Physician compensation,

MGMA does not endorse any solutions put forth in this column. We urge readers to explore the legal issues — federal, state and local — that may arise from a particular course of action.

The federal physician self-referral law (“the Stark law”) is now almost 25 years old, but time has not produced clarity or certainty in many aspects of its implementation. After original enactment in 1989, significant amendment in 1992 and various efforts to curtail or expand the scope of the law since, Congress never seems quite finished with its policymaking function. Similarly, the Stark law has produced a long and tortured history of rule-making by the Centers for Medicare & Medicaid Services (CMS), including, among others, Stark 1 and Stark 2, and within Stark 2, Phases I, II and III (collectively, “the regulations”).

More recently, the courts have begun to add their paint to an already crowded canvas. Two recent cases have generated considerable notoriety in the healthcare trade press and are the subjects of hot debate among healthcare lawyers, institutional compliance officers and others concerned with ensuring compliance of physician compensation arrangements in diverse practice settings.

Both cases involved physician compensation relationships with hospital systems that were structured as employment relationships, not compensation plans in physician-owned medical groups. Similar facts would likely have produced different legal outcomes in a physician-owned group setting.

In less than six months’ time, two federal district courts have interpreted critically important provisions of the Stark law’s exception for compensation paid to bona fide employees and have sided with the government’s interpretation of the law in both instances, which was adverse to hospitals and more restrictive than what at least some healthcare lawyers, consultants and appraisers previously thought the law to be. Both of these cases are only district court decisions. One has been settled without the benefit of an appellate review of the lower
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The Tuomey case

The Tuomey case involved a number of factual and legal disputes leading up to the blockbuster decision. The central issue among these was the manner in which that hospital system paid a group of part-time employee physicians for professional surgical services rendered at the hospital. The hospital billed and collected for their professional services and compensated the physicians through a combination of base and
incentive pay. The formula was a rich one indeed, resulting in compensation dollars that, on average, exceeded the physicians’ professional collections by 31%. In other words, as designed and operated, it virtually ensured a significant hospital subsidy in favor of the physicians as compared with what a physician in a free-standing group practice, doing his or her own billing and collections for the same services, could have realized.

*Tuomey* is particularly significant because of the size of the judgment and because it suggests a new criterion for determining whether a given compensation arrangement will be considered to exceed fair market value or not be “commercially reasonable.” To the extent that this court focused heavily on the compensation being in excess of professional collections, it suggests a new standard not found anywhere in the Stark statute, the regulations or prior CMS commentary on physician compensation. The *Tuomey* decision is currently on appeal to the U.S. Circuit Court of Appeals for the Fourth Circuit. Given the size of the judgment, which would be catastrophic to virtually any hospital system, it seems likely the case will at some point be settled. The government has asked the hospital to escrow $50 million while the appeal and, presumably, settlement talks continue.

**The Halifax case**

Shortly after the *Tuomey* decision, a federal district court in Florida issued a similarly significant judgment against Halifax Hospital (U.S. *ex rel. Baklid-Kunz v. Halifax Hosp. Med. Ctr.*, 2013 WL 6017329 (M.D. Fla. filed Nov. 13, 2013)).

This case involved, among other issues, compensation paid to a group of six employed, full-time medical oncologists who practiced at the hospital. Those oncologists were eligible for an incentive bonus as part of their total compensation. The bonus was characterized as a productivity incentive, and it was apportioned between and among the six physicians in proportion to their individual professional productivity as measured by personally performed services. However, the bonus pool being thus distributed was derived from 15% of the operating margin of the hospital's medical oncology program. That margin included not just personally performed services, but also designated health services, including hospital outpatient charges and oncology drugs.

Unlike *Tuomey*, where the principal legal issue was whether the physician compensation met the Stark law’s test for fair market value payment, the legal issue in *Halifax* was whether the bonuses reflected the volume or value of the physicians’ referrals to the hospital. The court concluded that it did because the bonus pool included profits from hospital department operations, not just professional billings. As a result, even though the resulting compensation might have been within relevant salary survey ranges, the traditional determinant of fair market value (and each physician’s share was determined by looking only at his or her professional productivity, not including hospital referrals), the formula was effectively tainted by virtue of how the productivity bonuses were funded.

Also, unlike the decision in *Tuomey* where the judge and jury assessed damages, the *Halifax* decision simply ruled on what it considered to be the relevant legal issue, leaving a determination of damages to be assessed against the hospital system.

The Stark exception for bona fide employment relationships

Both cases (*Tuomey* and *Halifax*) interpret the Stark law’s exception for compensation paid by employers to physicians in bona fide employment relationships (“the employment exception”), which is found at 42 CFR 411.357 (c) and has these elements:

- The employment is for “identifiable services.”
- The compensation:
  - Is consistent with fair market value of the services.
  - Is not “determined in a manner that takes into account (directly or indirectly) the volume or value” of the physician’s referrals.
  - Might include a productivity bonus based on “personally performed services.”
- The compensation is paid under an agreement that would be “commercially reasonable” even if there were no referrals made to the employer.
Suffice it to say, however, that these decisions, and particularly the dollar amount of both, have driven fear into the hearts of hospital management, legal counsel, compliance officers and valuation consultants, and perhaps hospital-employed physicians as well. Going forward, all parties involved are likely to approach hospital-physician employment negotiations with greater caution and with a more conservative approach to permissible compensation formulas.

Implications for group practices
The obvious question is the significance of these judicial developments for existing compensation plans in group practices throughout the country. Both cases interpreted the Stark law’s employment exception, upon which most hospital-employed physicians and their employers rely.

Physician-owned group practices, on the other hand, do not and cannot rely principally on the employment exception for their Stark compliance strategies because it protects only a physician’s compensation relationship with an employer and not whatever ownership interest a physician might have in the practice. Most if not all physician-owned practices, therefore, rely on the exception for in-office ancillary services found in 42 CFR 411.355 (b) of the regulations, which exception protects both ownership and compensation relationships. And in most instances, for group physicians ordering ancillary services from their own groups to rely on that exception, the group itself must meet the Stark law’s definition of what constitutes a bona fide medical group practice. That definition is found in 42 CFR 411.352 of the regulations.

The rules governing compensation practices in such groups are found not in the in-office exception, but in the group practice definition, and specifically in subsections (g) and (i) of Section 411.352, which provide compensation alternatives that are in some respects similar to, and in other respects distinct from, the compensation test in the employment exception. Those distinctions provide more flexible treatment to group practices in several important respects.

As a general matter, they permit compensation formulas that indirectly reflect the volume or value of a physician’s referrals to his or her own practice as long as the method falls under either (1) permissible productivity bonus provisions of the definition or (2) permissible profit-sharing methods. That greater flexibility is found principally in these attributes of the definition, all of which differ from the employment exception:

• There is no fair market value test in the group practice definition.
• Productivity bonus formulas might include services “incident to” a physician’s professional service in addition to personally performed professional services.
• There is protection for any productivity bonus calculated in a “reasonable and verifiable” manner that is not directly related to the volume or value of a physician’s referrals for designated services.
• Certain “deeming provisions” provide regulatory certainty for particular productivity bonus approaches that might otherwise be subject to potential scrutiny.
• Profit-sharing formulas, as opposed to productivity bonus mechanisms, are permitted if they do not relate directly to the volume or value of referrals, provided the profits being distributed derive either from the designated services provided by the entire group or a component of the group consisting of five or more physicians.
That the compensation provisions of the group practice definition are more permissive than those in the employment exception is by no means accidental. The law was written this way as a result of advocacy efforts by MGMA and others, with both the Congress and the regulators in the early days of the Stark law’s development.

So what are the implications of the recent Tuomey and Halifax cases for physician-owned groups relying on the in-office ancillary services exception and the compensation provisions in the definition of group practice? The Tuomey case appears to have little substantive significance since the court’s decision turned largely on an analysis of the employment exception’s fair market value standard, and fair market value is not an element of the compensation provisions in the group practice definition. Similarly, Halifax’s “tainted” funding source reasoning should be less applicable to groups given the greater flexibility for productivity bonuses that relate indirectly to referrals and the express provision supporting profit-sharing mechanisms.

On the other hand, one can imagine a challenge based on a blending of the two case theories: If a productivity bonus mechanism is funded in part with ancillary profits (Halifax) and results in compensation in excess of professional collections (Tuomey), then is it really a productivity mechanism at all, or is it a profit-sharing plan in sheep’s clothing? In other words, might the outcome turn on proper characterization of the plan, and does that favor use of the Stark law’s permissive provisions for profit sharing rather than, or in addition to, production-based bonuses? Unfortunately, as with everything that is Stark-related, some uncertainty will remain unless and until courts are asked to interpret in an adversarial context a government challenge to a group’s compensation system.

One aspect of both cases likely does have significant implications for any challenge to a group’s compensation methods and that aspect is not substantive but procedural. In both cases, the respective judges placed the burden of proof on the defendants to prove compliance with an exception. The government’s burden was limited to proving that a financial relationship existed and that there were referrals for designated health services subject to the Stark law.

Another possible implication of these two rulings relates to hospital-physician service contracts as opposed to employment relationships. For a variety of reasons, some hospitals contract with medical groups to purchase professional services. Group physicians serve hospital patients, the hospital bills and collects for its professional services, and the hospital pays the group as outlined by the contract. These arrangements are typically protected under the Stark law’s exception for “personal service arrangements” found in 411.357(d) of the regulations or for “fair market value compensation” found in 411.357(l) of the rules.

Like the employment exception, both of these contract exceptions have a fair market value test and prohibit compensation that takes referrals into account. The fair market value exception also has a commercial reasonableness test. These are precisely the factors that became problematic when interpreted in Tuomey and Halifax. Were a court asked to interpret these compliance factors in the context of a professional services contract rather than employment, it might reach similar conclusions. It is not hard to imagine a future case in which a hospital that pays more for professional services than it collects for those same services finds itself accused of paying more than fair market value. Similarly, production-driven payments funded from sources other than mere professional collections may well be challenged as inevitably volume related.

Finally, we should not leave Tuomey and Halifax without noting that many hospital systems employing large numbers of doctors might be able to structure their physician practices to qualify as bona fide groups under the Stark law definition. These hospitals and their physician practice managers should explore compliance strategies based on the combination of the group practice definition and the in-office ancillary services exception instead of relying on what, prior to Tuomey and Halifax, legitimately seemed like the much simpler approach of reliance only on the employment exception.

Notes:
2. 42 CFR 411.351 et seq.