Professional Perspective

Regulatory Compliance & Physician Compensation Arrangements

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The landscape of physician compensation has changed significantly in the past several years. The productivity model has taken center stage, specifically around compensating physicians based on their wRVUs (work relative value units reflecting specific work activities). That approach deserves a fresh eye based on revisions in the Federal Physician Self-Referral law, commonly known as the Stark Law.

Based on the changes in the Stark Law, several concepts should be revisited in physician compensation arrangements: the meaning of fair market value (FMV), the meaning of commercially reasonable (CR), and the changing indirect compensation definition. See 85 Fed. Reg. 77,492 (Dec. 2, 2020) (MCR Final Rule); see also 86 Fed. Reg. 64,996, 65,343 (Nov. 19, 2021) (2022 MPFS).

Fair Market Value

First, the MCR Final Rule refined the FMV definition, and importantly, CMS refused to make a safe harbor or rebuttable presumption based on a range of values in salary surveys—e.g., no rebuttable presumption that salary at or below the 75th percentile is always appropriate and above the 75th percentile is suspect. See **85 Fed. Reg. at 77,558**. As such, there should not be an automatic presumption that if a physician is paid at the 50th percentile, the physician's compensation is FMV. If that physician is, for example, producing at the 25th percentile, the physician's compensation may be inflated above FMV for the work.

As an important side note, FMV for both the Stark Law's exceptions and the Federal Anti-Kickback Statute's safe harbors is a continuing obligation, so do not set it once and forget it. Mechanisms should be developed to ensure that dips in productivity are flagged with the ability to revise payments made pursuant to the agreements and vetted by the individual or team that handles physician compensation.

Commercially Reasonable

Second, in the MCR Final Rule, CMS added a definition of "commercially reasonable." CR is defined to mean that the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty.

Despite attorneys using consultants for commercial reasonableness determinations for years, in the Federal Register preamble to the MCR Final Rule, CMS stated that CR is not a valuation determination. See **85 Fed. Reg. at 77,531**. That statement is true because it is not a determination of FMV, but it is a factual assessment that can be aided by the consultant's experience. Among other mechanisms, holistically reviewing your medical director agreements to ensure no overlap or "overlap as needed" for the services at issue is important, for example.

Indirect Compensation Arrangements

Third, the indirect compensation analysis—including the definition and exception—has been changing. Most recently, in the Stark Law updates in the 2022 Medicare Physician Fee Schedule Final Rule (2022 MPFS), CMS further clarified the definition of "indirect compensation arrangement" and its guidance regarding personal productivity. See 86 Fed. Reg. 64,996, 65,343 (Nov. 19, 2021).

As noted by CMS, although the statute defines "compensation arrangements" as including both direct and indirect compensation, the statute does not define the term "indirect compensation arrangement." See 86 Fed. Reg. at 65,344. In Phase I regulations, CMS set forth the definition of "indirect compensation arrangements" and the indirect compensation exception. See 66 Fed. Reg. 856, 864-870 (Jan. 4, 2001).

In Phase II, CMS revised the regulation to distinguish the language identifying when an indirect compensation arrangement exists from the exception for indirect compensation arrangements. See 69 Fed. Reg. 16,054, 16,069 (Mar. 26, 2004). In the MCR Final Rule, CMS further revised the regulation at section 411.354(c)(2) that identifies when an indirect compensation

arrangement exists, dividing into separate subsections the aggregate compensation and unit of compensation components. See 85 Fed. Reg. 77,492, 77,544-46 (Dec. 2, 2020).

For an indirect compensation arrangement to exist, the aggregate compensation from the person or entity in the chain with which the physician or immediate family member has a direct financial relationship varies with the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS. That aggregate compensation concept has remained consistent over time, but the concept of unit-based compensation was added to the definition of "indirect compensation arrangement" in 2021.

Specifically, the MCR Final Rule added the concept of unit-based compensation, and the 2022 MPFS clarified that concept. CMS added the following:

> The amount of compensation that the physician or immediate family member receives per individual unit – (i) is not fair market value for items or services actually provided; (ii) could increase as the number or value of the physician's referrals to the entity furnishing DHS increases, or could decrease as the number or value of the physician's referrals to the entity decreases; (iii) could increase as the amount or value of the other business generated by the physician for the entity furnishing DHS increases, or could decrease as the amount or value of the other business generated by the physician for the entity furnishing DHS decreases; or (iv) is payment for the lease of office space or equipment or for the use of premises or equipment.

42 C.F.R. § 411.354(c)(2)(ii)(A)(2). Based on the 2022 MPFS, the individual unit of compensation is either an item, a service, or time.

Effective Jan. 1, 2022, under section 411.354(c)(2)(ii)(B), the individual unit of compensation includes all the following:

- The item, where the physician or immediate family member is compensated solely per item provided.
- The service, where the physician or immediate family member is compensated solely per service provided, including arrangements where the "service" provided by the physician or immediate family member includes both items and services, such as "under arrangements" service arrangements where both items and services are included in the complete service or package of services provided to the purchaser, e.g., per wRVU.
- Time, in all other circumstances, including arrangements where the physician or immediate family member receives compensation for each item provided or unit of service performed, or both, in addition to compensation for each unit of time worked, e.g., per hour or per year. See **86 Fed. Reg. at 65,352**. "Hybrid" compensation, i.e., compensation that is comprised of payments for both time-based units and service-based or items-based units, or both, is analyzed by converting it to compensation for a unit of time.

As noted, in the 2022 MPFS, CMS clarified the conditions that must be met for aggregate compensation and the conditions that must be met for the individual unit of compensation, in order for an indirect compensation arrangement to exist. See 86 Fed. Reg. at 65,352.

- First, for an indirect compensation arrangement to exist, the referring physician or immediate family member has a direct financial relationship that varies with the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS. For example, when a physician is paid on a per unit of service or time basis, the physician's aggregate compensation will increase as the physician performs more services or completes more units of time. And, where the services performed by the physician correlate to DHS-referred or other business generated by the physician for the entity, the aggregate compensation received by the physician varies with the volume or value of referrals or other business generated by the physician for the entity.
- Second, one of the conditions in section 411.354(c)(2)(ii)(A)(2) for the individual unit of compensation received by the physician or immediate family member must also be met for an indirect compensation arrangement to exist. For example, with tiered compensation increasing from $15 to $20 if the physician provides over 100 units of service to the entity, assuming the services are correlated with DHS or other business generated for the hospital and $15-$20 is within the range of FMV, because the amount of compensation increases as the number or value of the physician's referrals to the entity increase or the

amount or value of the other business generated by the physician to the entity increases, the conditions for an indirect compensation arrangement at section 411.354(c)(2)(ii)(A)(2)(ii) and (iii) are met. As such, the unbroken chain of financial relationships between the physician and the hospital would constitute an indirect compensation arrangement under section 411.354(c)(2).

It is important to note in the unit of compensation analysis that it does not matter if the physician is being paid for the physician's personally performed services or if the tiered compensation formula does not include DHS or other business generated as a variable. Although important in determining compliance with certain exceptions, e.g., the indirect compensation arrangements exception at section 411.357(p), the unit compensation analysis under the indirect compensation arrangements definition focuses solely on whether the individual unit of compensation could increase as referrals or other business generated increase, or could decrease as referrals or other business generated decrease. See 86 Fed. Reg. at 65,352.

Further, even if the physician never performed the required number of services to trigger the higher value, because the amount *could* increase under the tiered compensation formula, the conditions for an indirect compensation arrangement definition are met. CMS expressed concern with regard to tiered compensation models as described above as well as arrangements under which the conversion factor per wRVU increased after meeting a targeted threshold, e.g., $35 per wRVU if the physician furnishes 500 wRVU per month, but only $30 per wRVU if the physician does not reach the targeted 500 wRVUs. See 86 Fed. Reg. at 65,353.

The compensation arrangement or the individual referrals of DHS must satisfy the requirements of an applicable exception to the Stark Law. If the compensation arrangement to which the physician is a direct or deemed direct party is not a value-based arrangement and the entity is not an MCO or IPO, the only available exception in section 411.357 is the indirect compensation arrangements exception at section 411.357(p). (Note that the services may meet the in-office ancillary services exception at section 411.355(b)).

Among other things, the exception at 411.357(p) requires that the compensation received by the physician or immediate family member is not determined in any manner that takes into account the volume or value of referrals or other business generated by the physician. The special rules at section 411.354(d)(5) and (d)(6) are applied for purposes of determining the satisfaction of this requirement.

The concept of compensation for personally performed services is relevant in the analysis of the Stark Law exception. CMS made clear in the proposed rule and in the 2022 MPFS that arrangements involving compensation to a physician for items or the services of others where the physician's referral of DHS to an entity or other business generated by the physician or an entity may contribute to the compensation received by the physician are distinguishable from arrangements that solely involve compensation for a physician's personally performed services. See 86 Fed. Reg. at 65,346.

CMS expressed that "[p]rogram integrity concerns arise when payment for items or services provided as the result of a physician's referrals or other business the physician generates, rather than the physician's own labor, is included in the calculation of compensation." 86 Fed. Reg. at 65,346. In the 2022 MPFS comments, CMS addressed the meaning of "personally performed," stating that commenters discussing incident to billing may be "conflating" Medicare billing conventions with physician self-referral policy, and thought clarification was warranted. See 86 Fed. Reg. at 65,350.

For purposes of the definition of "referral" in section 411.351, CMS stated DHS is not "personally performed" by the referring physician if it is performed or provided by any other person, including, but not limited to the referring physician's employees, independent contractors, or group practice members. This includes DHS furnished incident to the referring physician's professional services. See 86 Fed. Reg. at 65,350 (citing 66 Fed. Reg. at 871-872; 69 Fed. Reg. at 16,063). We would note the same could be said of split/shared visits. But the practical issue is how to separate those incident to and split/shared services billed under the physician's NPI from personally performed services rendered by the physician in, for example, a wRVU compensation model.

Employed Surgeon Example

Below is a practical example highlighting various elements of the analyses described above.

A health system consists of two hospitals and a medical group. The group employs a surgical physician and an advanced practice provider (APP) who supports the surgeon in providing various patient clinical services. For purposes of this

example, the group does not meet the group practice standards under the Stark Law (section 411.352), and services do not meet the in-office ancillary services exception (section 411.355(b)).

The surgeon is compensated by the group on a wRVU productivity basis. Specifically, the Surgeon is paid a fixed base compensation with a wRVU productivity bonus. The wRVU productivity bonus is equal to wRVUs billed under the surgeon's NPI—i.e., the surgeon is the billing provider—and multiplied by a fixed conversion factor. A benchmarking analysis prepared by the group indicates the surgeon is paid at the median and generates wRVUs at the median. The surgeon is paid monthly.

CMS did not make a safe harbor or rebuttable presumption based on a range of values in a salary survey. While the results of the benchmarking analysis "seem safe" with compensation and productivity aligning at the median, a more thorough analysis to determine if the compensation is FMV is warranted.

The surgeon collaborates with an APP, and the productivity bonus is based upon wRVUs billed under the surgeon's NPI. With respect to an indirect compensation analysis:

- Because the compensation is a combination of annual compensation with a wRVU productivity bonus, i.e., time-based plus service-based (a Hybrid model), CMS considers the unit of compensation to be time-based and reflect the aggregate compensation paid to the physician during the period of time applicable to the payment. Typically, valuators will perform their assessments on an annual basis. The unit of compensation is a year, and the formula for determining the compensation per year is $X annual salary plus (conversion factor multiplied by the number of wRVUs personally performed during the year).

- The analysis of whether in this example compensation meets the "indirect compensation arrangement" definition reflects the following factors: (1) there is an unbroken chain of financial relationships; (2) the aggregate compensation does not vary with the volume or value of referrals or other business generated by the surgeon for the hospitals because the payment is based solely on personally performed services; and (3) the per-unit compensation must be fair market value for the year (as described above); the per-unit compensation does not vary based on volume or value of referrals or other business generated because the compensation is based on personally performed services (discussed further below); and there is no payment for the lease of equipment or office space.

- In this scenario, assuming the per unit compensation is fair market value, an indirect compensation arrangement does not exist. However, if the individual unit of compensation was tiered or increased as services increased, an indirect compensation arrangement may exist.

In analyzing FMV under a Stark Law exception, it is important to consider what is personally performed, i.e., actually provided, by the surgeon. Recall CMS expressed concerns surrounding compensation for services provided as a result of a physician's referrals or other business generated, including those services performed by an APP. Specifically, with respect to the analysis of fair market value in this example:

The wRVU productivity incentive is determined by multiplying the number of wRVUs billed under the surgeon's NPI by a dollar conversion factor (aggregate wRVUs).

- If the aggregate wRVUs include services billed incident-to, such services were not personally performed by the surgeon.

- If the aggregate wRVUs include services billed split-shared, where a portion of the service was personally performed by the surgeon and a portion of the service was personally performed by the APP, such services were not personally performed in their entirety by the surgeon.

- If the aggregate wRVUs include services billed globally, where a portion of the service was personally performed by the surgeon and a portion of the service was personally performed by the APP, such service is not personally performed in its entirety by the surgeon.

- If using aggregate wRVUs in the productivity incentive formula causes the surgeon's compensation to be in excess of FMV, an adjustment to compensation would be required. Further, compensating the surgeon for work not actually performed (i.e., personally performed by the APP) could call into question the commercial

reasonableness of the arrangement, and, depending on the facts, potentially whether the compensation was based on the volume of value of the surgeon's referrals or other business generated by that surgeon.

Compliance Takeaways

As takeaways, we recommend reviewing the following:

- If your review of compensation is only triggered when productivity is above the 50th or 75th percentile, you should fine-tune those assumptions to make compensation consistent with the physician's personal productivity, not an assumption that anything below the 50th or 75th percentile is deemed FMV.
- With regard to the CR analysis, ensure that the compensation is commensurate with the services being performed. For example, if a physician is compensated based on the physician's APPs' wRVUs, please ensure that such compensation is for services the physician performs, i.e., supervision, rather than a boon based on a productive APP with no connection to services the physician is performing.
- We would advise reviewing current arrangements that could fall under the definition of indirect compensation arrangements. As an example, we have found certain compensation arrangements that take into account APP's wRVUs as physicians' compensation may have issues meeting CR and FMV tests and the indirect compensation arrangements exception under section 411.352(p).

Conclusion

CMS continues to revise fundamental concepts in the Stark Law. As such, you should carefully review how recent pronouncements—e.g., the MCR Final Rule and 2022 MPFS—affect your current financial arrangements with physicians.