I. Introduction.

II. Industry Conditions Leading to Surge in Physician Employment.

A. Key reasons for physicians to consider employment by a hospital or health system affiliate:
   1. Incomes flat or decreasing.
   2. Hard to recruit younger docs to join practices.
   3. Challenges, distractions, and costs of practice management.
   4. Continual downward pressure on reimbursement for services.
   5. Pursuit of opportunities for ancillary revenue may cause duplication of services in community.
   6. Legal/regulatory compliance increasingly difficult and costly.
   7. Need access to capital resources for electronic health records systems and other infrastructure.
   8. Market pressure to join a hospital system: everyone else is doing it.

B. Key reasons for hospitals/systems to pursue employment of physicians:
   1. Challenges with effective and efficient utilization of hospital resources.
   2. Incentives and objectives of independent physicians are not necessarily aligned with those of hospital/system.
   3. Hard to recruit and retain physicians to maintain private practices in community.
   4. Managed care contracting increasingly difficult with dominant payors.
5. Competition from other systems for patients, providers and opportunities.
6. More attractive to potential suitors.
7. Pressure to increase market share by acquiring practices and employing physicians.

C. Motivation for both physicians and hospitals – future impact of healthcare reform:
1. Changing reimbursement requires greater coordination of care (e.g., ACOs, bundled payments, pay-for-performance, readmission penalties, management of chronic conditions, medical homes, etc.) -- effectively forcing hospital-physician alignment and integration, in one way or another.
2. EMR implementation, enhanced (or made possible?) by hospital-physician integration.
3. The devil you don’t know.
4. Align before competitors do or be the last one standing alone.
5. Market repositioning for ACOs, clinical integration and population health.

D. The win-win scenario offered by employment:
1. Offers income stabilization for physicians at fair market levels.
2. Promotes effective/efficient utilization of hospital resources.
3. Permits coordination of patient to avoid duplication of resources, reduce overall costs, enhance patient well-being, etc.
4. Aligns economic and strategic objectives of hospital/system and physicians.
5. Facilitates physician recruitment and retention.
7. Positions hospital/system and physicians to better respond to outside competition.
8. Equips hospital/system and physicians for “future state” of industry.

III. Compensation Objectives and Concerns for Both Parties.

A. Physician perspective on compensation:
1. Objective of income stability and predictability.
2. Assurance of compensation at FMV, reasonable levels.
3. Seek equity and fairness relative to peers (level playing field).
4. Protection from risks of:
   a. Deeper discounts associated with payor concentration and contracting leverage.
   b. Adverse changes in payor mix.
   c. Care for indigent, uninsured, underinsured.
   d. Inefficiencies in billing/collection.
   e. Effects of hospital/health system strategic or operational decisions (e.g., recruitment, ancillaries).
   f. Traps posed by applicable laws and regulations.

B. Hospital/system perspective on physician compensation:
   1. Concern with potential financial drain and unsustainable losses in physician practice.
   2. Must ensure ease of administration, and availability of resources.
   3. Promote continued work effort by physicians (effectiveness of incentives), as well as efficiencies and appropriate use of resources.
   4. Must be aligned with changing reimbursement models (commercial and governmental).
   5. Ensure compliance with law.

C. Particular challenges to be addressed:
   1. Guarantees during transition or start-up periods.
   2. Loss of ancillary income or income from advanced practice clinicians.
   3. Changes in organization’s compensation model over time.
   4. Implications of new recruits or laterals who may be added to physician’s current practice site or other community locations.
   5. Physician’s potential reassignment to alternative practice site.
6. Compensating hospital-based physicians (e.g., hospitalists or intensivists).

7. “Reduced producers” (i.e., physicians with personal circumstances that cause their production to consistently fall below full-time levels).

8. Handling of administrative stipends, supervisory stipends, and revenues from outside activities.


A. Federal income tax laws.


   a. 2000 EO CPE Text, Physician Incentive Compensation.
   b. 2002 EO CPE Text, Introduction to IRC 4958
   c. 2003 EO CPE Text, Intermediate Sanctions (IRC 4958) Update
   e. 2004 EO CPE Text, Health Care Provider Reference Guide
   f. 2004 EO CPE Text, Section 4958 Research Shortcuts

2. The IRS view – general principles impacting compensation of employed physicians by § 501(c)(3) organizations:

   a. Each physician’s overall compensation must not exceed reasonable, fair market levels for services rendered.
   b. Should be a cap on total compensation, whether:
      (i) Hard cap, i.e., absolute limit -- difficult in practice.
      (ii) Soft cap, i.e., trigger for review process to ensure integrity of information, no decline in patient satisfaction, and appropriate clinical quality.
   c. Compensation arrangement, when considered along with other facets of clinic operations, should be distinguishable from private practice of medicine.
(i) Compensation arrangement cannot give physicians a quasi-equity interest (i.e., share in net income), nor effectively function as a split of the net revenues or net income from a particular hospital activity, program, department or function.

(ii) Criteria for payment of incentive, or variable, compensation should be tied to factors directly relevant to a physician’s performance.

(iii) Where net income is used as a criterion for compensation, should consider only the net income associated with a particular physician’s activities (including those under his or her direct supervision).

(iv) If using net income at all in determining compensation, better to consider it as merely a trigger or circuit-breaker for payment of a predetermined amount.

d. To ensure fulfillment of charitable purposes, employed physicians should be incentivized to provide care without regard to a patient’s payor source (or lack thereof).

(i) For this reason, IRS takes comfort in compensation tied to wRVUs, rather than dollars (e.g., charges or collections).

e. Compensation should be determined (or confirmed as FMV, if pursuant to formula) by an independent board or committee (no physicians, and without conflicts of interest), based on a review of independent market data.

(i) Process should incorporate criteria for achieving rebuttable presumption of reasonableness under IRC § 4958 in at least some situations (e.g., physician board members, physician executives, or other physicians constituting disqualified persons under § 4958).

f. All compensation decisions, arrangements and payments should be timely documented, including through board or committee minutes, written employment agreements, filing of appropriate Forms W-2, and thorough and accurate reporting on Form 990 as required.

g. If it violates the Anti-Kickback Statute or Stark Law, it violates tax law too.
B. Federal Fraud and Abuse Laws - The Stark Law and Anti-Kickback Statute.

1. Background reading: The Stark Law, 42 USC §1395nn, and regulations; 42 CFR §351 et seq; the Anti-Kickback Statute, 42 USC §1320a -7b(b), and Safe Harbor regulations, 42 CFR §1001.952.

2. The Stark Law view - general principles impacting compensation of employed physicians by hospitals or other entities to which they refer for Medicare/Medicaid services:
   a. Stark Law Employment Exception protects payment by an employer to a *bona fide* physician employee for providing services if:
      (i) Employment is for identifiable services;
      (ii) The remuneration is consistent with fair market value of the services and not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the physician;
      (iii) The employment arrangement is commercially reasonable even if no referrals were made to the employer; and
      (iv) Productivity bonuses are permitted based on services *personally performed* by the referring physician.

3. The Anti-Kickback Law view - general principles impacting compensation of physicians who may refer to the employer for any federal health care program services:
   a. Anti-Kickback Statute Employment Safe Harbor protects payment by an employer to a W-2 employee for services payable by Medicare, Medicaid or other federal healthcare programs.
      (i) Offers very broad protection for compensation paid to employees.
      (ii) No fair market value or commercial reasonableness requirement.

4. Generally, because the Stark Law is a strict liability law, and an exception must be met, a physician's compensation must be consistent with fair market value, and the arrangement must be commercially reasonable, even if the physician makes no referrals to the employer.

5. "Taking into account" referrals, such as anticipated or actual future referrals for hospital services, is not permissible when setting
compensation; compensation can only be based on the value of the physicians' services.

6. “Commercial reasonableness” means would a prudent employer enter into the employment arrangement on the same terms even if it received no referrals; legitimate business and strategic reasons can support commercial reasonableness apart from referrals (e.g., adding or expanding a specialty or program, expanding service area, bringing unique skills).

7. The Stark Law requires employers to use a reasonable method to determine the fair market value of compensation; regulators have approved using industry physician compensation surveys as a prudent practice (e.g., MGMA, AMGA, Sullivan Cotter).

8. The Stark law definition of fair market value means the value in arms'-length transactions, consistent with the general market value. General market value means the price an asset would bring a result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party.

9. The Stark Law and Anti-Kickback Statute do not expressly require hard caps, i.e., absolute limit, or soft caps, i.e., trigger for review process to ensure integrity of information, no decline in patient satisfaction or clinical quality (for example, billing and coding audits to review appropriate physician service coding, medical necessity review, proper crediting of wRVU productivity, etc.); however, caps can protect against outlier compensation arrangements that may raise compliance red flags and increase audit risk; using soft caps is an appropriate compliance measure and can ensure that compensation remains consistent with fair market value and is commercially reasonable.

10. The Stark Law permits an employer to require an employed physician to refer patients for services to a specified provider, such as the employer’s facilities and providers, if certain conditions are met. 42 CFR § 411.354(d)(4) (requires fair market value, written agreement, meets Stark exception, and not against patient preference, patient best medical interests or insurance plan requirements).

11. Recent government enforcement efforts have focused on physician compensation, and in particular, whether physician compensation arrangements are fair market value and commercially reasonable, as required by the Stark Law.

   a. See, e.g., Tuomey Healthcare System ordered September 30, 2013 to pay $39.3 million in Stark penalties and $276.8 million in False Claims Act fines (reduced on October 3, 2013 to $237 million) for violating Stark Law physician compensation requirements.
V. Application of Laws to Various Compensation Arrangements.

A. *Scenario A* -- Compensation is provided to a newly-employed primary care physician at a guaranteed, fixed annual rate throughout the term of his employment agreement.

1. Physician is new to the community, but the community is experiencing a demonstrated shortage of primary care providers.
2. Contract is for a term of 5 years.
3. Based on market analysis, the dollar amount is approximately the 80th percentile of the market.
4. Physician has no potential for incentive compensation based on production, quality or patient satisfaction.
5. Employment agreement expressly states requirement that Physician keep all referrals “within the System” (*i.e.*, to System hospitals, facilities or other employed providers).
6. The System’s finance department has prepared a pro forma showing that they’ll lose approximately $200,000 per year on Physician’s practice, but they’ll probably more than make it up in anticipated revenue from ancillary and hospital services.
7. Based on Physician’s last-minute hesitation in signing his employment agreement, System offers him a sign-on bonus of $50,000. The bonus is structured as a loan, with $10,000 to be forgiven at the end of each year during the 5-year term of employment.
8. After six months of employment, Physician finds that his work requires only about 38 hours per week. He’s a little bored and could use some more cash to repay those medical school loans. Physician decides to take on medical direction responsibilities at 3 local nursing homes, each of which will pay him an additional $30,000 per year.

B. *Scenario B* -- Compensation is provided to an employed orthopedic surgeon based on productivity, measured by net collections from services personally performed by Physician.

1. No cap on total compensation. Compensation for the prior year approached two times the ninetieth percentile of market data, and it is projected that he’ll exceed that amount in the coming year.
2. No periodic review or vetting mid-year by any board or committee. They’ve been told that the numbers “are what they are.”
3. Physician is a prolific referrer to the System’s flagship hospital, accounting for almost 15% of total hospital revenues.

4. Physician’s new compensation arrangement was implemented shortly after Physician cut off discussions with a local independent orthopedic group about the possible establishment of an ambulatory surgery center that would have been located less than 5 miles away from the hospital.

5. Per the compensation arrangement, “services personally performed” are deemed to include those of mid-level providers at the same office location.

6. Physician has been subject to multiple peer review procedures in the last few years based on quality concerns and adverse outcomes.

7. However, “his patients love him.” Patient satisfaction scores are off the charts.

C. Scenario C – Compensation is provided to an employed OB/GYN based on guaranteed salary, plus call pay and incentive compensation.

1. Guaranteed salary is set to approximate 25th percentile of market data.

2. Physician is also paid a fixed fee for each weeknight and weekend call shift.

3. Incentive compensation is calculated as a fixed fee for each maternity patient delivery at one of the System’s hospitals, including for deliveries made by Physician and those by any residents while the Physician is on call.

4. Physician also receives a “cut” for any deliveries made by the hospital’s other employed OB/GYNs with respect to Physician’s own patients during shifts where Physician is not on call.

5. Physician recently became the new wife of the System’s CEO (she got to know him well over the years, having delivered each of the four children he had with his first wife).

D. Scenario D – Compensation is paid to an employed gastroenterologist based on a fixed salary, which is established at the start of each calendar year by applying a market-based conversion factor to the total wRVUs produced by Physician during the prior calendar year.

1. One month into the new calendar year, Physician tells his office staff that he shouldn’t be scheduled for more than a total of 30 hours per week, including office visits and procedures, and lets it slip that he’s thinking about retiring at the end of the calendar year.
2. Physician is currently the elected chief of the hospital’s medical staff and, by virtue of that role, serves as an *ex officio* non-voting member of the hospital board.

3. Physician instructs his office manager to be sure to bill any office-based labs or imaging under his provider number so he’ll get wRVU credit.

4. That same office manager has been thinking about quitting, since she has been passed over for promotion on three separate occasions. In each case, the position was given to a much younger candidate with several years’ less experience, so the office manager believes the decision was based on her being too old.

E. *Scenario E* – Compensation for a group of 4 employed primary care physicians is determined based on the overall performance of their clinic location.

1. A physician compensation pool is established based on the Clinic’s net income for the year, calculated as total revenues minus total expenses (other than physician compensation).

2. Each physician receives an equal, pro rata share of the pool (1/4), provided that the physician was employed on a full-time basis throughout the year.

3. There are 6 mid-level providers at the Clinic, all of whom have their own patient panels.

4. The Clinic has robust on-site lab and basic imaging.

5. System administrative leaders inform the physicians that, within the next 12 months, they intend to recruit 2 new physicians out of residency to join them at the Clinic. One of the new physicians will spend only 1/2 of her time at the Clinic for the foreseeable future, since she has taken on a substantial research project at a nearby university. Based on these changes, the compensation plan will be adjusted to split the pool on a (1 / 5.5) basis.

F. *Scenario F* – Compensation plan for hospital’s employed hospitalists provides for a guaranteed base salary.

1. Given the extreme difficulty of recruiting hospitalists to the geographic area, hospital offers a guaranteed salary at approximately the 90th percentile of market.

2. The hospitalists are not entitled to production-based incentive, but are paid a kicker of $50 for each inpatient under their care during a shift.

3. The hospitalists also may receive up to an additional 15% of base salary for achievement of established quality and patient satisfaction metrics.
across the hospitalist program each calendar year. The hospital tells the hospitalists that they, as a group, can decide what those metrics will be for each year; they’ll need to let hospital administration know by April 1st or so.

4. The hospitalists are scheduled on a weekly basis, with one week on, the next week off. Given the demand for hospitalists in the region, several hospitalists decide to work extra shifts for nearby hospitals during their “off” weeks.

VI. Administration of Physician Compensation.

A. Establish written physician compensation plan or policy; may be accompanied by separate physician compensation philosophy statement.

1. Designate board, committee or officer with board delegated responsibility for administration of plan and authority to establish physician compensation accordingly.

   a. Ensure that decision-making group is free of conflicts of interest, within the meaning of IRC Section 4958.

2. Identify which compensation matters will need to be brought to decision-making group, versus handled administratively.

3. Define which compensation matters will require analysis and support from a qualified compensation advisor.

4. Establish standards for documentation of all compensation arrangements.

5. Follow rebuttable presumption criteria for applicable situations (e.g., involving physicians who are disqualified persons).

B. Establish discipline and consistency in administration of plans and policies.

C. Anticipate and review proposed reporting of physician compensation in regulatory filings (e.g., Forms 990).

D. Important to get physician buy-in:

   1. Involve physicians in design or periodic review of current compensation plan or formula.

   2. Avoid appearance of data manipulation or hiding the ball.

      a. Example: Give physicians an opportunity for direct dialogue with independent compensation consultant.

   3. Avoid “sweet deals” or one-off arrangements with particular physicians.
4. Educate physicians on regulatory constraints requiring fair market value, commercial reasonableness and other compliance requirements.

VII. Implications of Healthcare Reform and Industry Changes on Physician Compensation.

A. ACOs, population health and payment reform continue to change the behavior employers of physicians may want to incentivize.

B. Individual productivity models will increasingly be coupled with other components of compensation to incentivize physicians to change health care delivery and to achieve enterprise goals, such as increasing components of “at risk” compensation for achieving quality metrics, practicing evidence-based medicine, using electronic health records, and other organizational goals.

C. Evolving payment and care delivery models continue to develop rapidly, while legal requirements and enforcement approaches lag behind.

D. The “old laws” still apply, and have not be amended or clearly interpreted to apply to the new models, except for certain regulatory waivers from the Federal Trade Commission, the IRS and the Centers for Medicare and Medicaid and the Office of Inspector General with respect to ACOs participating in the Medicare Shared Savings Program, (“MSSP”) and other similar Medicare pilot programs.

E. Many health care providers are taking steps to form ACOs or ACO-like organizations to begin to embark on population health and clinical integration, yet regulatory guidance is lacking, creating uncertainty and risk for organizations not in the MSSP.