Physician Compensation for Quality Within Groups: Complying with Stark and The State of The Art

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I. Traditional Physician Compensation Models


A. Equal per capita: still exists
   1. Creates commonality
   2. Doesn't encourage hard work

B. Pure productivity: "eat what you kill"
   1. Rewards volume or expensive procedures
   2. Creates no team culture
   3. Makes people work hard

C. Base plus productivity bonus after expenses
   1. RVUs
   2. Cash in the door
   3. Encounters: protects those who see indigents or Medicaid

D. Non-clinical contributions: all in one pot or allocated to the physician who earned them or a combination
1. Administration of the group

2. Hospital work (e.g., medical directorships, leadership, committee work, product line management, on-call or indigent care payments)

3. Research

4. Teaching

5. Marketing

II. How Stark is Relevant

A. Statutory definition of a "group practice"

1. Have to meet the definition in order to

   a. Refer to a physician "in the group" or a member of the group

   b. To qualify to bill for in office ancillary services (IOAS)

   c. Qualify for group practice arrangements with a hospital

2. Definition of a group addresses compensation

   A physician "in a group practice" may be paid a share of overall profits of the group or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals. (42 USC 1395nn(h)(4)(B(i))

3. Definition of a group addresses overhead and expenses

   a. Each physician who is a member of the group provides substantially the full range of services which the physician routinely provides, including medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment and personnel

   b. in which the overhead expenses of and income from the practice are distributed in accordance with methods previously determined.

4. Special rules in the statute for profits and productivity bonuses

   a. A physician in a group practice may be paid a share of overall profits of a group
b. Or a productivity bonus based on services personally performed or incident to such personally performed services

c. So long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician

B. If the group does no Medicare (e.g., pediatric practice with no Medicare) or no DHS (e.g., no imaging or lab in the practice), then none of these rules matter

III. Permitted Approaches Under Stark

A. Stark on Overhead Expenses: 66 Federal Register 905-907 (Jan 4, 2001)

1. No real position about cost allocation as long as the determination is made prospectively

2. Can use cost centers by location, by specialty or by any other reasonable measure that does not directly reward volume or value

B. Productivity is the fruits of a physician's own labors: -- he does it himself with his own hands; 3 safe harbors are offered

1. Bonus based on physician's total patient encounters or RVUs

2. Bonus based on non DHS revenues

3. Revenues derived from DHS are less than 5% of the group’s total revenues AND allocated portion is less than 5% of physician's total compensation from the group

4. It can be calculated before or after expenses are deducted

5. Cost center and location based

C. Some myths about productivity

1. You cannot pay independent contractors a percentage of what they generate (66 Fed Reg 908, Jan 4, 2001) -- you can

2. You have to have a base salary and cannot pay purely on productivity -- not so
3. You have to treat all revenues -- DHS, non-Medicare, etc -- the same way -- Stark only pertains to Medicare and a 'referral' is only for DHS by its own definition

4. You can't include DHS -- you can include anything the physician literally does himself.

D. Incident to revenues: 42 CFR §§ 410.10(b), 414.34(b) and 410.26

1. Services of non-physicians must be rendered under the direct supervision of the physician – on premises and in the office suite

2. Need not be employees or leased employees – problem of whether PAs must be

3. There must be a physician professional service to which ancillary services are incident
   a. supervision itself is not a physician service
   b. cannot enter into a relationship with a physician merely to "bill through"

4. Conundrum of diagnostic service benefit and “incident to now diagnostic services can never be “incident to” and a physician can be billed incident to another physician, according to informal guidance from CMS; but no regulation says that.

5. Services must be of a kind commonly furnished in a physician's office or clinic -- no use of PAs or NPs in hospital care for billable services “incident to”; do not confuse with Transmittal 1776 below, which appears to be the same

6. Services must be commonly rendered without charge or included in the physician's bill.

7. If 4 categories of advance practice personnel (physician assistants, nurse midwives, nurse practitioners and clinical nurse specialists) perform, can bill applicable E & M code; otherwise only 99211 – but in no event can ancillary personnel provide counseling or coordination of care billing without physician involvement. (CPM 100-04 Chptr. 12 §30.6)

E. Transmittal 1776: Shared Visits. Now it’s in the Medicare Claims Processing Manual under Shared Visits: (CPM 100-04 Chptr. 12 §30.6.1)

1. Physician and NPP in the same group, working together in hospital
NPP can see patient first, physician can follow and perform any part of an E/M visit in an encounter with the patient face to face and total service may be billed at 100% under physician’s number

3. Cannot share a consult

4. But this is not incident to.

5. It is “personally performed” for Stark purposes

F. PAs, NPs, CNSs (all collectively are NPPs (Non-Physician Practitioners)), at 85% of Physician Fee Schedule

1. May order physical therapy, occupational therapy, and speech pathology services when state law authorizes them to do so;

2. They may certify and recertify plans of treatment, order diagnostic tests and perform diagnostic tests.

3. These individuals are authorized to bill for services which would be covered if provided by a physician or incident to a physician’s services and which they are authorized to perform under state law.

4. In SNF: Physician must do initial assessment – NPs may substitute thereafter.

5. Must comply with state law: Medicare does not trump state license laws

6. They may perform diagnostic tests, but may not supervise them;

7. Services “incident to” NPP will be covered if they would be “incident to” a physician.

8. May bill time based codes for counseling and coordination of care.

9. Care plan oversight provided by non-physician practitioners is payable but they may not certify a patient as needing home health: 42 CFR § 414.39(c)

a. May be billed if the physician who signs the plan of care provides regular ongoing care under the same plan of care as the NPP billing for care plan oversight and they are part of the same group or have a collaborative agreement or if the NPP is a physician assistant, the physician signing the plan of care is also the
physician who provides general supervision of PA services for the practice.

b. Payment may be made when the NPP has seen and examined the patient not functioning as a consultant and integrates his/her care with that of the physician.

G. Some myths about incident to: Read page 66 Fed Reg 909 (Jan 4, 2001) preface to the regulations, which has been repeated multiple times since. (72 Fed Reg 51023 (Sept 5, 2007)

1. Can't allocate DHS which is incident to directly to the ordering physician. YES YOU CAN! (e.g., chemotherapy, PT rendered incident to, etc)

2. You can't give the treating physician credit for non-incident to E and M services rendered by NPPs, billed on their own numbers. Yes you can. Stark has nothing to say about that. It's not DHS.

3. You can give physicians credit for the PC of a diagnostic study they order if it meets IOAS. No you can't. The PC is not IOAS. It is a referral to another physician and does not meet the standard for productivity because it is not personally performed by the ordering physician.

H. Profit Sharing: the fruits of others' labors

1. A share of 'overall profits': a share of the entire profits from DHS

   a. Of the entire group; or

   b. Any group of at least five physicians

2. Three safe harbors

   a. Per capita equal division of the profits

   b. A distribution of DHS revenues based on the distribution of the group practice's revenues attributable to the services that are not DHS

   c. Any distribution of DHS if the group practice DHS revenues and no physician's allocated portion of those revenues is more than 5% of the physician's or the group's total compensation

3. Other methods are fine: examples are offered

   a. Per ownership interest
b. Seniority

c. Adequately documented

d. Supporting information to be made available to the Secretary upon request

4. All diagnostic testing profits on the TC DHS have to be allocated in profit sharing formula; PC personally performed can be allocated to the guy who did it.

5. Creative approaches based on "any group of 5"

a. Not all physicians participate in all pods (imaging vs. infusion vs. PT)

b. Not all productivity bonuses have to be distributed as productivity and some can go in profits, e.g., the windfalls to the interventionists, helping the PCPs

c. Historically high, middle and low utilizers in separate pods

d. Using historical data, previous two year average to determine allocation

i. Physician gets compensated in accordance with formula regardless of volume of current referrals

ii. If physician is sick for three weeks he gets what the formula gives him

e. Mix and match pods among specialties if necessary

f. Quality metrics -- patient satisfaction, compliance with guidelines – are fine

g. Value metrics -- length of stay, lower resource use -- is not a problem in a group practice where it would be when compensated by a hospital

IV. What Motivates Changed Incentives

A. Physician Value-Based Purchasing Modifier

1. Starts with quality
2. Coordinated with hospital VBpurchasing

3. Includes efficiency after 2015

B. Commercial Pay for Performance

C. Physician Quality Reporting System --
   1. Today it is merely reporting
   2. Tomorrow it likely will feed the physician VBP program

D. Bundled Payments - CMMI Demonstration; pilot project

E. Episode Rates and the Episode Grouper

F. Medicare Shared Savings Programs (ACOs)
   1. Broad waiver under Stark for participating entities
   2. Even pre-participation compensation among participants is exempt
   3. This will be important to hospitals who today can't pay physicians for 'incident to' or profit sharing like groups unless they are in a separate entity

G. Transparency everywhere

H. Benefit design

V. State of The Art

"The best physician compensation model is the one you will use next."

----Physician manager of a large medical group

A. 2007: I did a survey and got 13 answers

http://www.gosfield.com/PDF/Published.Chapter1.pdf

http://www.gosfield.com/PDF/Gosfield_May_2008_GPJ%5B1%5D.pdf

1. Lessons learned
a. Unroll gradually and measure quality before attaching financial impact

b. 5-10% at risk to get anyone's attention

c. Transparency of results helps

d. Quality improved but not because of the payment; because of overall strategy

2. Three historically different groups

a. Doing it less than two years

b. Having done it between 2 and six years

c. Doing it more than 7 years

B. Most even high performing organizations like Henry Ford, Intermountain Health, Lahey Clinic, Ochsner still pay predominately on productivity


C. AMGA Survey -- May 2011


1. 26 groups responded positively -- 35 answers in total

a. 7 groups said they paid on productivity; their data wasn't counted

b. 2 IPAs answered -- not what I was interested in

c. Michigan, Massachusetts, new York, Florida, Iowa, Montana, Tennessee, Wisconsin, Ohio, District of Columbia, Maryland, Pennsylvania, Oregon, Minnesota, Washington, California

d. Self-selected because they are members of AMGA
e. Most are integrated systems but two pediatric groups and some stand alone physician groups

2. Everett Clinic which in 2007 had been paying on quality for more than ten years last year did a complete about face and now pays only on productivity
   a. Change of leadership
   b. Sense of complacency

3. Groups doing it less than two years
   a. Most began with primary only
   b. 3%-7.5% base salary at risk
   c. Some say it is a bonus, some a withhold
   d. Some pay a stipend for participating in quality projects
   e. Several mentioned counting attendance at meetings to build culture and all reported that it worked to get people dealing with each other
   f. Results reported -- all reported positive impact; one year with no financial impact, two years of payment with 7.5% at risk, medication reconciliation rate improved from 26%-71%
   g. Few report measuring and compensating on value except for hospitalists where they measure LOS, readmission rates and utilization of order sets with 10% at risk for those guys
   h. One group doing it only two years wants to put 25% at risk next year!
   i. All want to use in negotiations but none yet has
   j. All cited transparency of results within the group as important
   k. Sentara Medical Group in Virginia, Mayo-Owatonna in MN, Sutter Gould Medical Foundation in CA, Olmstead Medical Center in MN, Henry Ford Medical Group, Wenatchee Valley Medical Group in WA, Bozeman Deaconess Medical Group in MT
2. Mid-range Adopters -- Between 3 and 6 years
   a. Longer time, more at risk
      i. Low end 1-2% at risk, another 3%, and one 5-10%
      ii. Higher end have 4-7% at risk or use a stipend ($10,000) with half on quality and the remainder on meeting attendance, citizenship standards and OSHA compliance
   b. More specialty specific criteria mentioned here --
      i. asthma action plans and spirometry in pediatrics
      ii. Improving colonoscopy rates in patients over 50
   c. One group introduced a clinic-wide customer service metric
   d. Participation in meetings, timely closing of visit encounters in the EMR
   e. Few have changed the amount at risk over time
   f. Two reward value with incentives of 2-4%, hospitalists cited gain
   g. All report some positive impact
   h. One cited ease of implementation of EMR as a result of bonuses linked to using them
   i. Advocate Medical Group in IL, Mount Kisco Medical Group in NY, Summit Medical Group in TN, the Iowa Clinic, Pediatric Associates in FL, Children's Primary Care Medical Group in CA, PeaceHealth Medical Group in WA

3. Pioneers -- more than 10 years
   a. 12 groups -- one paying this way for 16 years
   b. Most have contracts that pay for quality unlike the others above
   c. 3%-15% at risk
d. HealthPartners in MN rewards participation in improvement activities as well as outcomes

e. Healthcare Partners Medical Group in CA only does it with primaries and tracks directly to HEDIS data

f. Billings Clinic was a mid ranger in 2007 and now has spread the program to 12 specialties which set their own measures; 3% for some and stipends for others

g. Some like Geisinger share data on group-wide measures but not individual measures which are part of each physician's compensation package

h. All keep an eye on outside metrics but their own cultures are more important

i. In addition to those above, MedStar Physician Partners in DC, IHA in MI, PriMed Physicians in OH, Sutter Medical Group in CA, First Health Physician Group in NC, Thedacare in WI

4. Lessons for Others

a. Start small

b. Choose credible well regarded evidence-based measures

c. Make sure physicians understand the measures and documentation of them before money attaches

d. Periodic feedback during the year is helpful

e. Don't measure too much. No more than 8-10 measures

D. Fairview Clinic in MN has implemented 50% of compensation at risk for quality designed by the physicians to get off the hamster wheel

E. What do hospitals aligning with physicians report?


1. 76%: Medicare and Medicaid influence their compensation models
2. 59%: health reform is a primary driver
3. Three quarters pay salary plus incentive or productivity
4. 14% pay straight salary
5. 50% say they are using patient satisfaction scores
6. 52% report *physicians have little or no influence on payment models*