Track 1 – Session 4

Compliant Physician Compensation Strategies
About the Presenters...

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Compliant Physician Compensation Strategies

Health, Labor & Employment Institute
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I. Legal Concepts Overview

A. Stark (Physician Self-Referral Law)

1. 42 C.F.R. § 411.351

2. If a Physician (or immediate family member) has a direct or indirect Financial Relationship with an Entity, unless an exception applies:

   a. The Physician may not Refer any Designated Health Services (“DHS”) to the Entity.

   b. The Entity may not bill for any DHS referred by the physicians.

   c. No Medicare payments may be made for DHS referred by the physician, and

   d. The Entity must refund all moneys collected for DHS referred by the physician (unless no actual knowledge or reckless disregard for the physician’s identity).

3. Designated Health Service Entity includes:

   a. Entity that bills Medicare

   b. Entity that performs DHS

4. Exceptions (42 U.S.C. § 1395 nn)

   a. Rental of office space or equipment

   b. Bona fide employment relationships

   c. Personal service arrangements
d. Physician recruitment

e. Isolated Transactions

f. Fair Market Value Compensation

g. Group practice and in-office ancillary services

B. Anti kick Back Statute

1. 42 U.S.C. § 1320a-7b

2. Unlawful to:

   a. Knowingly and willfully

   b. **Solicit or receive**

   c. Any remuneration (directly or indirectly, overtly or covertly, in cash or kind)

   d. **In return for**

      Referring any item or service reimbursable by Federal health care programs, or

      Purchasing, leasing, ordering or arranging for (or recommending any of the same) any good, facility or service reimbursable by Federal health care programs.¹

3. Unlawful to:

   a. Knowingly and willfully

   b. **Offer to pay**

   c. Any remuneration (directly or indirectly, overtly or covertly, in cash or kind)

   d. **To induce**

¹ 42 U.S.C.§ 1320a-7b(b).
Referring for any item or service reimbursable by Federal health care programs, or

Purchasing, leasing, ordering or arranging for (or recommending any of the same) any good, facility or service reimbursable by Federal health care programs

4. 3 necessary elements:

   a. Intentional Act

   b. Direct or Indirect Payment of Remuneration

   c. To **Induce** the Referral of Patients or Business

5. Statutory Exceptions and Safe Harbors

   a. Discounts;

   b. **Employees**;

   c. Group Purchasing Organizations;

   d. Sale of a practice;

   e. Referral Services;

   f. Warranties;

   g. Investment Interests;

   h. Space Rental;

   i. Equipment Rental;

   j. **Personal Services and Management Contracts**; and

   k. Waiver of Deductibles and Coinsurance.²

6. What is Remuneration?

   An extremely broad scope, whether in cash or in kind, and whether made directly or indirectly, including:

   Kickbacks;

   Bribes;

   Rebates;

   Gifts;

² 42 C.F.R § 1001.952(a)-(k); see also 56 Fed. Reg. 35,952(1991).
Above or below market rent or lease payments;

Discounts;

Furnishing of supplies, services or equipment either free, above or below market;

Above or below market credit arrangements; and

Waiver of payments due.

C. False Claims Act


2. The federal False Claims Act (FCA) prohibits a person from “knowingly” submitting claims or making a false record or statement in order to secure payment of a false or fraudulent claim by the federal government.\(^3\)

3. The statute specifically provides that the terms “knowing” and “knowingly” mean that a person:

   a. has actual knowledge of the information;

   b. acts in deliberate ignorance of the truth or falsity of the information;

   c. act in reckless disregard of the truth or falsity of the information.\(^4\)

   Therefore, no proof of specific intent to defraud is required. Under the False Claims Act, civil actions must be brought within six years after the date of the violation, or within three years after the date when material facts are known or should have been known by the government; in any event, no claims may be made more than 10 years after the date on which the violation was committed.\(^5\)

4. Key elements

   a. false claims

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\(^3\) 31 U.S.C. §§ 3729

\(^4\) Id. §3729(b).

\(^5\) Id. §3731(b).
b. intent

c. materiality

d. causation

5. Key Healthcare False Claims Theories

a. Up coding/Billing for Services not Rendered

b. False Certification of Compliance with Regulations

c. Quality of Care/Worthless Services

d. Improper Retention of Overpayments

e. Anti-Kickback Statute/Stark Law

f. “Causing” submission of False Claims

6. The False Claims Act does not cover false tax returns. This FCA “tax bar” has been held to apply broadly whenever a false claim is made or a benefit is procured under the Internal Revenue Code, and is not limited to false income tax claims.6

D. Gainsharing

1. A hospital gives physicians a share of any reduction of hospital’s costs for patient care.

2. These payments are structured in a variety of ways, to include hourly payments for services performed by the physician or as a percentage of the cost savings realized under the arrangement.

3. Generally speaking approved gainsharing programs by the Department of Health and Human Services (HHS), Office of the Inspector General (OIG) include:

   a. substitution of less costly products for products previously in use;

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6 31 U.S.C. § 3729(e) provides that “This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1954.”
b. product standardization;

c. opening items and supplies only when needed; and

d. eliminating the use of or limiting the use of certain items and supplies.

4. Recent examples of Gainsharing, include:
   a. ACO

   b. Service Line Co-Management

   c. Use of certain medical devices, supplies and medications

5. OIG continues to analyze each program with highly fact-specific discretion prior to approving. In addition, these arrangements are not analyzed to comply with Stark Law. How gainsharing arrangements comply with the Stark Law remains a debate.7

II. Employed Physicians

A. Stark Law Exceptions:

1. An individual to be an employee of an entity if the individual satisfies the common law rules for an employer-employee relationship under §3121(d)(2) of the Internal Revenue Code. The Internal Revenue Service (IRS) traditionally has applied a 20-factor test to determine whether a worker is an employee or an independent contractor, but recently has looked at three overall factors:

   behavioral control,

   financial control, and

   type of relationship.

2. Precautions

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a. The IRS view – general principles impacting compensation of employed physicians by § 501(c)(3) organizations:

i. The IRS has an economic interest in classifying relationships as employer/employee, rather than as principal/independent contractor.

ii. There are payroll tax obligations, which facilitate the collection of income and employment taxes by the IRS. It also effects state unemployment insurance and workers’ compensation funds.

iii. Each physician’s overall compensation must not exceed reasonable, fair market levels for services rendered.

iv. Compensation levels when considered along with other facets of clinic operations should be distinguishable from private practice of medicine.

v. All compensation decisions, arrangements and payments should be timely, documented, including through board or committee minutes, written employment agreements, filing of appropriate Forms W-2, and thorough and accurate reporting on Form 990 as required.

3. The Wage and Hour Division (WHD) of the U.S. Department of Labor recently issued Administrator’s Interpretation 2015-1: The Application of the Fair Labor Standards Act’s “Suffer or Permit” Standard in the Identification of Employees Who Are Misclassified as Independent Contractors. This document analyzes how the Fair Labor Standards Act’s definition of “employ” guides the determination of whether workers are employees or independent contractors under the law.

B. Anti-Kickback Safe Harbor:

1. Protects payment by an employer to a bona fide physician employee for providing services if:

   a. Identifiable services.  

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8 42 USC §1395 nn (e)(2)(A); 42 CFR §411.357 (c)(ii).
One of the broadest and most commonly used compensation exceptions available under the Stark law is for payments made by an employer to a physician, or an immediate family member of a physician, with whom there exists a bona fide employment relationship.\(^9\)

b. Employers may be hospitals, medical foundations, physician groups, or other entities. **To qualify for this exception, the physician must be considered an “employee.”**

i. Remuneration is consistent with Fair Market Value of the services and not determined in a manner that takes into account the volume or value of any referrals.\(^10\)

ii. Remuneration commercially reasonable even if no referrals were made to employer.\(^11\)

iii. Productivity bonus permitted if based on personally performed services.

III. **Independent Physicians**

A. **Stark Law Exceptions**

1. Periodically review PSAs (“Professional Services Agreements”).

2. Serve as an alternative to the primary structure considered under full integration employment.

3. “Employment life” – the physician is not directly employed and still maintains some semblance of control.

4. Not to be confused with clinical co-managements, directorships, or other professional arrangements, generally have 4 models:

   - Traditional PSA

   - Global payment PSA

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\(^9\) 42 USC §1395 nn (e)(2)(D); 42 CFR§411.357(c)(4).

\(^10\) 42 USC §1395nn €(2)(B)(i-ii); 42 CFR §411.357(c)(2)(i-ii).

\(^11\) 42 CFR §1395 nn (e)(2)(B)(i-ii); 42 CFR §411.357 (c)(2)(i-ii).
• Practice management arrangement
• Hybrid arrangements

B. Anti-Kickback Safe Harbors

1. Personal service remuneration is permitted, meeting the following criteria:
   The arrangement is in writing,
   Signed by the parties,
   Specifies the services covered by the arrangement, and
   Is for a term of at least one year.

2. The arrangement covers all of the services to be provided to the DHS entity.

3. The aggregate services contracted do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

4. The compensation to be paid over the term is set in advance, does not exceed FMV, and is not determined in a manner that takes into account volume or value of any referrals or other business generated between the parties.

5. The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

IV. Physician Compensation Arrangements

A. Current Components

1. Salary – Base Compensation

2. Retention

3. Quality Bonus/Penalty

4. Medical Director - Considerations
   a. Are the medical director duties legitimately needed, and for the specific number of hours?
b. Are co-medical directors or multiple medical directors within a single service line actually needed?

c. Are the time sheets submitted by the physicians compelling (or do they simply appear as identical photocopies from one month to the next)?

d. Is the rate of payment consistent with FMV (see below)?

5. Management of Practice

6. Forgiveness of Loan

7. Housing or relocation reimbursement

B. Fair Market Value Physician Compensation- Things to Consider

1. Stacking of compensation
   a. When assessing Fair Market Value, need to consider all aspects of compensation including Base Pay, retention bonus, recruitment bonus, medical directorships, quality bonus, loan forgiveness, housing, etc.

2. Incentive Based Compensation
   a. Can’t factor in payment for volume of referral services (lab, x-rays, surgery referrals, etc.)
   b. Can be based on personal production
   c. In the future, more compensation arrangements will include incentives for quality metrics, population health, and enhanced patient experience

C. Assess Fair market value Compensation

1. Appraisers are often engaged to perform fair market value analysis

2. Use compensation surveys such as MGMA, AMGA, Sullivan Cotter, etc.

3. Profitability of the related service line (revenue less related expenses). Sometimes, this may mean the net income after physician compensation is negative.
4. Actual recruitment, training, and retaining efforts (if difficult to recruit or retain, could warrant higher compensation)

5. Approaches:
   a. Cost Approach – attract, train and retain
   b. Income Approach – value of income from physician less expenses including compensation
   c. Market Approach – compensation surveys, market rate, etc.

D. Commercial Reasonableness – How it is different from Fair Market Value

1. Commercial Reasonableness consider the business purpose of the arrangement and whether reasonable minds would enter into the arrangement, absent referrals

E. Future Compensation Components

1. Population Health + Patient Cost + Patient Experience
   a. Utilization of evidence-based guidelines
   b. Population health metrics
   c. Quality metrics and value measures
   d. Patient satisfaction
   e. Productivity tied to panel size and management
   f. Variation – department/specialty-specific

V. Relevant Case Examples

A. June 2015 – OIG released a fraud alert advising physicians to ensure their compensation arrangements reflect fair market value for bona fide services physicians actually provide. If not, they could face liability under the Anti-Kickback Statute. The OIG encouraged physician ‘to carefully consider the terms and conditions of medical directorships and other compensation arrangements before entering into them, and contemplate the nature, scope and performance terms of the services in those arrangements make sense in light of industry practices and compensation data.
Recent settlement with 12 individual physicians who entered into questionable medical directorship and office staff arrangements. Three reasons were cited for improper remuneration: 1. The payments took into account the physicians’ volume or value or referrals; 2. The payments did not reflect fair market value for the services to be performed, and 3. The physicians did not actually provide the services called for under the agreements.

The Fourth Circuit recently affirmed a $237 million judgment against Tuomey Healthcare System, Inc. This nonprofit hospital located in rural South Carolina, in 2000 began sought out and negotiated part-time employment contracts. The ruling found that compensation tied to collections for physician professional services may be compensation that varies with the volume and value of referrals.

One outcome of the Tuomey case has been the increased focus by Employers on the outside employment of physicians, other revenue streams, and drains on physician time which may detract from his value to Employer. These can impact the commercial reasonableness of an arrangement with a physician.

C. Halifax Health in Florida reached an $85 million settlement with the Department of Justice for a False Claims Act lawsuit. Halifax Health was accused of providing improper incentive bonuses to its medical oncologists and paying more than fair market value for the services of its neurosurgeons.

E. Citizens Medical Center of Victoria Texas. Case questions FMV for physician compensation. Three cardiologists filed a qui tam lawsuit against CMC alleging violation of FCA for knowingly submitting claims in violation of Stark Law and Anti-Kickback Statute. The allegation is that CMC entered into physician compensation arrangements that were disguised incentives for patient referrals.

F. United States ex. rel Singh v. Bradford Regional Medical Center. 752 F. Supp. 2d 602 (W.D. Pa. 2010). The hospital subleased a nuclear camera from a physician practice and paid not only the pass-through cost of the lease, but also substantial additional compensation, including payment for a non-compete agreement and a guaranty of the practice’s financial obligations under a second equipment lease. Whistleblower physicians brought this case against the hospital, the practice, and two physicians individually. The government signaled that flat fees, with respect to leasing and non-compete payments, may take into account the volume or value of referrals, if the fee is set in a manner that takes into account referrals or if it includes some sort of payment above and beyond the market value of the physician’s services or items provided.