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Physician compensation: Stark and the new quality, value environment

» Regulation and market forces are driving health systems and provider groups to consider new physician compensation models.
» The Stark regulations are a critical touchstone for most physician compensation models.
» Profit sharing and productivity bonuses are different and require separate consideration.
» Common wisdom is often wrong about Stark.
» Leading organizations are already paying physicians for their quality and value performance.

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Although much attention has been focused on the pernicious effects of fee-for-service reimbursement on controlling costs and improving quality, far less attention has been paid to how internal compensation models within physician groups affect costs and quality. Now that health systems are employing physicians in record numbers, they should also be paying attention to what their physician compensation models reward. The Stark Laws and regulations provide boundaries that must be confronted as well. This article examines how the context for physician compensation has changed, elucidates how Stark is relevant—debunking some myths along the way—and then presents some information on what leading organizations are doing to compensate physicians for quality.

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What's new?

The health reform legislation calls for the creation of a value-based purchasing modifier that will be applied to the Medicare Physician Fee Schedule, beginning in 2015. At this writing, we do not even have a word of proposed regulations regarding this, but because physicians will be paid differentially depending on their quality performance and, after two years, for their efficiency ("value"), that reimbursement system will create changed incentives, even though it will remain as fee-for-service.

Commercial pay-for-performance programs, including Bridges to Excellence and others, have provided additional dollars to physician groups who manifest both quality infrastructure and good results as demonstrated in scorecards. The Medicare version of this is the Physician Quality Reporting System (PQRS). Today, it is only about reporting, but the data from this system will likely feed the Physician Value Based Purchasing (VBP) program under Medicare. In addition, under Medicare, the Center for Medicare and Medicaid Innovation is conducting a demonstration project around bundled payments, as are commercial payers. Still other payers are experimenting with episode rates; and the health reform legislation has called for a publicly transparent episode grouper to analyze resource consumption by all Medicare

providers that render care within an episode. Physicians in the Midwest have begun to receive reports from Medicare regarding their resource utilization. The reports are intended to facilitate their ability to change their behavior over time.

Within the Medicare Shared Savings program, Accountable Care Organizations (ACO) physicians will be expecting additional dollars as a result of their effective management of care delivery. The burgeoning commercial ACO partnerships are touting their aims of controlled costs with better quality results. None of them will succeed unless physicians are actively driving change. How the physicians are paid for their work is unquestionably relevant. However, in order to design any new incentives, the Stark Laws must be confronted.

The Stark Law definitions

Not very much attention has been paid to date to the impact on compensation of the Stark definition of a group practice, which must be met in order to be able (1) to refer to a physician "in the group or a member of the group" for physician services, (2) to qualify to bill for in-office ancillary services, or (3) to qualify for protection of group practice arrangements with a hospital. Now that Stark violations can convert to false claims if monies received pursuant to tainted arrangements are not returned in 60 days, this is new territory for whistleblowers.

The definition of a group practice says that physicians 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 bonus share is not determined in any manner which is directly related to the volume or value of referrals.[1] The definition further addresses overhead and expenses. The group must engage in "the joint use of shared office space, facilities, equipment, and personnel" and "the overhead expenses of and income from the practice are distributed in accordance with methods previously determined." The interpreting regulations take no real position about cost allocation as long as the determination as to how it will occur is made prospectively. Groups can use cost centers by location, by specialty, or by any other reasonable measure that does not directly reward volume or value of referrals of designated health services (DHS).[2] The Stark regulators are really not much concerned about allocation of overhead. Rather, they are far more concerned about rewarding volume or value of referrals within the group.

Productivity

Further interpreting the statutory definition, the regulators have defined productivity based compensation as allocation of dollars that result from the fruits of a physician's own labors. This means that the physician must literally provide the service himself to be given dollar-for-dollar credit for it. Three safe harbors are offered: (1) a bonus based on the physician's total patient encounters or relative value units (RVUs), (2) a bonus based on a non-designated health service revenues, or (3) where revenues derived from DHS are less than 5% of the group's total revenues and the allocated portion is less than 5% of the physician's total compensation from the group. The calculation can be made before or after expenses are deducted.

Myths about productivity are common. Some people believe that you cannot pay independent contractors a percentage of what they generate. This is inaccurate and independent contractors may be paid on a productivity basis just as members of the group may.[3] Some people believe that you must have a base salary and cannot pay based purely on productivity. There is nothing in the regulations that says that. Other people believe that you have to treat all revenues (e.g., DHS, non-Medicare, etc.) the same way. The Stark statute only pertains to Medicare and a referral is defined as only

a referral for DHS. Therefore, Stark only has relevance for Medicare DHS revenues. Finally, some people believe that you cannot pay a physician for personally performed DHS. This is not true; you can pay a physician the revenues from anything that he literally does himself. If he personally does the imaging without the services of a technician, he can be given credit for the technical components of the imaging.

Incident to

A wrinkle on the rule of productivity as the fruits of the physician's own labors is the reference to "incident to" revenues. Services that are incident to a physician require the direct supervision of a physician on premises and in the office suite, although not necessarily in the same room.[4] The clinical personnel who render the services need not be employees or leased employees, although Medicare will only pay the employer of a physician assistant. There must be a physician professional service to which the ancillary services are incidental. Supervision of a service alone does not count as a physician service except for a code such as 93015 where the service itself *is* supervision.

The services must be of a kind commonly furnished in a physician's office or clinic and must be commonly rendered without charge or included in the physician's bill. No non-physician personnel (NPP) may bill incident to for counseling or coordination of care. However, NPPs such as physician assistants, nurse midwives, nurse practitioners, and clinical nurse specialists can perform and bill the applicable visit codes for their services. If more than 50% of the service is counseling or coordination of care, the service should be billed under the NPP's number and not incident to the physician's services.[5]

A similar rule, although applicable only in the hospital setting, is the shared visit rule first published in Transmittal 1776.[6] Where the physician and an NPP are in the same group, for hospital inpatient and outpatient settings as well as the Emergency Department, the NPP can see the patient first, and the physician can follow later and perform any part of the visit in a face-to-face encounter with a patient. Then the total service may be billed at 100% of the Medicare Fee Schedule under the physician's number. This counts as personally performed services for Stark regulations. However, visits are not DHS and so that transmittal should cause no problems under Stark.

Like productivity, there are some myths about incident-to billing. Despite multiple repetitions from the regulators, many people still believe you cannot allocate DHS which is "incident to" directly to the ordering physician. This is not true.[7] Although diagnostic testing can no longer be considered incident to, revenues from chemotherapy or physical therapy rendered incident to a physician can be allocated directly to the physician's compensation, if the revenues meet all of the other incident-to requirements. Some people believe that you cannot give the treating physician credit for non-incident to evaluation and management services that are rendered by NPPs and billed on their own numbers. Of course you can. This is not DHS and therefore Stark has nothing to say about it. Some people think you can give physicians credit for the professional component of a diagnostic study they order, but do not render, if it meets the in-office ancillary services requirements. That is inaccurate. The professional component is not an in-office ancillary service. 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.

Profit sharing

The second leg of the Stark compensation definition is profit sharing—the fruits of others' labors. Here, the rules allow a share of "overall profits," meaning a share of the entire profits

from DHS of the entire group or any group of at least five physicians. There are three safe harbors here as well: (1) per capita equal division of the profits; (2) a distribution of DHS revenues based on the distribution of the group practice's revenues attributable to the services that are not DHS; and (3) any distribution of DHS of the group practice DHS revenues, and no physician's allocated portions of those revenues is more than 5% of the group physician's total compensation. The regulators explicitly state that other methods are fine, offering as examples per-ownership interest and seniority. Any other method used must be adequately documented and supporting information made available to the DHHS Secretary upon request. Since diagnostic testing can no longer be incident to, all diagnostic testing profits from the technical component have to be allocated in a profit sharing formula. Professional components personally performed can be allocated to the interpreting physician.

Far more creativity is possible in these rules than many people recognize. Because any subgroup of five physicians can qualify as a pod for compensation, in larger groups, not all physicians need participate in all pods. For example, some physicians can be in the imaging pod, others in the infusion pod, and still others in the physical therapy pod. Others need not be paid any DHS profits.

You could look at data over several years and determine historically who are the high, middle, and low utilizers of various DHS and put them in separate pods of at least five physicians. As long as the compensation is fixed going forward and does not change to reflect volume of current referrals, this would comply with the law. You can mix and match pods among specialties if necessary.

The Stark regulations do not address quality metrics within a group practice, but patient satisfaction and compliance with guidelines are already recognized for direct payment by hospitals to independent physicians.[8] As long as the measures do not capture volume or value of DHS referrals, no compliance problem would arise. Value metrics, including length of stay or lowered resource use within a group practice, would not be problematic either. In contrast, if a hospital were directly compensating its employed physicians for lowered resource use, that would run afoul of a different rule prohibiting hospitals from compensating physicians for reducing services.

The leading edge of compensation

Although it is true that most high performing organizations like the Henry Ford Health System, Intermountain Health, Leahy Clinic, and Ochsner still compensate their physicians predominantly on productivity,[9] data from May 2011 demonstrate that groups from across the country are already compensating their physicians for quality and, increasingly, for value. Based on a survey I created which was distributed by the American Medical Group Association (AMGA) by email, 26 groups from Michigan, Massachusetts, New York, Florida, Iowa, Montana, Tennessee, Wisconsin, Ohio, District of Columbia, Maryland, Pennsylvania, Oregon, Minnesota, Washington, and California have been paying this way, from very recently to longstanding pioneers who have paid this way for more than 15 years. The Everett Clinic (which in 2007 answered an earlier survey[10]) had been paying for quality as part of its compensation package for more than 10 years. Interestingly, in 2011, Everett completely reversed their position and now pay only on productivity.[11] This was attributed to both a change of leadership and concern for complacency that had developed among the physicians.

Similar to four years ago, the groups responding to the survey broke out into three time horizons: groups which had been paying on quality performance less than 2 years; mid-range adopters between 3 and 6

years; and pioneers who have been doing it for more than 10 years. Most groups began with primary care only. Those doing it less than 2 years have 3%–7.5% of base salary at risk. Some say it is a bonus; some say it is a withhold. Some groups pay a stipend for participating in quality projects.

Several mentioned counting attendance at meetings to build culture, and all who spoke of that reported that it worked to get physicians to deal better with each other. All groups reported a positive impact. All suggested spending one year of measuring with no financial impact to be certain physicians are comfortable with the program. One of the groups that had been at it for 2 years with 7.5% at risk had their medication reconciliation rate improve from 26% to 71%. One group doing it only 2 years wants to put 25% at risk next year.

Very few of the youngest programs report measuring and compensating on value, except for hospitalists, where they do measure length of stay, readmission rates, and utilization of order sets. Those physicians have 10% at risk. Participating groups here include Sentara Medical Group in Virginia, Mayo Clinic in Minnesota, Sutter Gould Medical Foundation in California, Olmsted Medical Center in Minnesota, Henry Ford Medical Group in Michigan, Wenatchee Valley Medical Group in Washington, and Boseman Deaconess Medical Group in Montana.

Mid-range adopters put more money at risk than those who are just starting out. At the low end, they have 1%–2% at risk, some have 3%, and another group has 5%–10%. Still additional groups have 4%–7% at risk or use a stipend of $10,000, with half that earned based on quality metrics and the remainder on meeting attendance, citizenship standards, and OSHA compliance.

More specialty-specific criteria were mentioned here, such as asthma action plans, spirometry rates, and improving colonoscopy rates in patients over age 50. One group introduced a clinic-wide customer service metric. Again, participating in meetings was mentioned, along with timely closing of visit encounters and efficient use of electronic health records. Few have changed the amount they put at risk over time. Two reward value with incentives, again, to their hospitalists. All report some positive impact. These include Advocate Medical Group outside Chicago, Mount Kisco Medical Group in New York, Summit Medical Group in Tennessee, the Iowa Clinic, Pediatric Associates in Florida, Children's Primary Care Medical Group in California, and the PeaceHealth Medical Group in Washington.

Among the twelve pioneer groups, one has been paying based on quality for 16 years. Most of them have contracts from payers that reward quality as well, as distinct from the less experienced groups above. They range from putting 3% to 15% at risk. HealthPartners in Minnesota rewards participation improvement activity as well as outcomes. HealthCare Partners Medical Group in California only pays primary physicians this way, and tracks directly to Healthcare Effectiveness and Data Information Set (HEDIS) data, because managed care is so strong there.

The Billings Clinic was a mid-range reporter in 2007, but now has spread the program to 12 specialties which set their own measures. Some have 3% at risk and others get stipends. Some groups, like Geisinger Health System in Pennsylvania, share data on group-wide measures, but not individual measures which are part of each physician's compensation package. All keep an eye on outside metrics, but their own cultures are more important. In addition to the groups mentioned above, pioneers include MedStar Physician Partners in the District of Columbia, IHA in Michigan, PriMed Physicians in Ohio, Sutter Medical Group in California, First Health Physician Group in North Carolina, and ThedaCare in Wisconsin.

The lessons learned by these groups are very similar to those learned in 2007:

- Start small;
- Choose credible, well-regarded evidence-based measures;
- Make sure physicians understand the measures and their documentation before financial impact occurs;
- Feedback during the year is helpful to the physicians; and
- Use no more than eight to ten measures a year.

Conclusion

As more and more health care gets measured and reported publicly and with financial impact for performance, how individual physicians are compensation and rewarded should be the subject of more intense scrutiny. Although fee-for-service is not disappearing completely, rewarding physicians for the kinds of results that are measured would seem increasingly important. Leading edge groups are already headed that way. All physician employers should consider these approaches.

1. 42 USC §1395nn(h)(4)(B)(i)
2. 66 Fed. Reg. 905-907 (Jan. 4, 2001)
3. 66 Fed. Reg. 908 (Jan. 4, 2001)
4. 42 CFR §410.10(b), 414.34(b), 410.26
5. CMS: Medicare Claims Processing Manual 1000-04, Chapter 12 §30.6
6. CMS: Medicare Claims Processing Manual 100-04, Chapter 12 §30.6.1
7. 66 Fed. Reg. 909 (Jan. 4, 2001) and 72 Fed. Reg. 51023 (Sept. 5, 2007)
8. 72 Fed. Reg. 51046 (Sept. 5, 2007) citing earlier statements at 69 Fed. Reg. 16091. March 26, 2004
9. Mark Kelley: "Productivity Still Drives Compensation in High Performing Group Practices," *Health Affairs* Blog , Dec. 20, 2010. Available at http://healthaffairs.org/blog/2010/12/20/productivity-still-drives-compensation-in-high-performing-group-practices/
10. Gosfield: "Compensation for Quality: The Next Inevitable Step," *Group Practice Journal*, May 2008, pp. 10-15. Available at http://gosfield.com/PDF/Gosfield_May_2008_GPJ%5B1%5D.pdf; and Gosfield: "Physician Compensation for Quality: Behind The Group's Green Door, Part 1, Physician Issues. *Health Law Handbook*, 2008 edition, pp. 3-44. Available at http://gosfield.com/PDF/Published.Chapter1.pdf
11. Gosfield: "Compensating Physicians for Quality and Value: A Changing Landscape," *Group Practice Journal*, Sept 2011, pp. 16-26; Available at http://gosfield.com/PDF/MD%20Comp%20for%20Qual.amga.911.pdf; and Gosfield: "Bolstering Change: Physician Compensation for Quality and Value." *Health Law Handbook* (2012 Ed.) Available at http://gosfield.com/PDF/AGG_HLH2012_Bolstering%20Change.pdf.