Professional Perspective

Physician Compensation Arrangements After Stark Law Changes

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The Centers for Medicare & Medicaid Services' (CMS) regulatory revisions on Dec. 2, 2020, and Nov. 19, 2021, to the federal Physician Self-Referral Law, commonly known as the Stark Law, have had significant effects on physician compensation arrangements. These revisions may impact current financial arrangements with physicians and, in particular, the fair market value (FMV) and commercial reasonableness (CR) analyses supporting them.

This article analyzes the compliance takeaways below, including specific FMV and CR considerations, using a practical example.

In a previous article, the authors highlighted certain key concepts involving FMV, CR and indirect compensation arrangements. 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).

Compliance Takeaways

• 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, instead of assuming that anything below the 50th or 75th percentile is deemed FMV.

• Regarding a CR analysis, ensure the compensation is commensurate with services performed. For example, if a physician is compensated based on their advanced practice providers' (APPs') work relative value units (wRVUs) reflecting specific work activities, 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. For the purposes of this discussion, APPs include nurse practitioners and physician assistants.

• Review current arrangements that could fall under the definition of indirect compensation arrangements. As an example, certain compensation arrangements that consider APP wRVUs as physician compensation may have issues meeting CR and FMV tests and the indirect compensation arrangements exception under section 411.352(p).

Further, the example provided in Part 1 focused on indirect compensation analysis and the consideration of what is personally performed, i.e., actually provided by the surgeon.

Employed Surgeon Example

The facts of our employed surgeon example follow. A health system consists of two hospitals and a medical group. The group employs a surgical physician and an 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 (42 C.F.R. section 411.352), and services rendered do not meet the in-office ancillary services exception (42 C.F.R. section 411.355(b)).

The group compensates the surgeon, in part, 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 is multiplied by a fixed conversion factor. A benchmarking analysis prepared by the group indicates the surgeon's total compensation is at the median consistent with wRVUs billed at the median.

The surgeon's historical compensation is summarized as follows.

Table 1: Surgeon Historical Compensation

Description	Amount	Formula
Base Compensation	$550,000	A
wRVU Conversion Factor	$75.98	B
wRVUs Required Before wRVU Productivity Bonus	7,238	C=A/B
Actual wRVUs Attributed to Surgeon (Billed Under Surgeon NPI)	8,550	D
wRVUs Available for wRVU Productivity Bonus	1,312	E=D-C
wRVU Productivity Bonus (Rounded)	$99,686	F=B*E
Total Surgeon Compensation	$649,686	G=A+F

Using the background of the arrangement summarized above, below are the key FMV and CR considerations with respect to personally performed services and APP collaboration.

• The benchmarking analysis prepared by the group indicates the surgeon's total compensation and wRVUs billed are at the median. CMS did not make an exception for, or rebuttable presumption of, FMV 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 is warranted.

• The APP supports the surgeon by providing various clinical services. The wRVUs attributed to the surgeon represent those billed under the surgeon's NPI. 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." See 86 Fed. Reg. at 65,346.

In the 2022 MPFS comments, CMS thought clarification was warranted and addressed the meaning of "personally performed," writing that commenters discussing incident to billing may be "conflating" Medicare billing conventions with physician self-referral policy. See 86 Fed. Reg. at 65,350.

• Allowing the wRVUs related to work not personally performed by the surgeon to accumulate in the wRVU productivity bonus determination could call into question the CR of the arrangement and potentially whether the compensation was based on the volume or value of the surgeon's referrals or other business generated by that surgeon.

Recall that for the purposes of this example, the group does not meet the group practice standards under the Stark Law (42 C.F.R. section 411.352), and services do not meet the in-office ancillary services exception (42 C.F.R. section 411.355(b)). If the group met the group practice standards and in-office ancillary services exception, this analysis would not apply.

- Services performed incident to are rendered by the APP and billed under the surgeon's NPI. The surgeon does not personally perform these services. The FMV and CR analysis should consider removing these wRVUs from the wRVU productivity bonus calculation.
- Split-shared services are partially performed by the APP and partially performed by the surgeon. For those services billed under the surgeon's NPI, the surgeon does not personally perform these services in their entirety. The FMV and CR analysis should consider removing a portion of these wRVUs from the wRVU productivity bonus calculation, i.e., crediting the physician with only the pro-rata share of the wRVUs that the physician performs.
- Services performed and billed under a global package are likely partially performed by the APP and partially performed by the surgeon. These services are billed under the surgeon's NPI. The FMV and CR analysis should consider removing a portion of these wRVUs from the wRVU productivity bonus calculation—as with split-shared, crediting the physician with only the pro-rata share of the wRVUs that the physician performs.

Practical Guidance

Because billing for physician professional services and the related wRVU calculation is a highly automated process, the practical question becomes: How can wRVUs related to services not personally performed by the surgeon be reasonably determined and assessed?

• For services performed incident to, wRVU accumulation should be based on services rendered by the surgeon. Accumulating wRVUs by the rendering provider will eliminate those wRVUs billed incident to under the surgeon's NPI but rendered by an APP, thus removing services not personally performed by the surgeon.

• For services performed split-shared or globally, the answer, even with the current, available tools, is unclear. One possible option is to explore billing system capabilities for attaching a designating modifier or a flag that causes the information system to allocate the wRVUs between the surgeon and APP based on each one's portion of personally performed services.

A second possible option is to complete a time study, shadowing analysis, and/or medical record review of the surgeon to determine an estimate of the portion of split-shared and globally billed services potentially performed by the APP and attributed to the surgeon as the billing provider. This option would then allow the group to assess a reduction of the surgeon's wRVUs as a result of the study to capture personally performed services by the surgeon for purposes of assessing FMV and CR.

• Absent a reduction in the surgeon's wRVUs for the services not personally performed, another mechanism or analysis would be required to assess FMV and CR.

Assume a time study, shadowing analysis, and/or medical record review completed by the group indicate approximately 15% of the surgeon's billed wRVUs are not personally performed. As further displayed in the example, the wRVU productivity bonus is equal to wRVUs billed under the surgeon's NPI and multiplied by a fixed conversion factor. Specifically, no contractual mechanism exists for reducing wRVUs attributed to the surgeon by the billing system before multiplying by the conversion factor for wRVU productivity bonus determination purposes. The assessment of FMV and CR should consider the compensation structure as outlined in the employment agreement, but make adjustments to the underlying FMV analysis using the valuator's judgment to focus only on the physician's personally performed services.

• Assessment of the personally performed portion of the surgeon's wRVUs and related impact on surgeon compensation is summarized in the following table.

Table 2: Assessment of Personally Performed wRVUs and Impact on Compensation

Description	Amount	Formula
Base Compensation	$550,000	A
wRVU Conversion Factor	$75.98	B
wRVUs Required Before wRVU Productivity Bonus	7,238	C=A/B
Actual wRVUs Attributed to Surgeon (Billed Under Surgeon NPI)	8,550	D
Adjusted Actual wRVUs Attributed to Surgeon (Reduced by 15% to Represent Personally Performed Services [Rounded])	7,268	E=(D*(1-.15))
Adjusted wRVUs Available for wRVU Productivity Bonus	30	F=E-C
Adjusted wRVU Productivity Bonus (Rounded)	$2,279	G=B*F
Total Adjusted Surgeon Compensation for Personally Performed Services	$552,279	H=A+G
Total Unadjusted Surgeon Compensation (From Table 1)	$649,686	I
Difference Between Unadjusted and Adjusted Surgeon Compensation	$97,407	J=I-H
Effective wRVU Conversion Factor (Compensation Per wRVU)	$89.39	K=I/E

The analysis in Table 2 indicates the impact on the surgeon under the current contractual arrangement for services not personally performed is approximately $97,000. Questions arising from this analysis are addressed in the assessment of FMV and CR as follows.

• Is it FMV and CR to compensate the surgeon $97,000 for services not personally performed? In this scenario, the compensation structure allows the surgeon to receive compensation for services provided by the APP, but does not subtract the expense the group incurs to employ that APP. The group bears the expense of the increased surgeon compensation and the expense of the APP. The original compensation methodology does not consider whether the services performed by the APP may or may not increase professional collections and offset the expenses of the APP.

• Does the $97,000 represent a reasonable APP supervision stipend compensation for the surgeon? The industry recognizes the value of APP supervision by a physician. The level of APP supervision required varies by organization, specialty, and by state regulation and could further vary based on the APP's experience and the number of APPs the physician supervises.

In this example, the APP supervision value was not segregated within the surgeon's compensation structure. If it had been separately compensated, it would be important to consider whether the supervision compensation has been double-counted—once within a supervision stipend, and once within the wRVU productivity bonus. Based on PYA's experience, current market data suggests the value of an APP supervision stipend ranges from approximately $10,000 to $24,000 annually per APP supervised.

• Is the group's original benchmarking analysis indicating the surgeon is compensated at the median and produces wRVUs at the median when compared to market data still true? In the analysis above (Table 2), and without adjustment to the surgeon's employment arrangement, the surgeon's total compensation did not change. As such, the surgeon is still compensated at the median.

However, the group's internal analysis indicates that after deducting an estimate of wRVUs not personally performed by the surgeon, i.e., 15%, the surgeon is producing wRVUs less than the median. As a result, the effective wRVU conversion factor (formula row K in Table 2) increases from a median level of $75.98 (formula row B in Table 2) by approximately 18% to $89.39, which approximates the 75th percentile of benchmark data utilized by the group.

The analysis highlights a misalignment between compensation—median—and productivity—less than median—that requires further analysis from an FMV perspective. It also highlights CMS' rebuttable presumption discussion within its commentary. Assuming a physician at a median level of compensation immediately passes an FMV test is problematic. Additional analysis to resolve this issue may include understanding the community need for the surgeon, the surgeon's call coverage requirements, tenure and experience, and the recruiting needs and difficulties of the medical group.

• Is the compensation structure financially sustainable or otherwise supported as CR? Table 2 highlights the analysis of one surgeon in the group. Similar financial impact on the group will repeat with other employed physicians practicing in different disciplines. It is important to recognize that the example utilized a 15% APP impact, but this amount may vary based upon individual surgeon facts and circumstances applicable to each physician and the results of in-depth studies and analyses conducted by the group.

This example does not include any other compensation components for the surgeon. It is common in the industry for physicians to receive additional compensation—e.g., administrative services, call coverage, teaching services, and quality and engagement incentives. Such additional compensation components will further complicate the analysis, especially when the additional compensation components do not generate additional wRVU productivity.

Specifically, a physician compensation arrangement, including productivity components and non-productivity generating components, calls for an analysis of FMV and CR at each component level and in total. Any such FMV analysis should understand that national benchmark survey data is "all in," i.e., it includes all components of compensation, not only clinical productivity compensation.

Further, while national benchmark survey submission instructions may request that only personally performed wRVU productivity data be submitted, there is no guarantee that participating organizations will adjust wRVU data for incident to, split-shared, and globally billed services before submitting. As such, FMV analysis should rely upon national benchmark survey data as a launching point, but not the only source for determining FMV.

Conclusion

CMS has revised fundamental concepts in the Stark Law. Such revisions may impact current financial arrangements with physicians, and especially the FMV and CR analyses supporting them. A thorough Stark Law exception analysis of physician arrangements, including FMV and CR determinations, is not evergreen and requires continued focus and comprehensive review.