Pitfalls of Practitioner Compensation

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Federal and state regulations limit the manner in which physicians and other health care providers may be compensated as employees, independent contractors, or members of group practices. Although the regulations are fairly easy to satisfy, it is still important to analyze compensation arrangements to ensure compliance. This memo provides a brief overview of some of the more relevant limitations for such arrangements.

1. Employed Physicians. If the contract concerns a physician and the physician may refer patients to the employer for certain designated health services (“DHS”) payable by Medicare, the compensation structure must comply with the federal Stark regulations. (See 42 C.F.R. § 411.351 et seq.). To fit within Stark’s exception for bona fide employees (id. at § 411.357(c)), the compensation structure must satisfy the following:

   **Fair market value.** The overall compensation paid to the physician must be consistent with fair market value. (42 C.F.R. § 411.357(c)(2)(ii)). “Fair market value” is defined as the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties who are not otherwise in a position to generate business for the other party. (Id. at § 411.351). Thus, the value of referrals should not be considered in determining fair market value. (See OIG Compliance Guidance for Individual and Small Group Practices (10/00)). In analyzing fair market value, the parties should consider all the compensation that will be paid to the physician, including salary, bonus, and benefits. The parties may evaluate and document fair market value by any reasonable method, including but not limited to comparison of national or regional compensation surveys. (See 69 F.R. 16107). However, CMS has warned that employers should take reasonable steps to ensure that the data is relevant to the particular market and the physician and contract at issue, and is not distorted by referral relationships. (Id.; see also 66 F.R. 944). For hourly compensation structures, a physician’s compensation will be deemed to reflect fair market value as a matter of law if it satisfies certain regulatory tests based on (1) the hourly rate for emergency room physicians in the relevant market; or (2) the average of national compensation levels listed in certain specified national surveys for physicians with similar specialties. (See 42 C.F.R. § 411.351).

For non-profit corporations, documenting fair market value will also help avoid any allegation of

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1 This memo does not address income from a practitioner’s ownership or investment interest (e.g., group practice membership or ownership of an ancillary service provider). Different rules apply to ownership or investment relationships. (See, e.g., 42 C.F.R. §§ 411.355-.356 and 1001.952(a), (p)).

2 “Designated health services” include inpatient and outpatient hospital services; outpatient prescription drugs; clinical laboratory services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; prosthetics and orthotics; physical therapy, occupational therapy, and speech-language pathology services; home health services; and parenteral and enteral nutrients, equipment and supplies. (42 C.F.R. § 411.351).
private inurement or intermediate sanctions. As with Stark, the total compensation must be considered, including salary, fringe benefits, pension plans, etc. (IRS Health Care Provider Reference Guide (2004) at p.18). The compensation must be reasonable to the physician’s specialty and area. (Id.). Although not required, the IRS suggests that physician compensation should be determined by an independent board or committee subject to a conflict of interest policy, and, if possible, be based on current compensation studies of similarly situated employees in similar geographic locales. (Id.).

**Not Based on the Volume or Value of Referrals for DHS.** A physician may generally be paid by any methodology so long as the compensation is not based on the volume or value of referrals for DHS. (See 42 C.F.R. §§ 411.357(c)(2)(ii)). Services that are personally performed by the physician are not “referrals” (id. at §§ 411.351; 69 F.R. 16087-88), and therefore a physician may always be paid in a manner that directly correlates to his or her own labor (e.g., the professional component of charges). (See 69 F.R. 16087). However, to satisfy the *bona fide* employee exception, a physician generally cannot be paid based on his or her referrals for DHS performed by others (e.g., ancillary services, “incident to” services, or the technical component of DHS charges). (Id.).

The practical effect of these rules is that a physician employee may generally be paid based on a salary; per unit of time (e.g., per hour, day or week) (42 C.F.R. § 411.354(d)(2)-(3)); per unit of service personally performed by the physician (e.g., per relative value unit (“RVU”), patient encounter, or fee schedule) (id.; see also 66 F.R. 877); a percentage of charges or collections for services personally performed by the physician (69 F.R. 16066); or any combination of these. (See id. at 16066-68). In addition, a physician may be paid a bonus based on the physician’s personal productivity (42 C.F.R. § 411.357(c)(4)), or the achievement of specified quality indicators. (69 F.R. 16087). Finally, a physician may be paid for the physician’s own labor in supervising others. (See id. at 16087-88). However, unless the physician is in a group practice as described below, a physician generally cannot be paid an amount for, or percentage of, services performed by others or share in the overall profits of a facility or department. (Id.).

**Commercial Reasonableness.** In the case of physicians, Stark requires that the overall contract (including the compensation) must be “commercially reasonable” even if no referrals were made by the employed physician. (See 42 C.F.R. § 411.357(c)(3)). For example, the parties should confirm and document that the physician actually performs the contracted services, and that those services serve a legitimate, commercially reasonable purpose independent of the physician’s referrals.

**Non-Physician Employees.** The foregoing rules generally do not apply to non-physician employees because (1) Stark is limited to physicians, and (2) the Anti-Kickback Statute does not apply to *bona fide* employees. However, non-profits will still want to ensure that the compensation reflects fair market value to avoid any issue concerning private inurement or intermediate sanctions.

2. **Independent Contractor Physicians and Practitioners.** If the contract involves independent contractors (e.g., contract physicians, medical directors, etc.) who are in a position to refer patients or provide items or services covered by Medicare or Medicaid, the parties must comply with the federal Anti-Kickback Statute (“AKS”). (42 U.S.C. § 1320a-7b(b); 42 C.F.R. § 1001.952). In addition, if the contract involves a physician who may refer DHS, the contract must also comply with Stark. (42 C.F.R. § 411.351 et seq.) Unlike Stark, a practitioner is not required to fit within one of the AKS regulatory safe harbors to comply with the AKS; however, practitioners should structure the contract to fit within a safe harbor if possible and, if they cannot, they should come as close as they can and, in addition, document that the contract represents fair market value for legitimate services. To satisfy the Stark and AKS “personal services” safe harbors (id. at §§ 411.357(d) and (l) and 1001.952(d)), the contract should generally comply with the following:

**Fair Market Value.** As with physician employment contracts, the aggregate compensation must represent fair market value. (42 C.F.R. §§ 411.357(d)(1)(v) and § 1001.952(d)(5)). Again, for non-profit corporations, documenting fair market value avoids allegations of private inurement or intermediate sanctions.

**Not Based on the Volume or Value of Referrals.** As with physician employment contracts, the compensation cannot be based on the volume or value of referrals for services covered by Medicare or Medicaid. (42 C.F.R. §§ 411.357(d)(1)(v) and 1001.952(d)(5)). In addition, if the contract involves a physician who may refer DHS, the compensation cannot be based on the volume or value of other business generated between the parties, including referrals for services payable by private payors. (69 F.R. 16067). Thus, independent contractors generally cannot be paid based on their referrals for services performed by others, nor may they participate in profit sharing plans. (See id.). However, as
with physician employment contracts, independent contractors may always be paid based on services they personally perform. (See 42 C.F.R. § 411.354(d)).

Compensation Set in Advance. Unlike physician employment contracts, an independent contractor’s compensation must be set in advance. (See 42 C.F.R. §§ 411.357(d)(1)(v) and 1001.952(d)(5)). Stark and the AKS differ on the compensation methodology that may be used to obtain safe harbor protection for independent contractor arrangements. To comply with Stark, a physician’s compensation formula must be set in advance, i.e., it must be stated with sufficient detail so that it can be objectively verified, and may not be changed or modified during the term of the agreement in a manner that reflects the volume or value of referrals. (Id. at §§ 411.354(d)(1) and 411.357(d)(1)(v)). Accordingly, Stark permits independent contractors to be paid according to percentage-based, per unit of service, per unit of time, or similar formulas so long as the formula is set in advance. (Id. at § 411.354(d)(1)-(3); 69 F.R. 16066-67). In addition, Stark also allows independent contractor physicians to receive productivity bonuses based on services the physician personally performs. (69 F.R. 16067).

In contrast, the AKS “personal services” safe harbor requires that the aggregate compensation must be set in advance. (42 C.F.R. § 1001.952(d)(5)). As a result, percentage-based, per service, per unit of time, or similar formulas will not qualify for AKS safe harbor protection because the aggregate compensation is not determined in advance. Nevertheless, the risks associated with such formulas are probably minimal if the parties confirm and document that the compensation represents fair market value for legitimate services actually provided.

Commercially Reasonable. As with physician employment contracts, the overall agreement must be commercially reasonable, and the contracted services should not exceed those which are necessary for legitimate business purposes; the agreement should not be a subterfuge for buying referrals or conferring private benefits. (See 42 C.F.R. §§ 411.357(d)(1)(i) and 1001.952(d)(7)).

3. Group Practice Requirements. Stark and the AKS also limit the manner in which compensation may be paid to physicians who are owners, employees or independent contractors of a group practice. For example, as a general rule, the group’s compensation structure must comply with certain requirements if group members will refer patients to other group members for DHS or ancillary services provided by the group (See 42 C.F.R. § 411.355(a)-(b)), or if the group wants to fit within the AKS safe harbor for payments to owners of a group practice. (Id. at § 1001.952(p)). However, the regulations give group practices greater latitude in the manner in which they compensate their members, employees and independent contractors. (69 F.R. 16067). In general, the compensation structure must satisfy the following:

Not Based on the Volume or Value of Referrals for DHS. Subject to special rules for profit shares and productivity bonuses described below, physicians in a group practice (including owners, employees, and independent contractors) cannot be compensated based directly on the volume or value of referrals for DHS. (42 C.F.R. § 411.352(g)). Thus, physicians in a group practice may be paid based on a formula that is not directly related to DHS referrals. (Id. at § 411.352(i)). They may also be paid based on services the physician personally performs. (Id.). Unlike physicians in other settings, physicians in a group practice may also be paid based on services performed by others that are “incident to” services3 personally performed by the physician. (Id.; see generally 69 F.R. 16066, 16080). However, group practice physicians generally cannot be paid based directly on their referrals for ancillary services that are DHS.

Profit Sharing. Physicians in a group practice may share in the overall profits from DHS so long as the profits are not divided and distributed in a manner that directly relates to the volume or value of DHS referrals. (42 C.F.R. § 411.352(i)(2)). Stark offers three compensation methods that are deemed not to relate to the volume or value of referrals: (1) if the profits are divided per capita (e.g., per physician in the group); (2) if the revenue from DHS is divided according to the division of revenue for non-DHS; or (3) if the revenues derived from DHS amount to less than 5% of the group’s total revenues, and the allocated portion of those revenues to each physician in the group constitutes 5% or less of the physician’s total compensation. (Id.). A group is free to use any other appropriate method so long as it is not based directly on the volume or value of referrals for DHS, but compliance with one of these three “safe harbor” formulas offers the greatest protection.

Productivity Bonus. Physicians in a group practice may also receive a productivity bonus so long as the productivity bonus calculation is not based on the volume or value of DHS referrals. (42 C.F.R. § 411.352(i)(3)). As with profit sharing, Stark offers three compensation methods that are deemed not to relate to the volume or value of referrals: (1) if the bonus is based on the physician’s total patient encounters or RVUs; (2) if the bonus is based on the allocation of the physician’s compensation attributable to services that are not DHS payable by a federal health care program or private payor; or (3) if the revenues derived from DHS amount to less than 5% of the group’s total revenues, and the allocated portion of those revenues to each physician in the group

3 “Incident to” services must meet the requirements of § 1851(s)(2)(A) of the Social Security Act and § 2050, “Services and Supplies,” of the Medicare Carriers Manual. (See 66 F.R. 876).
constitutes 5% or less of the physician’s total compensation. (Id.). Again, a group is free to use any other appropriate method, but compliance with one of these three formulas offers the greatest protection.

**Fair Market Value.** The Stark and AKS group practice exceptions do not require that the compensation paid to physician owners or employees or contractors represent fair market value. (See, e.g., 42 C.F.R. §§ 411.352 and 1001.952(p)). However, documenting fair market value may be important to avoid AKS liability if the compensation structure does not otherwise fit within an AKS safe harbor. In addition, if the group is a non-profit corporation, documenting fair market compensation will be important to maintain tax exempt status and avoid intermediate sanctions.

4. **Payments to Induce or Limit Services.** Stark generally allows certain managed care organizations (“MCOs”) to offer participating physicians incentives if they achieve cost cutting measures. (See 42 C.F.R. § 411.357(d)(2); 69 F.R. 16089-90). However, outside of the MCO context, Stark and the Civil Monetary Penalty Law generally prohibit hospitals from paying practitioners to reduce or limit services covered by federal or state health care programs. (42 U.S.C. § 1320a-7a(b)(1)). Although the OIG has recently approved several “gainsharing” proposals, most gainsharing arrangements would presumptively violate the Civil Monetary Penalty Law as well as Stark, and therefore they should be reviewed carefully by legal counsel before they are implemented.

5. **Summary.** The federal regulations governing compensation must be evaluated anytime an employee, independent contractor, or group member is in a position to refer Medicare or Medicaid items or services to the employer. The regulations are fairly easy to satisfy so long as the compensation (1) reflects fair market value for legitimate services, and (2) is not based on the volume or value of referrals. The trick is recognizing when a proposed compensation arrangement runs afoul of the limits, and then structuring the agreement to comply with relevant regulations. This memo provides only a brief summary of the relevant requirements. It is always best to review the regulations themselves when negotiating, drafting, or reviewing an employment, independent contractor, or group practice arrangement.