C., told Tuomey to
pay $39,313,065, on the jury verdict that 21,730 false claims were submitted to Medicare, and
$237,454,195 in false claim fines.

The story began more than a decade ago, when Tuomey panicked that its referring physi-
cians would shift outpatient procedures from the hospital to their own practices or an ambu-
latory surgery center. To prevent a loss of revenue, the hospital offered 10-year employment
contracts to 19 specialists. In exchange for performing all outpatient procedures at Tuomey
Hospital or its other facilities, the specialists were paid an annual base salary that varied ac-
cording to the net cash collections for outpatient procedures and a productivity bonus equal
to 80% of net collections, and were eligible for an incentive bonus worth up to 7% of their
productivity bonus, court documents say. Not everyone went along for the ride. Orthopedic
surgeon Michael Drakeford turned down Tuomey’s offer after raising concerns about it and
filed a false claims lawsuit alleging violations of the Stark law. DOJ signed on, and when
Tuomey refused to settle, the case went to trial in U.S. District Court in Columbia, S.C. The
jury declared the hospital in violation of Stark but not the False Claims Act. The drama, how-
ever, was far from over. The judge decided he made a mistake excluding certain evidence and, in a post-trial ruling, ordered a new false claims trial while preserving the government’s Stark victory. Tuomey appealed to the U.S. Court of Appeals for the Fourth Circuit, which threw out the entire case on the grounds that the hospital’s 7th Amendment right to a jury trial was violated by the post-trial ruling. The government took Tuomey back to trial in May 2013 with a new trial judge, and this time the jury found the hospital violated both Stark and the False Claims Act.

**Judge Disagreed With Tuomey’s Arguments**

After the verdict was handed down, Tuomey filed motions asking the trial judge to throw out the verdict or grant a new trial. Here are some of Tuomey’s arguments, along with reasons why the judge turned it down:

1. Tuomey argued there was no Stark violation because the government never proved the physicians’ compensation took into account the volume or value of referrals. But the judge said “a reasonable jury could have found that Tuomey took into account the volume or value of referrals” based on its perception of the credibility of a valuation consultant and the testimony of various witnesses.

2. Because the hospital sought the advice of counsel in good faith, Tuomey argued that the government can’t prove it “knowingly” submitted a false claim. Tuomey relied on several consultants and lawyers, including its counsel, who said the contracts didn’t violate the Stark law. But another lawyer, Kevin McAnaney, former chief of the HHS Office of Inspector General’s Industry Guidance Branch, advised Tuomey that the physician contracts were problematic partly because the salaries were above fair market value. Tuomey sent McAnaney packing and told him not to put his opinion in writing. The judge said “a reasonable jury could have found that Tuomey possessed the requisite scienter once it determined to disregard McAnaney’s remarks.”

3. The government failed to prove damages, Tuomey argued, and therefore it’s entitled to win “as a matter of law.” The government got the services it paid for, and it would have paid the same amount of money if the services were performed at another hospital. But the judge didn’t buy it. She noted that Stark says “no payment may be made...for a designated health service” when it’s provided in violation of the law.

What bothers Rumph most about the way things have shaken out is that the appeals court applied a different standard to the volume or value issue than the trial judge did. The Fourth Circuit said the jury had to decide whether the hospital’s contracts, on their face, took into account the volume or value of the physicians’ referrals when setting compensation (i.e., how much money the hospital makes in facility or technical charges resulting from procedures performed by the employed physicians). “That was Tuomey’s primary argument in asking the court to set aside the verdict — that the documents on their face don’t take into account the value or volume of referrals,” Rumph says. But in her order, Judge Seymour never addresses the issue. She uses a more “subjective and expansive” definition of “taking into account the volume or value of referrals,” he says. “This particular issue is the reason why we are all having so much trouble with Tuomey.” He notes, however, that the Fourth Circuit sent mixed signals on the issue.
The Role of the Board Said to Be Paramount

Compliance experts put the Tuomey case under the microscope at the Oct. 1, 2013, Fraud and Compliance Forum co-sponsored by the American Health Lawyers Association and Health Care Compliance Association in Baltimore. “We have the benefit of 20/20 hindsight,” but it’s instructive to look at the board’s role, said Lewis Morris, former chief counsel to the HHS Inspector General. Boards generally have a duty of reasonable inquiry. They are supposed to ask the right questions at the right time and use the compliance program as “a critical pipeline of information,” he said. When the proposed physician employment contracts were being hashed over at Tuomey, its board “did the right thing by hearing Drakeford out,” said Morris, who is with Adelman Sheff & Smith in Annapolis, Md. The hospital and Drakeford agreed to jointly retain an attorney (McAnaney) to review the contract. “This was a critical opportunity for re-evaluation. But then they passed a resolution that no one could come before the board unless the CEO or chair approves it and they bring a lawyer….It seems extraordinary that they cut off communication with a guy who seemed to have a legitimate concern.”

Hambleton says it should have been a red flag that the board allegedly didn’t want to meet with Drakeford. “Compliance officers face this” — people who raise concerns may be treated like “disgruntled, belligerent troublemakers,” she says. Discounting concerns of people like Drakeford “is one of the biggest mistakes that compliance officers can make.”

Morris emphasized the importance of hearing people out. “Are all whistleblowers the type of people you want to take a 12-hour car ride with? Perhaps not,” he said. “But you have to listen to them. Otherwise they will be out the door, going to the government.”

None of the experts was clear on why Tuomey fought the allegations at trial, given the risk of staggering penalties if they lost. “Stark cases are turning into anti-kickback cases dressed up as Stark cases. Juries won’t care about technical Medicare payment rules, but they do understand bribes and payments for referrals,” said Chicago attorney Daniel Melvin, who is with McDermott, Will & Emery. “Letting Stark cases get before the courts is not a good idea” — at least until the courts sort out some Stark interpretations, such as the volume and value of referrals standard.

Four Corners of Stark Are ‘Not Sexy’

Because “the four corners of Stark are not sexy to a jury,” prosecutors spent little time there, Hambleton said. There’s a message here for compliance officers: In addition to worrying about fair-market value and commercial reasonableness, they should look at physician agreements in context “and have a voice as loud as the CEO,” she says. “Dig your heels in if problems are not adequately addressed.”

Melvin doesn’t think the Tuomey case “stands for the notion that getting a second opinion is shopping for opinions. The Stark law is sufficiently complex that to proceed in the face of dueling opinions doesn’t mean you are opinion shopping.” McAnaney said at the conference that Tuomey asked him only for his “view of the risks — not his opinion.”

DOJ could still agree to settle for a smaller dollar figure in exchange for Tuomey dropping its appeal, according to Rumph. As of February 2015, Tuomey’s appeal regarding the amount to be paid is still with the court.
In its statement, the hospital emphasized that “patient care, safety and the health of the Sumter community remain Tuomey’s number-one focus.”

Contact Rumph at arumph@bakerdonelson.com, Hambleton at Margaret.hambleton@stjoe.org and Morris at lmorris@hospitallaw.com. ♦

Court: Halifax Hospital Violated Stark but Issues Are Unresolved

The U.S. District Court for the Middle District of Florida, on Nov. 13, 2013, found that Halifax Hospital Medical Center violated the Stark law. In an order on the Department of Justice motion for partial summary judgment, the court concluded that the hospital’s bonus arrangement with six oncologists did not fit within the *bona fide* employment exception of the Stark law because the bonus pool was not restricted to the physicians’ personally performed services. The bonus pool was divided up only based on those services. Therefore, the court ruled, the oncologists were prohibited from making referrals to the hospital and the hospital was prohibited from submitting claims to Medicare arising from these referrals for the facility fee.

However, the court found “genuine issues of material fact” that still need to be resolved. First, it could not resolve the extent of the violation based on the filings. Originally, DOJ asked for more than $34 million in damages but reduced the figure to approximately $27 million after Halifax disputed the calculations. But the government did not submit any calculation so the court could not verify the figure or address other Halifax arguments. “Despite diligent effort,” the order says, “the Court is unable to determine which of these arguments are allegedly addressed in which of the listed documents and therefore cannot determine which party ought to prevail in regard to them.”

As a result, the court denied summary judgment to the government on each of its theories of recovery — the False Claims Act, payment by mistake of fact or unjust enrichment. With regard to recovery under the FCA, the court found that there was a genuine issue of material fact regarding whether the defendants acted knowingly. Under the False Claims Act, the court must find that the defendant knew or should have known or acted with deliberate ignorance or reckless disregard.

MD Services Director Is the Whistleblower

The motion for summary judgment stems from DOJ’s false claims lawsuit against Halifax Hospital and its subsidiary, Halifax Staffing, of Daytona Beach, Fla. The case was filed in 2009 by whistleblower Elin Baklid-Kunz, director of physician services at Halifax Staffing, who accused the hospital of violating the Stark and anti-kickback laws and billing Medicare for medically unnecessary admissions. The Department of Justice intervened only in the Stark part of the lawsuit, alleging that Halifax’s compensation agreements with three neurosurgeons and six medical oncologists included salary plus incentives based on the volume or value of their referrals. The whistleblower pressed on, and all allegations were presented in one trial, in March 2014. The two sides have been battling furiously for more than a year over discovery; and, more recently, over Halifax’s destruction of medical records.

For more information, contact Wilbanks at mbw@wilbanks-bridgeslaw.com. ♦
Another Halifax Compensation Deal Gets Different Response From Judge

A federal judge on Nov. 18, 2013, said a jury will decide whether three neurosurgeons employed by Halifax Hospital Medical Center were compensated in violation of the Stark law. U.S. District Judge Gregory Presnell for the Middle District of Florida declined to throw out the Department of Justice’s allegations and said the matter will proceed to trial March 3, 2014.

The ruling came down five days after the judge found that compensation received by six medical oncologists employed by Halifax violated the Stark law. In a victory for the Department of Justice, which had filed a motion for partial summary judgment, the judge concluded the hospital’s bonus arrangement did not fit within the bonafide employment exception of the Stark law because the bonus pool was not restricted to the oncologists’ personally performed services. The bonus pool was divided up only based on those services. Therefore, the judge ruled the oncologists were prohibited from making referrals to the hospital, and the hospital was prohibited from submitting claims to Medicare arising from these referrals for the facility fee. However, the court found “genuine issues of material fact” that still need to be resolved, including the extent of the violation based on the filings. The court also denied summary judgment to the government on each of its theories of recovery — the False Claims Act, payment by mistake of fact or unjust enrichment.

The Nov. 18, 2013, ruling was prompted by Halifax Hospital’s motion for summary judgment. It had asked the judge to throw out the Stark allegations against the neurosurgeons. The hospital argued they are bonafide employees “in all respects — i.e., the employment was for identifiable services, the compensation was consistent with fair-market value and did not take referrals into account, and the agreements would have been commercially reasonable even in the absence of any referrals,” the judge said. The government countered that this is a matter of debate and the court agreed. The government’s expert witness on physician compensation says that for several years, the neurosurgeons “appear to have been paid more than twice as much as neurosurgeons at the 90th percentile of their specialty despite collections from their work falling below…that rank,” the judge states.

Judge Did Not Rule on MD Comp and Stark

In contrast to last week’s ruling, the judge did not opine on whether the neurosurgeons’ compensation violates Stark. The difference between the two rulings is in the methodology of the compensation, says Atlanta attorney Alan Rumph, who is with Baker Donelson. The neurosurgeons were paid 100% of collections. “There is nothing inherently wrong with a percentage of collections for personally performed services,” he says, but it’s not surprising that the 100% figure has attracted scrutiny. As the judge noted, “this allowed the neurosurgeons to… keep 100% of their collections with no overhead expense.” Rumph says that the doctors providing significant charity care and assuming onerous call burdens could possibly, as the hospital argues, justify this level of compensation. But he generally favors the now more common compensation methodologies based on work RVUs. Hospitals have to ensure the compensation doesn’t take into account the volume or value of referrals.
The judge in Halifax found the compensation methodology for the oncologists to be prohibited as a matter of law, because the bonus pool included revenues from designated health services referred by the oncologists. When hospitals employ physicians, compensation can’t directly or indirectly take into account income from referrals of designated health services, Rumph says. But if hospitals own a separate legal entity that qualifies as a “group practice” under Stark, the physicians may receive a share of the group’s designated health services income, as long as it’s only indirectly related to their referrals. Rumph says that the Halifax oncologists’ compensation would appear to have satisfied the indirect requirement, had they been employed by a group practice. The “price” for such increased flexibility in compensation, he notes, is loss of the higher reimbursement generally available for physicians who work in provider-based clinics, which are not “group practices.”

Contact Rumph at arumph@bakerdonelson.com.

Compensation Models

Stark Law Is Not Obstacle for Providers Shifting to Quality-Based Productivity Pay

Unhindered by the Stark law, some medical groups are successfully using productivity compensation that mimics Medicare’s shift to pay for performance. But some hospitals are behind the curve, more likely to use older models that perpetuate the fee-for-service system, such as rewarding physicians for racking up relative value units (RVUs), some attorneys say. The hospitals that are rapidly moving away from this model, however, will be better prepared for the transformation under way in Medicare and the commercial sector.

“If you look at accountable care organizations and value-based purchasing, those are manifestations of increasing demand to get away from volume-driven performance to value-driven performance, which means improved quality with contained costs,” says Philadelphia attorney Alice Gosfield of Alice G. Gosfield & Associates. “But if you have internal compensation that is all about work RVUs, you are working at cross purposes. That just incentivizes the hamster wheel of more complex and expensive procedures. It won’t work in the new world order.” The Stark law does not inhibit more effective forms of productivity compensation that reward physicians for improved clinical care and patient satisfaction and attending meetings to build culture, she says.

The Stark law prohibits Medicare payments to entities providing designated health services if they are ordered or referred by physicians who have a financial relationship with the DHS entity, unless an exception applies. People often think the Stark law will interfere with productivity compensation for physicians, but that’s not true, Gosfield says. “Even with Stark, you can pay people for quality and value, but you have to make sure the compensation formula in general complies with Stark if you have DHS in your group,” whether it’s hospital owned or not, she says. Hospitals that employ physicians should establish a separate subsidiary that qualifies as a Stark-compliant group practice to reap the benefits from productivity compensation under Stark exceptions, says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind.
Under Stark, physicians who meet the definition of a group practice can bill for “in-office ancillary services” and qualify for group practice arrangements. These exceptions open the door for productivity payments. Gosfield says there are three safe harbors for productivity compensation, which is the fruit of the physician’s own labor: (1) a bonus based on the physician’s total patient encounters or RVUs, (2) a bonus based on non-DHS revenues, and (3) revenues derived from DHS if they are less than 5% of the group’s total revenues and if the amount allocated to each physician is less than 5% of his or her total compensation from the group.

Stark permits hospitals to own group practices and then fit them within the in-office ancillary services exception, “which allows more flexible compensation arrangements,” Wade says. But hospitals have to ensure that DHS revenue remains the revenue of the group practice and doesn’t flow to the hospital, he cautions. For example, employed orthopedic surgeons can receive productivity compensation for X-rays they perform in the practice that are billed by the practice but not for X-rays they refer to the hospital that are billed by the hospital. Also, group practices can pay physicians for lowering the length of a hospital stay, but hospitals can’t pay employed physicians directly for lowering length of stay because that runs afoul of the civil monetary penalty law that penalizes hospitals for limiting services to beneficiaries, Gosfield says.

Gosfield debunks some Stark myths about productivity payments:

- **Myth: Some base salary is required.** Not true, she says. It’s allowable under Stark to pay physicians entirely on productivity, with no base salary at all. That’s how Everett Clinic in Washington state does it, Gosfield says. After implementing productivity payments in 2007, last year it went all the way, prompted by a change in leadership and a vote from physicians. Also, she says, “there was a general sense of some complacency of physicians at the clinic. They weren’t working as hard as they could” before the productivity model went into effect.

- **Myth: You can’t pay independent contractors a percentage of revenue they generate.** That’s not the case, Gosfield says.

- **Myth: All revenue, including DHS and non-Medicare, must be treated the same way.** On the contrary, she says. “Stark is only a Medicare statute, and a referral is only for designated health services.”

- **Myth: DHS can’t be reflected in productivity compensation.** No, Gosfield says, because anything physicians do themselves is fair game. “If the physician took the X-ray himself or infused chemo himself, you can give dollar-for-dollar credit,” she says.

- **Myth: Revenue from services provided by a nonphysician practitioner incident to a physician’s services doesn’t count.** Not true, Gosfield says. The physician’s bonus can include incident-to revenue. In fact, you can give physicians credit for non-incident-to evaluation and management services provided by nonphysician practitioners that are billed under their own provider numbers.

Another way to reward physicians is through profit sharing — “the fruit of others’ labors,” Gosfield says. Physicians get a share of all DHS profits provided by the group or at least five physicians in the group. The Stark statute provides three safe harbors for profit sharing: (1) per capita equal division of the profits, (2) a distribution of DHS revenues based on the distribution of the group practice’s revenues attributable to the non-DHS services, and (3) “any dis-
tribution of DHS if the group practice DHS revenues and no physician’s allocated portion of those revenues is more than 5% of the physician’s or the group’s total compensation,” Gosfield says.

There are creative approaches to setting up compensation for “pods” of five physicians, Gosfield says. For example, not all physicians in a group have to participate. Pods can be organized by content — imaging pods or infusion pods, for example. Or they can be separated by high, medium and low utilizers. “You can mix and match in any combination you want as long as each pod has five doctors for allocating profits,” she explains.

With different options for compensation, some medical groups are rewarding quality and value. It’s a slow process, but they are motivated by an array of Medicare and commercial initiatives, including:

◆ The physician value-based purchasing modifier: The health reform law mandated the implementation of a value-based purchasing modifier with Medicare physician fee schedule payments starting in 2014. Physicians with higher scores on composite measures of quality will be paid more than physicians with lower scores. The physician value-based purchasing modifier “holds hands with hospital value-based purchasing” (RMC 2/13/12, p. 1), she says.

◆ The bundled payments initiative: CMS is developing a bundled payment for all services (e.g., physician, hospital) linked to an episode of care (e.g., inpatient plus post-acute care for orthopedic procedures).

◆ Accountable care organizations (ACOs): With or without the survival of the health reform law, ACOs are taking off. The OIG-CMS fraud and abuse waivers make it possible for hospitals that can’t otherwise pay physicians for profit sharing to participate.

◆ Physician quality reporting system: CMS uses a combination of payment carrots and sticks to encourage reporting of quality information. For now, providers get incentive payments for reporting data on quality measures for covered services paid by the physician fee schedule. But in 2015, physicians who drop the ball will face payment losses.

◆ Commercial pay-for-performance efforts: One example is Bridges to Excellence, sponsored by the Health Care Incentives Improvement Institute, which rewards clinicians who provide excellent care.

Medical groups that base productivity compensation on quality and value use different approaches, Gosfield found when she surveyed some of them with the help of the American Group Management Assn. For example, at Fairview Clinic in Minnesota, 50% of the physician’s compensation is at risk for quality in a system designed by the physicians, she says. Some practices call it a bonus or a withhold; others pay a stipend for joining in quality projects. Some put base salary at risk, with the amount all over the map. The results are generally positive in terms of improving quality.

The lessons learned for everyone, Gosfield says, are:

(1) Start small.

(2) Use well-regarded evidence-based measures “without financial impact [the first year] so physicians learn how to document for them and how to apply them before money attaches,” she says.
(3) Give periodic feedback to physicians.

(4) Don’t measure too many things — eight to 10 at most.

(5) Include physicians in the decision-making process. “It is astonishing how out of touch hospitals are with what they could be doing with physician groups,” she says. According to a September 2011 HealthLeaders article, 52% of hospitals report that physicians have little or no influence over payment models, she says.

Contact Gosfield at aggosfield@aol.com and Wade at rwade@kdlegal.com.

Hospitals That Move to ‘Nonproductivity’ Comp Face a New Kind of FMV Analysis

Paying physicians for their productivity is the norm, but some hospitals are experimenting with methods that reward other accomplishments without inviting fraud and abuse. “Nonproductivity” models of compensation are gaining traction as the first round of hospital-physician employment agreements come up for renewal. In a world of hospital-physician alignment and pay for performance, some hospitals are trying to use compensation as a lever to improve quality of care and patient satisfaction, shape utilization, promote efficiency and contain costs and practice expenses, according to Bob Wade, an attorney with Krieg DeVault in Mishawaka, Ind.

“This is a new concept in the past year or so. Hospitals and health systems are reacting to what they perceive the future to be: either accountable care organizations or the forced bundled payment model,” Wade says. “While productivity is still the common compensation methodology, it is probably decreasing in number or in the portion of the overall compensation. I am seeing in almost every fair-market valuation, there is a higher percent of compensation going toward nonproductivity factors.” However, in this context, establishing fair market value (FMV) — the crux of compliance with the Stark self-referral law — is more of a challenge, he notes.

For the past five years or so, during the first “tidal wave” of hospital acquisitions of practices and subsequent physician employment, hospitals rewarded physicians according to their work relative value units (wRVUs), Wade says. RVUs are one component of the Resource-Based Relative Value Scale (RBRVS) used by CMS to calculate Medicare payments to physicians. The harder physicians work and the more patients they treat, the more RVUs they generate. To get a wRVU, hospitals add the number and types of CPT codes (e.g., 99212, 99213). Productivity compensation can be a mix of base salary plus rewards or purely incentive based. Hospitals are supposed to derive base salary from data in major national surveys, including the Medical Group Management Association’s, according to the Phase II Stark regulations issued March 26, 2004. Then hospitals set the per-RVU incentive payment, which is the amount that physicians will earn for the work they do above and beyond the work RVU threshold established by the hospital. Next, hospitals determine the point at which the incentive part of the compensation kicks in. After a certain amount of RVUs are generated, physicians will earn a reward for every wRVU they generate thereafter. Then hospitals multiply the per-RVU payment (at the percentile appropriate for a particular specialist) by the number of wRVUs
the physician has earned beyond the threshold. The product of that equation is how much the specialist will be paid for incentive compensation.

Health Reform Drives Value Model

Now hospitals are looking beyond that model. “The industry, thanks largely to the Affordable Care Act, is moving from volume-based compensation to value-based compensation, meaning that physician compensation will be tied to the health and outcomes of their patients,” says Julie Chicoine, senior assistant general counsel at Wexner Medical Center at the Ohio State University in Columbus. The implementation of ICD-10 codes in October will fuel this trend because their “granularity” will reveal far more information about patients. “There will be an opportunity to quantify health outcomes based on the fact the codes are much more detailed.”

Recently Wade worked on a compensation arrangement that wasn’t rooted in productivity at all. “It’s hard from a fair-market value perspective,” he notes. The hospital wanted fair-market value assistance and he tried to use the MGMA data and work RVUs, “but how do you compare fair-market components like quality and utilization to a standard like MGMA data? It’s still applicable, but we have to think more critically about whether nonproductivity incentives are appropriate.” Another hospital decided to reward physicians for quality indicators, such as smoking cessation. The material question, Wade says, is how were its physicians performing at that moment in time? If the hospital established a $30,000 bonus for physicians who provided smoking cessation counseling for at least half their patients but it turned out most already achieved that for 75% of them, the threshold is too low. “With nonproductivity compensation, you want to challenge the physician to improve the patients’ health,” he says. “My problem from a fair-market value perspective is setting the thresholds too low and they hit a home run on every disease indicator.” A simple solution is to raise the threshold.

Suppose the fair-market value salary for a certain specialist (according to the MGMA survey) is $300,000. The hospital might set a base salary of $200,000 and then dangle bonuses for a series of utilization/efficiency and quality improvement measures. They could include expanding office hours to reduce patients’ non-urgent trips to the emergency room and improving patient outcomes on Medicare core measures (e.g., controlling high blood pressure, treating heart attacks). The specialist has the potential to earn $400,000 if she hits a home run with every quality improvement measure but would earn the fair-market value amount if she just did very well, Wade says. Hospitals have to monitor this closely; if physicians are perfect all the time and raking in the dough, the thresholds are probably too low and hospitals are playing with Stark fire. Or maybe they just have amazing physicians, but there are still fair-market value concerns. “If the doctor is already in the top 10%, it is OK to continue to compensate the doctor for meeting the thresholds, but with each utilization or quality initiative, you have to step back and look at the likelihood of success and where doctors may be willing to improve,” Wade says. “It’s a probability game.” It’s not always about paying them too much; some doctors refuse to play ball. One hospital he worked with has a physician who so far refused to engage in the nonproductivity compensation deal.

Wade cites three compliance concerns with nonproductivity models of compensation:
(1) Are thresholds for nonproductivity indicators set too low? If so, there’s a risk of compensation not being fair-market value or even being construed as a kickback to a referral source.

(2) Do hospitals have mechanisms to effectively monitor physician performance in each indicator? For example, if one indicator is the extent to which physicians reduce emergency-room use by their patients through appropriate methods (e.g., establish Saturday office hours), is there a way to track ER usage and count that back to the physician who receives incentives? Wade urges hospitals to avoid the mistakes he has seen with productivity compensation. Physicians received $30 per wRVU after the initial 3,000 wRVUs, but the hospital lacked a way to track it. “You should be able to go into the computer system and push a button, but a lot of systems track the personally performed work RVUs and the work RVUs for work not personally performed and allocate them to the supervising physician” — a recipe for a Stark violation.

(3) Is the overall compensation commercially reasonable and fair-market value, as required for compliance with the Stark law? MGMA data are still relevant in terms of the aggregate compensation, Wade notes. “It’s challenging. You may have a doctor so invested in improving overall patient health that his work RVUs drop. The doctor is performing in the 25th percentile based on wRVUs but is paid in the 90th percentile because he is focused on overall health and utilization. He keeps patients out of his office because of quality initiatives and utilization [changes].” This may become the gold standard, Wade says, and existing productivity models may be considered dinosaurs soon enough, but it will be a slippery slope in terms of fraud and abuse until the numbers are worked out. “There is art here,” Wade says. For example, a cardiologist who aggressively counsels a population of high-risk patients on smoking, diet and exercise may keep his volume of office visits low. “His work RVUs may go down because his patients are healthier,” and blood pressure and other data can be sent to him through the patients’ smart phones. Conventional productivity compensation will not do the physician justice. “Hospitals are truly thinking about it and entering this new analysis with baby steps,” he says.

Stark says when hospitals enter into a compensation arrangement, “you are probably fine as long as it was reasonable when you entered into it,” Wade says. “But you have to have the ability to rebase it year to year rather than locking it in for three to five years.”

Chicoine says hospitals will need data to make nonproductivity compensation meaningful and some of it will come from ICD-10. The number of codes increases from 17,000 in ICD-9 to 141,000 in ICD-10, allowing them to capture details about patients’ lifestyles, comorbid conditions, management of chronic illnesses and other factors, she says. ICD-9 can’t distinguish between a Type 2 diabetic who runs three times a week, has good blood sugar numbers and no comorbid conditions and a diabetic who is obese, cavalier about blood sugar and doesn’t exercise. But ICD-10 recognizes acuity and can help hospitals develop compensation models that recognize physicians for maintaining wellness for both kinds of patients. It’s good for physicians who complain they don’t get paid for spending time with patients, she notes.

Contact Wade at rwade@kdlegal.com and Chicoine at Julie.Chicoine@osumc.edu.