# Structuring Physician Employment Agreements

*Key Legal Considerations*

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Recent presentations specific to quality, cost savings, compliance and general physician strategies and compensation trends include:

- *Innovation Through Alignment: Strategies and Emerging Models for Successful AMC Physician Partnerships:* AHLA AMC Conference (March 14-15, 2016) Washington, DC.
- *Exploring Gainsharing and ACO Compensation Trends:* AMGA Annual Meeting (March 10, 2016) Orlando, FL.
- *Maintaining Compliance While Compensating Physicians for Quality and Cost Savings;* HFMA, National Payment Innovation Summit (February 12, 2016) Memphis, TN.
- *Strategies for Developing Compliant Physician Compensation Plans;* AMGA Compensation Conference (November 12, 2015) New York, NY.
- *Fundamentals of Healthcare Valuation for Health Lawyers and Compliance Officers;* AHLA Fraud and Compliance Institute (September 28, 2015) Baltimore, MD.
- *Implementing Value-Based Physician Compensation Models: Tackling the Regulatory Complexities;* Clear Law Institute (July 29, 2015).
- *The $10,000 Question: Tackling the Complexities of Value-Based Physician Compensation;* AHLA Annual Meeting (June 29, 2015) Washington, D.C.

# Webinar Agenda

I. Introductory Concepts
II. Overview of the Regulatory Standards
III. Drafting Employment Agreements
IV. Drafting Compensation Plans
V. Employment by a Stark Group Practice
IV. Auditing Compliance and Mitigating Risk
VI. Question and Answer

# Part I: Introductory Concepts

# Introductory Concepts

- The Enforcement Climate
  - More employment of physicians and physician groups
  - Rigid and technical (e.g., Stark Law) regulatory framework and group practice requirements
  - Aggressive government enforcement
  - **Disproportionate Penalties = Enterprise Risk**
- Considerations for Managing Risk
  - Employment arrangements with referring physicians must be defensible under the applicable health care regulations
  - Must focus on demonstrating technical compliance and the **Three (3) Tenets of Defensibility:**

    ***Fair market value ("FMV"), commercial reasonableness ("CR") and not taking into account ("TIA") referrals***
  - Documentation and governance processes (e.g., business planning, valuation, etc.) for employed physicians should support defensibility

# Stark Law = 3 Tenets of Defensibility

- **The Toumey Case**
  - FMV
  - CR
  - TIA

a. entered into compensation arrangements with physicians in violation of the Stark Statute, specifically by paying the physicians (who referred designated health services) under contracts that exceeded fair market value, were not commercially reasonable and which took into account the volume or value of the referrals or other business generated between the physician and Tuomey;

- **The Halifax Case**
  - FMV
  - CR
  - TIA

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# Focus on Business Planning

67. On April 28, 2008, for example, the Finance Committee of the Board met to approve the purchase of EMA and employment of Drs. Bradley, Corse, and Gaskin. Sharon Bell and Hart Williford, a former Chief Operating Officer and Senior Vice President of the Parent Company, prepared a PowerPoint Presentation to the Finance Committee in support of the addition of EMA (the "April 28 PowerPoint"), which was attached to the minutes of the meeting.

a. On a slide titled "Background Information," the April 28 PowerPoint notes that Drs. Bradley, Corse, and Gaskin are the "three busiest members of the Candler Medical Group" and EMA is a "high-volume practice with large numbers of hospital admission and referrals to specialists."

b. The next slide, also titled "Background Information," stated that "estimated gross revenues (including downstream revenues from referrals) to St J/C" are for

   2006: "$57 million + $3.4 million radiology"

   2007: "$63 million + $3.7 million radiology"

c. The slide indicated that the information was "reported by physician," and that these figures "account[] for almost 6% of St J/C total volume."

# Focus on Defensible Valuation

In his Report, Mr. Day notes that the Board of BRMC wanted a covenant not to compete associated with the sublease in order to protect "three revenue streams": CT and MRI revenues, inpatient net revenues, and outpatient net revenues (not including CT and MRI revenues). (Day Report, at 14.) In his appraisal of the covenant not to compete, Mr. Day created a table to show the expected revenues BRMC would receive with the non-competition agreement in place, and compared those revenues to how much BRMC would pay under the non-compete agreement. (Id. at 17.) Mr. Day explained that his table is "based on the assumption that the Physicians would likely refer this business to the Hospital in the absence of a financial interest in their own facilities or services, although they are not required to do so by virtue of any of the covenants contained in the Agreements or otherwise." (Id.)

Therefore, the Report itself indicates that the analysis of whether the non-competition agreement represents a fair market value is based, in part, on anticipated referrals from the doctors. BRMC affirmed that the Report evaluated expected revenues based on the assumption that Defendants would likely refer the business to BRMC. (Leonhardt Dep. at 56.)

# Focus on Group Practice Requirements

103. The DPG physicians' compensation also violated DHS compensation rules for "group practices" since the compensation was based on the physicians' DHS referrals and did not meet the conditions of the "Special rules [for p]rofits and productivity bonuses" for "group practices" under the Stark Law and regulations. *See* 42 U.S.C. § 1395nn(h)(4)(B)(i); 42 C.F.R. § 411.352(i).

b. **Defendants Did Not Take Adequate Steps "to Ensure Compliance" with the Stark Law and Anti-Kickback Statute**

104. Defendants deliberately ignored or recklessly disregarded basic requirements for Stark Law and Anti-Kickback Statute compliance, despite being aware of, and certifying that they would comply with, these laws and regulations.

105. Defendants did not train their employees or executives on Stark Law or Anti-Kickback Statute compliance so that they could evaluate and monitor such compliance at IMC-DMC or IMC-Northside.

# Focus on Penalties and Enterprise Risk

**Department of Justice**

Office of Public Affairs

FOR IMMEDIATE RELEASE — Monday, September 21, 2015

## Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations

Adventist Health System has agreed to pay the United States $115 million to settle allegations that it violated the False Claims Act by maintaining improper compensation arrangements with referring physicians and by miscoding claims, the Justice Department announced today. Adventist is a non-profit healthcare organization that operates hospitals and other health care facilities in 10 states.

# 2014 Cases and Settlements

- **Enforcement Actions:**
  - New York Heart Center $1.33 million
  - Infirmary Health System $24.5 million
  - All Children's Health System $7 million
  - Halifax Hospital $85 million
  - King's Daughters Medical Center $40.9 million

- **Recurring Issues:**
  - Executive, physician and compliance department whistleblowers
  - Allegations based on the Key Tenets of Defensibility: Fair Market Value, Commercial Reasonableness and not TIA DHS Referrals
  - Testing of Internal Group Practice Requirements
  - Application of Stark to Medicaid
  - DHS Pooling Issues

# 2015 Cases and Settlements

- **Enforcement Actions:**

| | |
|---|---|
| Memorial Health | $9.8 million |
| Tuomey Healthcare System | $72.4 million |
| Adventist Health System | $115 million |
| North Broward Hospital District | $69.5 million |
| Columbus Regional Health | $35 million |
| Dr. Andrew Pippas | $425 thousand |
| Westchester Medical Center | $18.8 million |
| Citizens Medical Center | $21.8 million |

- **Recurring Issues:**
  - Executive, physician and compliance department whistleblowers
  - Allegations based on the Key Tenets of Defensibility: Fair Market Value, Commercial Reasonableness and not TIA DHS Referrals
  - Systematic Practice Losses and DHS “Referral Tracking” Processes
  - Allegations involving up-coding, billing issues and overlapping duties
  - Enforcement against physicians

# Part II: Overview of the Regulatory Standards

# Regulatory Standards

- **False Claims Act (1863)**
- **Anti-Kickback Statute (1972)**
- **Federal Stark Law (1989)**
- **Other Relevant Laws**
  - Tax-Exemption Laws
    - Private Benefit and Private Inurement
    - Intermediate Sanctions
  - Civil Monetary Penalties Law
  - State Equivalents

# The Anti-Kickback Statute and Safe Harbors Relevant to Employed Physicians

# The Anti-Kickback Statute

- **Criminal Statute:**
  - Prohibits paying remuneration to induce items or services payable under federal health care programs
  - Intent is required (case law allows for inference of intent)
  - Broad and subjective statute
- **Safe Harbors:**
  - Protection requires strict compliance with all conditions of the applicable safe harbors
  - Safe harbor compliance is voluntary
  - Failure to comply with a safe harbor does not mean an arrangement is illegal
  - Arrangements that do not fit in a safe harbor must be evaluated on a case-by-case basis

# The Anti-Kickback Safe Harbors

- Investment Interests (large entity, small entity, underserved area)
- Space Rental
- Equipment Rental
- Personal Services and Management Contracts
- Sale of Practice
- Practitioner Recruitment
- Waiver of Coinsurance/ Deductibles
- Price Reductions for Health Plans/Managed Care Organizations
- Referral Services
- Warranties
- Discounts
- **Employees**
- Group Purchasing Organizations
- Ambulatory Surgical Centers
- Group Practices
- Obstetrical Malpractice and Insurance Subsidies
- Referral Agreements for Specialty Services
- Ambulance Replenishing
- Health Centers
- Electronic Prescribing/Health Records

# The Employment Safe Harbor 1001.952(i)

**§ 1001.952 Exceptions. The following payment practices shall not be treated as a criminal offense under section 1128B of the Act and shall not serve as the basis for an exclusion:**

(i)Employees. As used in section 1128B of the Act, "remuneration" does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs. For purposes of paragraph (i) of this section, the term employee has the same meaning as it does for purposes of 26 U.S.C. 3121(d)(2).

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## In Application

**•"Employee" has the same meaning for purposes of satisfying the safe harbor as it has for federal employment tax purposes under the Tax Code.**

**•Several courts, as well as the Office of the Inspector General, have indicated that paying greater than fair market value for items or services, can support an inference that improper remuneration was paid to induce referrals.**

**•Thus, any compensation paid in excess of fair market value, according to the OIG, would arguably not be protected by the employment safe harbor and, therefore, could be prohibited remuneration under the Anti-Kickback Statute and potentially subject to sanctions.**

# The Stark Law and Exceptions Relevant to Employed Physicians

# Stark Law Framework

- **If <u>Physician</u> + <u>Financial Relationship</u> + <u>Entity</u>:**
  - Physician **<u>may not make a Referral</u>** to that Entity for the furnishing of Designated Health Services ("**DHS**") for which payment may be made under Medicare; and
  - The entity **<u>may not bill Medicare</u>**, an individual or another payor for the DHS performed pursuant to the prohibited Referral…

  ***... unless the arrangement fits squarely within a <u>Stark exception</u>***

- **Threshold Compliance Statute**
  - Strict liability – no intent required. Civil (non-criminal statute)
  - Triggered by "technical" violations, inadvertence and error
  - Your regulatory "Litmus Test"
  - 11 Categories of DHS (*e.g.*, clinical lab services, radiology and certain other imaging services, radiation therapy and supplies, outpatient prescription drugs, inpatient and outpatient hospital services, *etc.*)

# Designated Health Services ("**DHS**")

- Clinical laboratory services
- Physical therapy, occupational therapy, and speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- **Inpatient and outpatient hospital services**

# The Stark Exceptions

- **Commonly Used Stark Exceptions:**
  - **Bona Fide Employment Relationships**
  - **In Office Ancillary Services Exception**
  - Physician Recruitment
  - Assistance to Compensate a Non-Physician Practitioner
  - Retention Payments in Underserved Areas
  - Rental of Office Space
  - Rental of Equipment
  - Time Share Arrangements
  - Personal Service Arrangements
  - Isolated Transactions
  - Fair Market Value Compensation
  - Medical Staff Incidental Benefits
  - Non-Monetary Compensation

# Stark's Key Tenets of Defensibility: FMV, CR and not TIA Referrals

# FMV Defined

- **Stark Statute – FMV:**
  - The value in arm's length transactions, consistent with the general market value… (1877 (h)(3) of the Social Security Act)
- **Narrower regulatory definition of FMV:**
  - Bona fide bargaining between well-informed parties to the agreement
  - Who are not otherwise in a position to generate business for the other party
  - Compensation does not TIA the volume or value of anticipated or actual referrals
  - FMV as of the date the agreement is entered into
  - See 42 CFR § 411.351

***Note: Any internal or external FMV analysis should expressly reference the Stark Law regulatory definition.***

# FMV – CMS Commentary

- **Burden of establishing FMV rests with the parties**
- **Appropriate valuation methods:**
  - CMS will not provide "bright-line" standards
  - Based on facts and circumstances
  - Look to nature of the transaction, **location** and other factors
- **Limited guidance from CMS:**
  - External valuations may be relevant to intent but will not ensure FMV
  - Use of multiple, objective, independently published surveys is prudent
  - Documentation sufficient to support FMV will vary – no rule of thumb
  - FMV for administrative services may differ from FMV of clinical services
  - Definition is qualified in ways that do not necessarily comport with the usage in standard valuation techniques and methodologies

# CR – CMS Commentary

- **No statutory or regulatory definition**
- **Language in the Stark exceptions is illustrative:**
  - CR, even if no referrals were made between the parties
  - CR, taking into account the nature and scope of the transaction
  - Reasonable and necessary for the business purposes of the arrangement
- **CMS commentary on the CR standard:**
  - Subjective: Sensible, prudent business agreement from the perspective of the parties
  - Objective: Would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential for DHS referrals
- ***Would the parties do this deal if there were no referrals? Does the deal stand on its own?***

# Documenting FMV/CR Compliance

- **Role of the Client**
  - The burden of establishing FMV and CR ultimately rests with the client
  - The client develops and implements the internal governance and documentation processes
- **Role of the Valuator**
  - Recommend compensation parameters and provide expertise
  - Issue an objective third-party opinion on FMV and CR
- **Role of Legal Counsel**
  - Manage the valuation process consistent with the a/c privilege
  - Work with the client to develop compensation plans and governance processes that support the valuator's FMV/CR parameters
  - Careful examination of the valuation opinion to enhance defensibility
  - Not to opine on FMV and CR

# The Taken into Account ("TIA") Prohibition

- **Most Stark Law exceptions prohibit TIA of DHS referrals:**
  - *Villafane's* Objective Test: TIA language previously viewed as prohibiting a formula that directly considers anticipated DHS referrals
  - *Bradford's* Subjective Test: Recent case law seems to indicate that the decision of whether or not DHS referrals were TIA should be left up to a fact finder's discretion
- **Note: There is risk of the TIA prohibition being triggered by normal business behavior:**
  - Simply stating a desire (or hope) for future referrals
  - Projecting referrals for facility planning
  - Transaction planning that examines downstream revenues
- **2016 PFS Final Rule: CMS is evaluating a TIA definition.**

# Requirements of the Stark Employment Exception

# The Employment Exception 411.357(c)

**For purposes of § 411.353, the following compensation arrangements do not constitute a financial relationship:**

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**(c) Bona fide employment relationships.** Any amount paid by an **employer** to a **physician** (or immediate family member) who has a bona fide employment relationship with the employer for the provision of services if the following conditions are met:

(1) The employment is for identifiable services.

(2) The amount of the **remuneration under the employment** is—

(i) Consistent with the **fair market value** of the services; and

(ii) Except as provided in paragraph (c)(4) of this section, is not determined in a manner that **takes into account** (directly or indirectly) **the volume or value of any referrals** by the referring physician.

(3) The remuneration is provided under an arrangement that would be **commercially reasonable** even if no referrals were made to the employer.

(4) Paragraph (c)(2)(ii) of this section does not prohibit payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or immediate family member of the physician).

# Employment by a Stark Group Practice

# Stark “Group Practices”

- **The Stark rules allow alternative compensation structures for organizations that qualify as “Group Practices”**
  - Stark group practices can compensate physicians for services ‘‘incident to’’ their personally performed services
  - Indirect bonuses and profit shares may include DHS revenues, if the distribution methodology meets certain conditions
- **Group Practice status is required for certain exceptions:**
  - In-Office Ancillary Services Exception
  - Physician Services Exception
- **Must develop processes for evaluating and documenting compliance with Stark’s hyper-technical group practice requirements.**

# Group Practice Requirements*

- **Single Legal Entity Test.** Must be a "single legal entity" operated primarily for the purpose of being a group practice (e.g., a hospital cannot be a group practice, etc.)
- **Physicians.** Two (2) physicians must be owners or employees of the group practice (i.e., not independent contractors)
- **Unified Business Test.** A body representative of the group practice must maintain "effective control" over its assets and liabilities
- **Distributions of Income and Expenses.** Methods of distribution must be determined by the group practice prospectively before the receipt of payment for services
- **Range of Care.** Each physician must furnish substantially his or her full range of patient care services through the group practice
- **"Substantially All" Test.** At least 75% of the aggregate total patient care services of the group practice members must be furnished and billed through the group
- **Physician-Patient Encounters.** Members of the group (i.e., not independent contractors), in the aggregate, must personally conduct no less than 75% of the physician-patient encounters of the group practice
- **Volume/Value Compensation Test.** Shares of overall profits and productivity bonuses cannot be determined in a manner that directly relates to the volume or value of a physician's referrals of DHS

*Not all detailed requirements are listed.

# New Stark Rules

- **New Exceptions**
  - Assistance to Compensate an NPP – 411.357(x)
  - Time-Share Arrangements – 411.357(y)
- **Reducing Burdens on Health Care Organizations**
  - Writing requirement
  - Term Requirement
  - Holdover Requirement
- **Clarifications/Corrections**
  - Remuneration
  - Stand-in The Shoes
  - Temporary Noncompliance
  - Takes into Account

# Part III: Drafting Employment Agreements, Related Compensation Plans and Effective Onboarding

# Physician Employment Agreements

- **Common Provisions**
  - **Recitals – Supportive of appropriate intent and structure**
  - **Establishment of the Employer-Employee Relationship**
  - **Employment Term** (initial and extension process)
  - **Duties of the Physician:** Scope, hours, additional duties and responsibilities, billing and compliance, following of rules and regulations, professional standards, billing/collection, managed care contracts, etc.

# Physician Employment Agreements

- **<u>Common Provisions (Con't)</u>**
  - **Employer Obligations** (equipment, facilities and personnel).
  - **Physician Compensation**
  - **Expense Reimbursement , Employer-Paid Benefits and Time Off**
  - **Non-compete , Non-solicitation and Confidentiality Covenants**
  - **Termination and Special Remedies**
  - **Miscellaneous Provisions:** Notice, governing law, counterparts, signature..

# Physician Employment Agreements

- **Other Considerations**
  - **Professional Liability Insurance**
  - **Non-Disclosure/ Non-Competition**
  - **Billing and Collection**
  - **Termination** (breach, notice, immediate)
  - **Discipline** (M.D./D.O. Board Certification, etc.)
  - **FTE Status**
  - **Outside Services/ Moonlighting**

# Physician Employment Agreements

- **Example Template Contract Addendums**
  - Signing/ Incentive Loans
  - Signing/ Incentive Bonuses
  - Military Leave
  - Relocation Assistance
  - Medical Director
  - Additional Shift Compensation
  - Adjustment of FTE Status/ Casual Employment
  - Incorporation of Previous Arrangements
  - Advanced Practice Clinician/ Physician Collaborative Agreement

# Onboarding Employed Physicians

- Identification of physician need
  - Community Needs Assessment
  - Relevant Whitepapers, etc.
- Posting of the position, identification of candidates
- Interviews with physician
- Employment and total compensation package developed
- Initial approvals of compensation package obtained, if applicable
- Offer letter/ term sheet developed and sent to physician
- Physician negotiations and offer letter accepted
- Additional approvals obtained, if applicable
- Development of contracts/addendums and sent for physician review
- Contract executed
- Credentialing processes
- Physician start date

# Part IV: Drafting Compensation Plans

# Compensation Plans

- **Common Compensation Components**
  - **Fixed Base Salary**
  - **Productivity Compensation (e.g., hours, wRVUs, collections, etc.)**
  - **Metric Driven**
    - Patient experience, outcomes, process, operational efficiency, provider engagement/citizenship, etc.
    - Determined by improvement in metric score, absolute metric score and/ or comparison with peers.
    - Critical: Must simulate metrics to understand impact.
  - **Other Arrangements:** Incentive/ retention loans; signing bonuses; relocation assistance; medical staff stipends; casual/part-time status; administrative/ medical director services; call coverage; physician extender supervision, etc.
  - **Consider Interaction with Compensation Process/ Policies**

# Part IV: Auditing Compliance and Mitigating Risk

# The Auditing Process

- Define the objectives, scope and parameters of the audit.
- Develop an audit compliance checklist for each type of financial arrangement
- Compile a list of all existing arrangements and confirm the accuracy of the list.
- Request existing documentation for each arrangement, including supporting information (e.g., agreements, amendments, related policies, and documentation supporting FMV and CR, etc.).
- Interview executives and individuals involved in the contract management process to verify information.
- Review and analyze arrangements against a compliance audit checklist.
- Evaluate technical compliance with the Stark exceptions
- Evaluate the key tenets of defensibility (i.e., FMV, CR and TIA prohibition).
- Identify action items to remedy any potentially non-compliant arrangements
- Critical:  Evaluate any existing employment focused governance processes.

# Strategies for Mitigating Risk

- Engage experienced health care regulatory counsel and appraisers and develop a strategy focused on defensibility.
- Formalize your physician employment and onboarding process (e.g., contract database, centralized contract approvals, etc.).
- Ensure all physician policies, processes, checklists, and templates are reviewed by legal.
- Review policies, processes, checklists, and templates periodically to ensure they are accurate and support compliance.
- Develop robust governance and operational processes for evaluating and monitoring new and existing physician compensation arrangements.
- Develop individualized compliance training programs for board/compensation committee members, management, physicians and staff involved in administering arrangements.
- Keep it as simple as possible – process and documentation should be geared towards satisfying the Stark exceptions and tenets of defensibility.

# Practical Takeaways

- Employment arrangements with referring physicians must be defensible
- Focus on Stark's technical requirements and the 3 Tenets of Defensibility
- Consider how to operationalize the Stark exceptions, the group practice requirements, interpretations/ clarifications
- **Compensation-Focused Compliance -** Documentation and governance should support defensibility:
  - Ensure employment policies, processes documentation are in alignment with Stark's technical requirements
  - Implement contractual arrangements consistent with their terms
  - Periodically audit all employment arrangements
  - Establish a consistent processes for review by legal and third-party appraisers
  - Continue monitoring the enforcement climate

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