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Partner Insight Series:

Recent Enforcement Actions Highlight Physician Compensation Pitfalls

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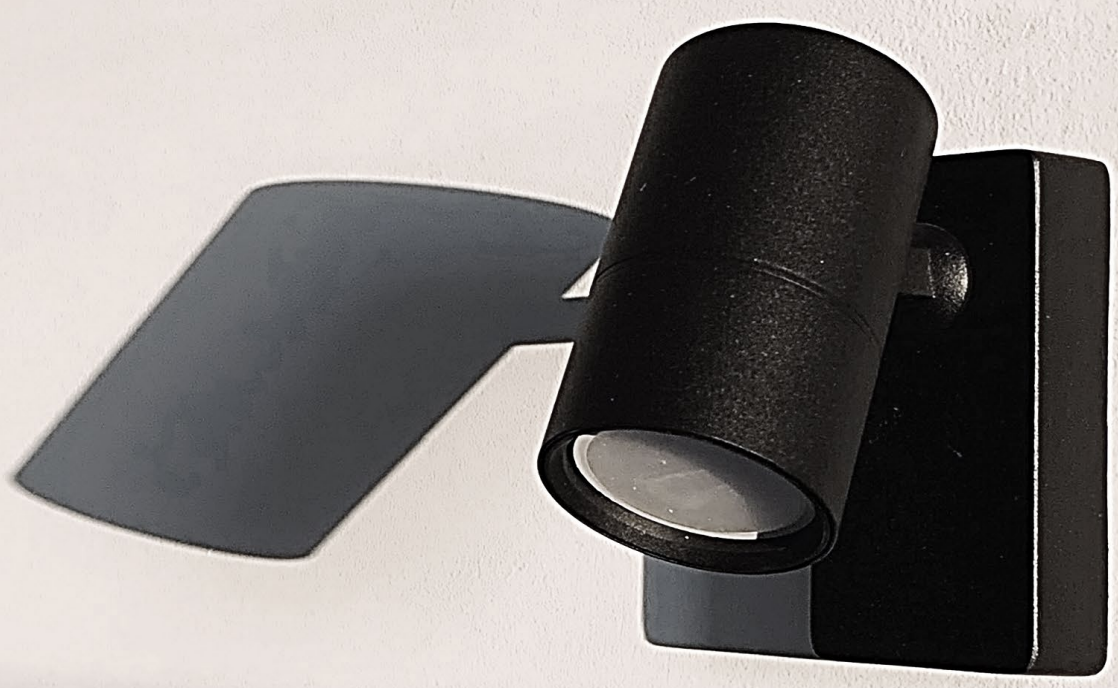

A Quick Glimpse: Community Health Network Enforcement Action[i]

Community Health Network, an Indianapolis-based health system with more than 200 care sites throughout Indiana, agreed to pay $345 million to resolve allegations that the health system failed to comply with regulations set forth by Stark Law and the False Claims Act (FCA) by recruiting physicians for the purpose of capturing their valuable referrals. According to a press release from the U.S. Attorney's Office, "Community successfully recruited hundreds of local physicians, including cardiovascular specialists, neurosurgeons, and breast surgeons, by paying them salaries that were significantly higher – sometimes as much as double – what they were receiving in their own private practices." Community Health Network also allegedly incentivized its physicians by awarding bonuses based on the number of referrals brought to the health system.

As many in the healthcare industry know, Stark Law and the FCA were enacted to combat this very issue. These regulations aim to ensure that patients are prescribed the most beneficial care for their unique circumstances and to protect against a physician's clinical judgment being corrupted by financial incentives. To remain compliant, employers of physicians must compensate their employed providers at fair market value (FMV) for personally performed services and are prohibited from considering the volume and/or value of a physician's referrals when deriving their compensation.

In the ever-evolving healthcare landscape, the heightened demand for skilled physicians has led to a highly competitive environment for physician recruitment and retention. In response to this competition, hospitals, clinics, and health systems are constructing increasingly aggressive compensation strategies to win over prospective health professionals. As creativity grows when designing compensation plans, so does the risk of violating regulations set forth by the Stark Law, Anti-Kickback Statutes (AKS), and the FCA.

In this article, we outline some of the common pitfalls seen in Department of Justice (DOJ) enforcement actions and provide suggestions for how to avoid them when designing and implementing provider compensation models.

Common Pitfalls

The nuances and complexities of physician compensation regulations, and their strict enforcement, can lead to frustration amongst physicians and employers alike. While some may interpret regulatory guidelines as a limiting factor in attracting and retaining physicians in an increasingly competitive labor market, it is important to remember the purpose of their inception. Creative solutions that achieve an organization's strategic and financial goals and simultaneously manage compliance risk are possible. While there are hundreds of variables and circumstances that can alter the regulatory risk associated with an arrangement, there are some common problematic areas that have emerged within the valuation community based on the outcomes of and types of arrangements the OIG chooses to pursue.

Below are some of the recurring pitfalls that exist in many of the recent enforcement actions:

1. Significant Increases in Compensation.

It is not uncommon for physicians to receive increased compensation when moving from a private practice setting to an employment arrangement. The context of transitioning a practice to an employment model is important, as the catalyst for many physicians pursing acquisition from larger health systems is the growing financial strain in a private practice model. Rising costs and decreasing reimbursement from government payors has made it increasingly difficult for independent physician practices to stay financially afloat in the aftermath of COVID. The move to an employment arrangement often brings compensation back to what the market would historically consider to be a "normal" level of compensation compared to the physician's level of productivity.

Employers, however, must be cautious. It is a longstanding stance of many regulators and valuators that clinical compensation generated by physicians in private practice is indicative of FMV. Therefore, when compensation increases significantly due to a move from private practice to employment, one could speculate that the increase is connected to referrals being generated by the physician for the health system, which is explicitly prohibited. This doesn't necessarily mean that an increase in compensation is always a violation of Stark Law, AKS, and/or FCA. However, given the prevalence of this pitfall being cited in numerous enforcement actions, it is a data point that health systems need to be mindful of.

It is best practice to ensure that there is a good understanding of the factors impacting a physician's compensation prior to employment, especially when dealing with physicians who already practice in the local market, and to document compliant reasons why compensation might be increasing in the employment model.

2. Compensation Linked to Volume or Value of Referrals.

Incentive compensation is common in provider compensation plan structures, as it is believed to help align provider behavior with desired outcomes and organizational goals. However, employers must approach incentives with caution. The incentive structure was a key focus in the Community Health case, and is an area that continues to receive regulatory scrutiny. Specifically, it is critical that incentive compensation is not in any way tied to an individual provider's referrals. To the extent incentive compensation, or any compensation, is tied to the "downstream" referrals to the health system's network, a Stark Law violation exists.

It is best practice to structure incentive compensation based on personally performed work and/or meaningful value-based metrics that increase access to, improve the quality of, or decrease costs of patient care. Further, when considering whether total compensation paid is compliant from an FMV perspective, your organization and valuation experts must ensure that the entirety of the contractually available incentive compensation (i.e., the maximum amount that could be earned) is considered along with all other forms of compensation. Lastly, if incorporating value-based incentive compensation, be sure to choose metrics for which data is readily reportable and set achievement targets that incentivize improvement from historical levels as opposed to status quo.

3. Stacking.

Physicians often provide a myriad of services (e.g., clinical, administrative, call coverage, precepting, supervision of advanced practice providers, academic research, etc.) for which they receive various forms of compensation (e.g., base salary, hourly rate, stipend, productivity-based compensation, value-based compensation, etc.). "Stacking," in its simplest form, refers to adding

these individual components of compensation together to derive total compensation. While each individual component may be considered FMV for the corresponding services rendered, it is important to also assess the aggregate compensation to ensure work efforts aligned with each form of compensation are reasonable and that the total amount of work effort and number of hours required to provide the services are feasible, and that there is no overlapping payment for the same services.

One area of scrutiny regarding stacked arrangements centers around a provider receiving multiple forms of compensation during the same hours worked. This is particularly an area of focus when addressing call compensation arrangements, as it is not uncommon for a physician to receive per diem compensation for the burden of being available in addition to productivity credit for clinical services provided during a call shift. All income streams should be considered when deriving contractual compensation terms to avoid inadvertently overpaying a physician, which could be perceived as payment for referrals and therefore increases the regulatory risk associated with the arrangement.

It is best practice to ensure the specific services provided and the corresponding compensation paid are separate and distinct for each type of service. Further, an organization needs to maintain appropriate documentation related to actual services provided by the physician and when such services are provided, as well as documentation regarding FMV and commercial reasonableness of the corresponding compensation for each type of service and in aggregate. Lastly, standardized policies and procedures related to physician contracting should be put in place to better understand when an outside opinion from valuation experts and/or legal counsel should be pursued in addition to internal documentation.

4. Paying Full-Time Compensation for Part Time Services.

A foundational valuation concept for physician compensation is tied to ensuring physicians are compensated commensurate with their contractual full-time equivalent (FTE). It is imperative to make adjustments in market data comparisons when a physician is providing services on a part-time basis.

When assessing a physician's FTE status, it should be reflective of all services provided by the physician and the physician's work efforts must align with the contractual obligations. While conceptually this seems straightforward, the implementation of a physician's work efforts may not always be so easily segregated. For example, it is not uncommon to see physicians contractually documented at a 1.0 FTE for the provision of their clinical services, with medical director services to be provided in addition to this 1.0 clinical FTE designation. Physicians commonly receive a base salary for the provision of the 1.0 FTE clinical services in addition to an annual stipend for the administrative services they provide as a medical director. While in theory this is acceptable, the physician may actually be providing the required administrative duties within their 1.0 clinical FTE efforts. One way to assess this dynamic is to evaluate a physician's productivity. A "red flag" in this situation would be a physician contractually stated as a 1.0 clinical FTE who generates wRVUs that benchmark below the 25th percentile. This is often an indicator that the physician is not truly practicing full-time and is instead performing administrative or other duties during what would contractually be considered clinical practice time. Possible solutions for this would be to 1) reduce the physician's clinical FTE designation and corresponding base salary so both clinical and administrative services equate to a 1.0 FTE designation, or 2) enforce the requirement that administrative work be completed outside of the contractually obligated clinical time. If the latter path is pursed, then the physician should naturally see an increase in productivity over time.

It is best practice to spend time understanding what is and is not captured in available market benchmark metrics and ensure that the financial and productivity data being used in internal analyses to assess FMV is reflective of the same underlying assumptions. Additionally, enforcing contractual minimum hours worked through time sheets, monitoring FTE status through productivity measures, and other procedures that improve documentation of a physician's work efforts should be incorporated into day-to-day operations.

Final Thoughts

Enforcement of regulatory compliance related to Stark Law, AKS, and FCA is ever evolving as the healthcare industry continues to incorporate increasingly creative ways to incentivize physicians to improve performance and expand the scope of their practices. That said, there continue to be common pitfalls allegedly at the center of most of the major settlements related to physician compensation related violations. It's important to remember that at the heart of the regulations, patients in our communities are protected when physicians are not financially tempted to provide services that are not medically necessary. It is advisable to not only avoid paying physicians for referrals, but also to avoid any perception of payment for referrals. Constructing compensation arrangements in collaboration with legal counsel, health system leadership, and experienced valuators is key to achieving competitive and compliant arrangements that tie into strategic organizational goals and lead to improved financial outcomes.

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Haley leads the firm's physician advisory service line where she serves clients in the areas of compensation valuation, compensation plan design, provider practice valuations, physician transaction related due diligence and general consulting related to hospital / physician arrangements. Her clients include large multi-hospital health systems, rural hospitals, critical access hospitals, physician-owned hospitals, and physician practices. Haley is passionate about helping her clients recruit and retain talented providers by ensuring provider compensation is competitive and compliant with applicable regulations such as the Stark Law and Anti-Kickback Statue.

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Katelyn joined JTaylor as an Associate in 2021 and provides consulting and valuation services. She has gained experience in various practice areas with an emphasis in the healthcare industry. Her fields of expertise include compensation valuation, compensation plan design, provider practice valuations, wRVU calculations, financial due diligence related to changes in the MPFS, and general consulting related to hospital / physician arrangements with Stark and/or Anti- Kickback implications. Her clients include large multi-hospital health systems, physician-owned hospitals, rural hospitals with FQHC and/or RHC designations, and both multi-specialty and single-specialty physician practices.

[i] Department of Justice. United States Attorney's Office, Southern District of Indiana. (2023, December 18). *Community Health Network Agrees to Pay $345 Million to Settle Alleged False Claims Act Violations* [Press release]. https://www.justice.gov/usao-sdin/pr/community-health-network-agrees-pay-345-million-settle-alleged-false-claims-act