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Is Median Compensation in the Crosshairs?

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Those involved in physician contracting generally understand that a compliant physician compensation relationship must be commercially reasonable and provide compensation that is consistent with fair market value (FMV). While these terms always have been vaguely defined, there has never been more ambiguity regarding their interpretation, nor more at stake if these requirements are not fulfilled. An employment agreement that provides median compensation to the physician employee would seem to satisfy these requirements by default and, as a result, may not receive a high level of review prior to execution. However, recent settlements have highlighted both the complexity of the Stark employment exception and the potential risks associated with just such an arrangement.

The Stark Law Employment Exception

To satisfy the Stark Law's exception for bona fide employment relationships, an employment arrangement must meet the following conditions:

1. The employment is for identifiable services;
2. The remuneration is consistent with fair market value for the services provided;
3. The compensation is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals; and
4. The agreement would be commercially reasonable even if no referrals were made to the employer.[1]

A violation of any of these conditions can ultimately result in liability under the False Claims Act (FCA) for referrals of designated health services made by the physician employee. As discussed in the following section, the failure to satisfy these conditions has become the frequent target of qui tam complaints.

Escalating Whistleblower Activity Surrounding Physician Employment Arrangements

During the past several years, whistleblower complaints related to allegedly improper physician employment arrangements have led to numerous large recoveries and have dominated the news surrounding the health care fraud and abuse landscape. During September 2015 alone, the U.S. Department of Justice (DOJ) announced three major settlements. In each of these cases, the whistleblower(s) asserted that a defendant employed physicians under agreements that did not qualify as bona fide employment relationships under Stark. Given the extensive analyses surrounding each of these cases, we provide only contextual summaries of the qui tam complaints and the resulting settlements within this article.[2]

United States ex rel. Drakeford v. Tuomey Healthcare System, Inc., No. 3:05-cv-02858 (MBS) (D.S.C.)

The well-documented *Tuomey* case was one of the first to highlight an alleged failure to satisfy the conditions necessary to meet Stark's definition of bona fide employment relationships. The suit ultimately settled for $72.4 million.

United States ex rel. Baklid-Kunz v. Halifax Hospital Medical Center, No. 09-cv-1002 (M.D. Fla.)

This 2014 settlement resulted from a complaint alleging that physicians employed by a subsidiary of Halifax Hospital Medical Center were compensated with incentive payments that were not based on personally performed services. The case ultimately settled for $85 million.

United States ex rel. Schubert v. All Children's Health System Inc., No. 8:11-cv-01687 (M.D. Fla.)

This qui tam action, settled for $7 million, alleged that numerous employment arrangements with physicians provided excessive compensation. Those allegations were partly based upon the sizeable increases in the operating losses of the practice as new physicians were employed.

United States ex rel. Barker v. Columbus Regional System, No. 4:12-cv-108 (M.D. Ga.)
United States ex rel. Barker v. Columbus Regional System, No. 4:14-cv-304 (M.D. Ga.)

One of the complaints alleged that, because an employed physician's compensation exceeded the receipts from his professional services, the compensation necessarily took into account the volume or value of referrals to Columbus Regional System. The suits ultimately settled for $35 million.

United States ex rel. Reilly v. North Broward Hospital District, No. 10-60590 (S.D. Fla.)

The complaint alleged that, among other things, substantial losses were generated by Broward Health's employed physicians if the profits from their referrals were not considered. The case ultimately settled for $69.5 million.

United States ex rel. Payne v. Adventist Health System/Sunbelt, Inc., No. 12-856 (W.D.N.C)

United States ex rel. Dorsey v. Adventist Health System Sunbelt Healthcare Corp., No. 13-217 (W.D.N.C)

In these cases, the relators contended that employed physicians and mid-level practitioners were compensated more than FMV, as demonstrated by consistent and substantial losses generated by the employed physicians' practices. The suits ultimately settled for $115 million.

Several common themes were evident among these complaints. First, many of the compensation plans identified by the relators were construed to be based upon the volume or value of referrals, rather than the physicians' personally performed services. Numerous complaints alleged that the aggregate compensation provided for clinical services, medical directorships, and call coverage exceeded FMV. Finally, in every suit, the relator(s) asserted that the material financial losses experienced by the employed physicians' practices either resulted from compensation in excess of FMV or demonstrated that the arrangement was not commercially reasonable.

Another commonality between each of these cases was that the allegations generally centered around physicians whose compensation exceeded common national benchmarks (e.g., 75th or 90th percentile). However, one case that settled in 2015 seemed to introduce an outlier.

The Citizens Medical Center Settlement

United States ex rel. Parikh v. Citizens Medical Center, Case No. 6:10-cv-64 (S.D. Tex.)

The relators in this case alleged that Citizens Medical Center (Citizens) maintained numerous improper physician employment arrangements. In a ruling on a motion to dismiss filed by Citizens, the court considered allegations pertaining to five employed cardiologists. Of note, the relators asserted that three of the employed cardiologists' combined income increased from $630,000 in 2006 to $1,400,000 in 2007 after being employed by Citizens. Further, the relators alleged that the cardiologists' practice incurred losses of $400,000 in 2008 and $1,000,000 in 2009. In its motion, Citizens argued that its cardiologists received compensation below the national median, and thus, the relators had not sufficiently alleged that Citizens provided improper remuneration.

Ultimately, the allegations pertaining to the cardiologists survived the motion to dismiss. In his ruling, Judge Costa stated:

> Even if the cardiologists were making less than the national median salary for their profession, the allegations that they began making substantially more money once they were employed by Citizens is sufficient to allow an inference that they were receiving improper remuneration. This inference is particularly strong given that it would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it were doing so for some ulterior motive.[3]

Eventually, the suit was settled for $21.75 million.

Impact to Physician Employment Agreements

Many of the above cases involved an aggregation of bad facts or at least allegations of bad facts (e.g., evidence of specific intent to induce physicians to make referrals) and did not necessarily focus on one specific issue related to the subject employment agreements; however, these recent settlements highlight several trends that should be considered when structuring physician employment arrangements:

- Whistleblowers are scrutinizing the economics of physician employment arrangements carefully. Both regulators and the courts appear to be developing a similar interest. Sustained practice losses may raise the likelihood of an allegation that compensation exceeds FMV or that an arrangement is not commercially reasonable.
- The willingness of physician employers to incur material financial losses, accompanied by significant post-employment compensation increases, appears to be increasing. Meanwhile, potential relators and, more importantly, the government, frequently challenge the argument that it is reasonable to offer a physician a pay increase upon employment, even when that physician might have been receiving "below-market" compensation prior to employment.
- The courts have demonstrated a willingness to hear evidence of potential violations involving relatively low levels of compensation (e.g., *Citizens*).
- While these cases advance no compelling argument to suggest that median values are not a reliable indicator of FMV compensation, they emphasize that a compliant physician employment arrangement requires more than compensation that is consistent with the market.
- Outside of those providing a relatively low base salary with no opportunity for incentive compensation, there may no longer be any "simple" physician employment arrangements.

Establishing Bona Fide Employment Relationships

In light of these developments in enforcement activity, hospitals should consider the following issues to help ensure that the physician employment agreement providing median compensation is truly as compliant as many have always believed it to be.

Commercial Reasonableness Is No Longer a Given

Whistleblowers seem to have created what many readers will consider to be an oxymoronic term: the commercially *un*reasonable employment agreement. After all, is there another type of health care transaction that makes more business sense than an employment arrangement? Nevertheless, based on enforcement in this area, some may presume that many employment relationships exist, solely or in part, to generate referrals for the employer. Thus far, the government and courts seem to have largely ignored the fact that Stark regulations clearly permit the compensation of a bona fide employee to be "conditioned on the physician's referrals to a particular provider, practitioner, or supplier."[4] To establish commercial reasonableness at the outset of a physician employment arrangement, hospitals should consider and document the following inquiries:

- Does the employment of this physician serve a legitimate business or mission-driven purpose absent consideration of referrals?
- Do the qualifications of the candidate align with the position's requirements?
- Can a single physician reasonably perform all of the duties that are being requested?
- Does the method of compensation make sense given the nature of the services?
- How does the compensation plan reward only those services that are personally performed by the physician? Could it be construed to provide compensation based upon the volume or value of referrals?
- Is the proposed compensation reasonable in the context of what the physician was earning prior to employment?
- Is there a solid business case to justify potential practice losses without considering any referrals?
- If there is an expectation of directed referrals, is the requirement, including an exception for patient preference, documented in the employment agreement?

Evaluate the Impact of Losses on Commercial Reasonableness

Approximately 2,600 practices owned by a hospital, health system, or integrated delivery system reported data to the Medical Group Management Association for its 2015 Cost and Revenue Report.[5] Of those, more than 75% of primary care and nonsurgical practices and 90% or more of surgical and multispecialty practices reported total operating costs that exceeded total revenue. Therefore, the presumption that practice losses and commercial reasonableness cannot coexist implies that the vast majority of the market has untenable physician relationships—an assertion that defies reason.

There are many situations in which it may be commercially reasonable to anticipate and incur losses from a physician's professional practice. A newly recruited physician may take time to develop their practice. The local payer mix or the hospital's relative lack of negotiating power may not allow for professional revenue that supports market-level provider income. There may be a community need for a particular specialty but insufficient population to generate professional fees exceeding the cost to employ a qualified physician. Finally, cost accounting practices may result in "optical" losses for the professional practice that do not reflect the economics of a private practice setting. Whatever the underlying reason, it is advisable to document thoroughly the legitimate business rationale for any expected losses resulting from an employed physician's practice.

Understand the Data Reported by Compensation Surveys

The compensation data reported by physician compensation surveys typically represents the respondents' total cash compensation from *all* sources, including patient services, administrative duties, call coverage, midlevel supervision, quality incentives, and ownership distributions. Therefore, the reported median represents the median compensation for a physician's complete basket of services, not any individual service. A base salary tied to the median coupled with additional payments for various other services may give rise to stacking concerns, as discussed below.

The compensation per unit data reported by the surveys (i.e., compensation per work-relative-value-unit (wRVU) and compensation as a percentage of collections), which are actually calculated by the surveys for each respondent that reports both compensation and productivity, generally displays a pattern of inverse correlation with production. In other words, the highest compensation per unit rates most often are attributable to physicians at the lower end of the production spectrum, as demonstrated in the figure on the next page. This phenomenon is generally thought to be a byproduct of guaranteed base salaries received by lower-producing physicians, and could potentially indicate a higher level of incremental cost needed to generate very high production.

As a result of this counter-intuitive characteristic of the reported compensation per unit data, compensating a highly productive physician with a relatively high production compensation rate (e.g., the reported 75th or 90th percentile value) almost certainly will generate total compensation that exceeds levels observed in the market at similar production levels. Physicians with extremely high production may require a compensation rate *well below* the reported median to achieve total compensation that is consistent with FMV.

Identify and Address Compensation Stacking Issues

Employed physicians are currently compensated for more duties than ever before. Today's employed physician may receive a base salary, production-based and quality-based

incentive compensation, and separate compensation for several additional services, such as call coverage, medical directorships, midlevel provider supervision compensation, and resident supervision. As these various services and forms of compensation are "stacked" upon one another, the aggregate compensation to the physician, whether on an annual or "per unit" basis, may far exceed median levels, even with a conservative base salary.

To mitigate stacking concerns, employers must ensure that separate forms of compensation are attributable to separate services and distinct time requirements. A physician that is provided an FMV base salary for his or her full-time efforts should only receive additional compensation for services that exceed those efforts. For example, a physician that is required to provide 40 hours of clinic services per week and receives an FMV base salary for those services should only be compensated for additional services performed in *excess of* those required 40 hours.

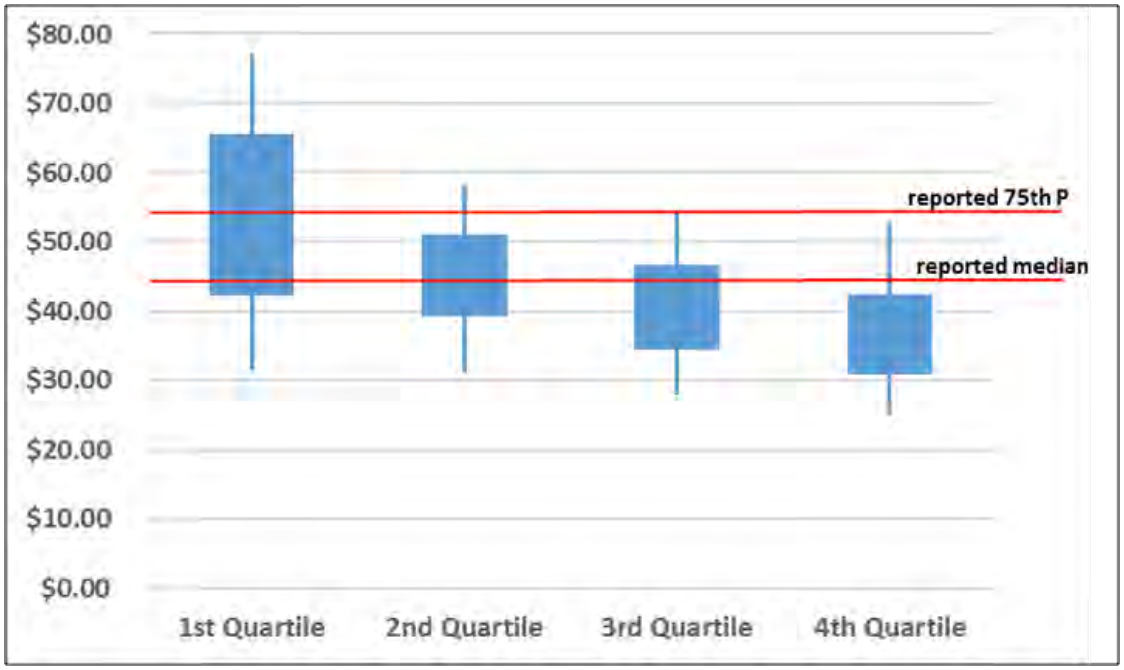
Furthermore, as discussed previously, the total cash compensation figures reported by physician compensation surveys include compensation for a "market level" of services. For most specialties, the reported median total cash compensation necessarily includes the compensation associated with typical call coverage requirements, administrative duties, and achievement of quality objectives. Careful consideration must be given to stacking of additional compensation elements atop an FMV salary for services that do not clearly exceed market norms.

Exercise Caution When Designing and Implementing Incentive Compensation Plans

Many of the settlements described above involved allegations that the employed physicians received incentive compensation that was not based upon the physicians' personally performed services, but rather upon the volume or value of their referrals to their employers. When the idea for a highly creative bonus structure emerges, be sure to consider the potential implications of such a plan carefully.

Incentive compensation plans based on wRVU production are by far the predominant model currently utilized for employed physicians, and likely the most conservative from a compliance standpoint. However, asking a handful of serious, but often overlooked, questions can prevent major pitfalls that can emerge with this common model. For example, does the employer's billing system provide the capability to distinguish the billing provider from the service provider, such that a physician is not inadvertently compensated for wRVUs produced by a midlevel provider for services billed as incident to the physician's services? Are wRVU calculations appropriately adjusted for modifiers (e.g., assistant at surgery, multiple

Figure 1: Illustration of Reported Compensation per wRVU Rates by Production Quartile[6]



procedures)? Are wRVU calculations based upon the most current version of the Medicare Physician Fee Schedule? Does the employer's calculation of wRVUs include a Geographic Practice Cost Index adjustment, and, if so, was this adjustment considered when determining that the compensation provided to the physician was consistent with FMV? Are wRVUs associated with claims that are denied and subsequently refiled accounted for properly?

Final Thoughts

DOJ reported that health care fraud and abuse recoveries under the FCA totaled nearly $2 billion in 2015, with $330 million paid to qui tam relators. Figures such as those are likely to drive increased scrutiny and reporting from within and outside the walls of physician employers. In isolation, median compensation may no longer provide the "safe harbor" that it once offered. Each component of the Stark exception for bona fide employment relationships must be considered carefully when structuring physician employment agreements in today's enforcement climate.

1 42 C.F.R. § 411.357(c).
2 Fried, A. and Ferrari. A; *Physician Compensation Arrangements Under the Microscope*, Hospitals & Health Systems Rx. American Health Lawyers Association (Jan. 19, 2016).
3 *United States ex rel. Parikh v. Citizens Medical Center*, 977 F. Supp. 2d 654, 670 (S.D. Tex. 2013).
4 42 C.F.R. § 411.354(d)(4).
5 Medical Group Management Association, *MGMA 2015 Cost and Revenue Report: Based on 2014 Survey Data*.
6 This chart was created using fictitious data to demonstrate the behavior observed by the authors. It does not represent actual data reported for any particular physician specialty.

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