Physician Compensation: What's New in Phase II

Apr 01 2004

Practice Area: Health Law

Phase II of the Stark II regulations covers a lot of territory, but certain key concepts repeatedly percolate to the surface. Some of the most significant provisions relate to the manner in which entities may compensate physicians without violating Stark's requirement that compensation not vary with, or take into account, the volume or value of referrals of designated health services ("DHS").

I. Percentage-Based Compensation

In Phase II, CMS finally yields to the criticism that followed its treatment of percentage-based compensation in the Phase I rules. In Phase I, CMS concluded that compensation based on a percentage of gross revenues, collections, or expenses is not fixed in advance, since it is based on a percentage of a "fluctuating or indeterminate amount." As a result, these compensation arrangements "take into account" the volume or value of referrals, and would not qualify for a Stark exception. CMS required that *aggregate* compensation be fixed in advance, and rejected the suggestion that only the *methodology* for example, a rental payment per use, or a payment per service) must be fixed in advance.

CMS' interpretation in Phase I was immediately criticized, for it would have restricted compensation methodologies that are widely used. In addition, this interpretation had a disparate impact on independent contractor physicians and those in academic medical centers ("AMCs"). In response, CMS delayed the effective date of this provision on four separate occasions while it re-considered the issue.

In Phase II, CMS deletes the offending language altogether. CMS recognized that the Phase I definition of "set in advance" would require hospitals, AMCs, and other entities to renegotiate numerous legitimate contracts for physician services, with a significant disruption within the health care industry. As a result of this revision, percentage-based compensation is permissible, even if based on a fluctuating measure such as revenues or collections, if the methodology for calculating percentage compensation is:

- established in advance, with specificity;
- objectively verifiable;
- not changed over the course of the agreement based on the volume or value of referrals or other business generated by the referring physician;
- set in an agreement before the services for which payment is being made are rendered.

II. Productivity Bonuses

CMS sought to harmonize permissible physician compensation arrangements for various categories of physicians in Phase II. This effort necessarily fell short, however, given the more liberal treatment of group practice physicians in the Stark statute.

"Incident-to" Services. In CMS' view, the statutory scheme under Stark allows productivity bonuses for "incident-to" services only under the inoffice ancillary services exception, which only applies in a group practice or solo physician setting.

CMS' position will have a significant impact on how hospital-employed physicians are compensated. Because hospital-employed physicians are not in a group practice, those employees may not receive payments that reflect ancillary DHS ordered by the physician and related to the physician's practice, but not personally performed by the physician, such as chemotherapy drugs ordered by an oncologist and administered by others.

Non-DHS Ancillary Services. Stark appears to allow productivity bonuses based on ancillary services ordered by an employed physician that are not DHS, even if not personally performed by the physician. This conclusion flows from the fact that the employment exception proscribes compensation that takes into account the volume or value of "referrals," but does not prohibit compensation that takes into account the volume or value of "other business generated" between the parties. Since the meaning of "referrals" is based on DHS, productivity bonuses for non-DHS ancillary services do not take into account the volume or value of referrals. Other elements of the employment exception still need to be met, such as the fair market value and commercial reasonableness requirements. As a practical matter, it may be difficult to fashion a productivity bonus package based on solely non-DHS ancillary services.

Services Subject to a Services-based Exception. Certain DHS may qualify for coverage under one of the servicebased exceptions. In effect, services that meet these exceptions are not DHS for purposes of the referral prohibition. These exceptions include physician services; services to enrollees under prepaid health plans; services provided by an AMC; and certain preventive screening tests, immunizations, and vaccines.

In Phase I, CMS indicated that the referral of services that qualify for one of these exceptions would not be prohibited, even if other direct or indirect relationships were present. The Phase I commentary was not retracted in Phase II. Thus, the availability of a services-based exception may allow production credit for the narrow categories clearly covered by the exceptions, but any such arrangement must be closely scrutinized for compliance.

Technical Component. In Phase II, CMS clarifies that the technical components associated with a physician's personally performed services constitute both "referrals" and "other business generated" within the meaning of Stark. This characterization is significant, since the personal services, fair market value, and AMC exceptions restrict compensation that is determined based on the volume or value of "other business generated" by the physician. In addition, the employment exception only allows productivity bonuses to be paid to employed physicians for DHS personally performed by the physician, but not referrals of DHS performed by others. As a result, the DHS entity may not pay a productivity bonus on the basis of a technical component.

Supervision. CMS received numerous comments addressing the extent to which productivity bonuses may be based on the physician's supervision of others. Some commenters requested that employers be permitted to pay productivity bonuses for DHS rendered under the supervision of an employee or, in the case of physicians in a group practice, under the supervision of another member of that group. In its preamble to the Phase II rules, CMS provided some guidance, and some cautions, on supervision payments.

- Physicians may receive productivity bonuses based on personally performed services, including personally performed DHS.
- Nothing in the employment exception prohibits a productivity bonus based on a physician's personal supervision of services that are not DHS, "since that bonus would not take into account the volume or value of DHS referrals."
- On the other hand, CMS expressed its concern regarding productivity bonuses based on the supervision of DHS since such a bonus "may merely be a proxy payment for having generated the DHS being supervised." CMS also expressed concern about the level of actual supervision. Under Medicare rules, supervision in many cases may consist of nothing more than being present in the facility. Implicit in this commentary is a suggestion that the employment exception will only protect productivity bonuses based on supervision when the payment reflects fair market value for active supervision.
- Finally, CMS observed that the employment exception would not bar "flat fee compensation based on the number of mid-level providers under the physician's supervision, as long as the compensation is fair market value for actual time dedicated to supervision services."

Note that Phase II has a greater impact on productivity bonuses in a hospital setting than in a group practice setting. Unlike hospitals, physician groups may rely on the in-office ancillary services exception to protect DHS referrals by their employed physicians. Since a group practice may pay productivity bonuses based on "incident-to" services, it is less likely that group practices will need to rely on the employment exception for productivity bonuses.

III. Fair Market Value Safe Harbor

Phase II creates a "safe harbor" provision in the definition of fair market value relating to hourly payments to physicians for their personal services. The safe harbor identifies two alternative methodologies for determining fair market value under Stark:

1. The hourly rate is less than or equal to the average hourly rate for emergency room physician services in the relevant physician 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 for physicians within the same physician specialty in at least four of six identified national surveys, and then dividing that compensation level by 2,000 hours. If the physician's specialty is not identified in the survey, the compensation level for general practitioners may be used.

CMS identifies the following national surveys that may be used under the second methodology:

- Sullivan, Cotter & Associates, Inc. – Physician Compensation and Productivity Survey.
- Hay Group – Physician's Compensation Survey.
- Hospital and Healthcare Compensation Services – Physician Salary Survey Report.
- Medical Group Management Association – Physician Compensation and Productivity Survey.
- ECS Watson Wyatt – Hospital and Health Care Management Compensation Report.
- William M. Mercer – Integrated Health Networks Compensation Survey

The new safe harbor methodologies are voluntary, and DHS entities may continue to establish fair market value through other methods. Note that the safe harbor is very narrow, and applies only to physicians who are compensated on an hourly basis. Physicians who are not compensated on an hourly basis will not fall within the strict terms of the safe harbor, even if their total compensation would meet safe harbor criteria on an annualized basis. The safe harbor is also limited to payments for services provided personally by a physician; it does not extend to payment for services provided by the physician's employees, or other persons or entities.

Note also that the first methodology is based on a rate that is "less than or equal to" the emergency room rate; while the second methodology involves an hourly rate that is "determined by" an average of national surveys. As a result, it is not clear whether an hourly rate that is "less than" the average survey compensation under the second methodology would qualify for safe harbor protection.

Finally, although CMS discusses the new fair market value safe harbors in the portion of the preamble relating to personal services arrangements, the safe harbors are not limited to arrangements covered by the personal services exception. While that may be the most common application of an hourly rate methodology, the safe harbors would also be available to employed physicians who are compensated on that basis.

IV. Directed Referrals

Hospitals and health systems often desire that their employed physicians refer DHS to the employer or affiliated entities. In Phase I, CMS recognized that required referrals may be a reasonable aspect of health care business arrangements, particularly in integrated systems. The Phase I rules stated that the "volume or value" standard is not violated when a physician's compensation is conditioned on such referrals, so long as the requirement is subject to exceptions where a patient expresses a preference for a different provider, the patient's insurer specifies a different provider, or the referral is not in the patient's best medical interests in the physician's judgment.

CMS received comments critical of such "directed" referrals following the release of the Phase I regulations. Commenters asserted that the rule fostered a competitive advantage for integrated health systems, as compared to competing entities that are not part of the system. CMS agreed, and added new restrictions on directed referrals. These restrictions permit required referrals to an entity only if:

- the required referrals relate solely to the physician's services covered by the scope of the physician's employment or contract;
- the referral requirement is reasonably necessary to effectuate the legitimate business purposes of the relationship;
- the agreement includes the other Phase I safeguards.

The Phase II revisions will still permit an employer to require its employed physicians, when working in their capacity as employees, to refer DHS to affiliated entities. Similarly, managed care organizations may still require network providers, when treating enrollees, to refer enrollees to other network providers. The restriction cannot extend to services falling outside the scope of the contract, however. As an example, CMS noted that an entity that employs or contracts with a physician on a part-time basis cannot condition compensation under the agreement on the physician's referrals of the physician's private practice business.

CMS was seeking a balance between the business of employers and health systems, and the protection of patient choice and physician judgment. Unfortunately, by requiring that such referral restrictions be "reasonably necessary" to accomplish the "legitimate purposes" of the relationship, CMS has departed from the "bright line" rules that it sought to establish in the Stark regulations.

V. Additional Resources

The Stark/Fraud & Abuse Team of von Briesen's Health Law Group has assembled a number of resources on the Phase II regulations under Stark.
