

MEDICARE COMPLIANCE

Formulas for Fair-Market Compensation: Paying MDs Without Violating Fraud Laws

Because global fees are potential vehicles for inflated hospital payments to physicians, hospitals have to divvy them up without running afoul of fraud and abuse laws. But ensuring a global fee doesn't turn into a sweetheart deal is easier said than done. One strategy: Link the physician's share of the global fee to relative value units.

Payers use global fees to cover both technical and professional components of services performed in certain specialties (e.g., cardiology, anesthesiology, radiology), leaving the hospital and physicians to determine how much of the fee reflects their respective contributions. It's a complex calculation, but more hospitals are willing to go the extra mile to ensure they pay fair-market value for physician services because they fear the heightened government scrutiny of hospital-physician relationships, says valuation expert Robert Hill. The big risks in hospital payments to physicians: violations of the anti-kickback statute, Stark self-referral ban and laws governing tax exemption.

"Hospitals can't just give physicians 50% of the money if they haven't provided 50% of the work or required resources. You can't use a global contract to overpay them," says Hill, a manager with Health Strategies & Solutions, a national management consulting firm based in Philadelphia (see related advice, p. 3).

Here are the basic steps for allocating global fees between hospitals and physicians using RVUs:

(1) Start with the RVU scale published by the government for all technical and professional services provided by physicians according to CPT codes. (An RVU reflects the relative value of a physician's work based on intensity of effort, skill and medical judgment, as well as a component for malpractice insurance.) For example, as of December 2003, Hill says there were 486 cardiology CPT codes, so you need to know the RVUs for those codes.

(2) Identify the RVUs associated with the CPT codes for the services performed by the respective specialists (e.g., cardiologists, radiologists, etc.) over the relevant time period.

(3) Multiply the quantity of services, by CPT code, that were performed under the global contract by the respective RVU level for each CPT code and adjust for geographic differences. (The formulas are also published by the federal government).

(4) Evaluate the aggregate physician payment earned based on RVUs (representing the participation in the care delivery by the physicians) vs. total reimbursement for those services. This ratio can serve as an indicator of inadequate reimbursement from the insurance company to the hospitals and physicians. It is calculated on a monthly basis to keep fair market value fresh and updated, he says.

(5) Implement a charge from the hospital to the physicians for these services (e.g., 6% to 15% of net collections) in cases where the hospital is completing all the efforts related to billing and collections, appeal of denials, etc.

For example, suppose a hospital collects a global fee of \$250 for CPT code 70450 (a CT scan). The CPT code represents approximately 1.18 RVUs for the radiologist's professional services (subject to an adjustment for the respective metropolitan region). Assuming an RVU payment rate of \$35 per RVU, the radiologist would earn approximately \$41 for professional services, or 16% of the global payment. For the same CPT code, the global RVU value is 6.09. The ratio of the professional RVU value to the global RVU value is 19%, which can also be an indicator on the reasonableness of fee distribution, Hill says.

"This makes sense for these hospitals because in the past, they didn't have a scientific means of calculating how they'd pay," Hill says. "All the money went to the hospital. The hospital did billing and collections and paid the physicians their share of the global fee, but the numbers they used were outdated, and there was no consistency among specialties and no test of reasonableness of those numbers."

This is just one of the compensation strategies that hospitals are starting to use amid fear of the government's ongoing crackdown on hospital-physician sweetheart deals.

Here are other approaches devised by Hill and his colleagues:

- ◆ Payments to physicians for on-call coverage is an expensive thorn in hospitals' sides. They need coverage to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to ensure the emergency room can summon specialists of all kinds, as needed. In more and more instances, physicians are demanding high payments, which strains hospitals' finances and violates the anti-kickback law. At one Colo-

Ensuring Fair-Market-Value Compensation for Physicians

To avoid anti-kickback and Stark self-referral violations, hospitals and other entities must ensure physician compensation is set at fair market value and is commercially reasonable. Here is advice on accomplishing this from Robert Hill, a director of Health Strategies & Solutions. (For specific formulas, see story, p. 1.) Contact Hill at bhill@hss-inc.com.

Compensation Arrangements Between Physicians and Health Care Organizations

Formal compensation arrangements between physicians and health care organizations are more prevalent than ever. The type and nature of the arrangements also varies more so than at any time in the past. Many health care organizations now compensate physicians to ensure on-call coverage, meet guaranteed levels of income, provide mentoring/training to new physicians, offer clinical services at a hospital, or as part of management contracts or services and employment arrangements.

Guidelines for Establishing Effective Compensation Arrangements With Physicians

There are a number of issues that health care organizations must keep in mind when negotiating compensation arrangements with physicians. Here are some guidelines to consider:

- ◆ Clearly articulate performance expectations and measurement criteria in the compensation arrangement.
- ◆ Make a substantial portion of compensation at risk, based on achievement of performance and quality targets.
- ◆ Issue monthly physician performance summaries.
- ◆ Measure and review performance before paying out bonuses, typically quarterly or annually.
- ◆ Make every effort to ensure that the contract duration is neither too short nor too long; two to five years with options for renewal is generally reasonable.
- ◆ Review and revise compensation arrangements as market conditions, regulations, and other circumstances change.
- ◆ Terminate arrangements with physicians in cases where performance is at unacceptable levels or shows little potential for improvements.

Complying With Government Regulations

The government's fraud and abuse regulations are intended to ensure that health care providers that receive Medicare and Medicaid funding do not offer or receive anything of value to encourage the referral of business. Nonprofit organizations may lose their tax-exempt status if they engage in transactions that result in prohibited private inurement or excessive private benefit. In addition, the officers and directors of a tax-exempt organization may be personally liable if their organization engages in an excess benefit transaction with a physician or other private party. Health care organizations are strongly encouraged to consult legal counsel for appropriate guidance.

One focal point for government compliance efforts has been fair-market-value assessment of compensation paid to physicians employed or under contract by health care organizations. To ensure that health care organizations are abiding by CMS regulations, use three criteria to determine the reasonableness of compensation:

(1) Financial Performance. Health care organizations should evaluate their net operating gains or losses by practice or clinical service and the aggregate operating gains and losses for all employed and contract physicians. Compensation paid to physicians should take into account financial performance so that a hospital is not viewed as inappropriately subsidizing physicians.

(2) Regional Comparisons. Health care organizations should compare compensation paid to physicians with averages or medians from the hospital or system's regional market.

(3) National Survey Data. Health care organizations should compare compensation paid to physicians to industry benchmarks.

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rado hospital, a group of trauma surgeons demanded a \$2,000-a-night rate for on-call coverage, an amount that would have totaled \$730,000 a year. On the hospital's behalf, Hill's company conducted local and national surveys to determine the going rate for trauma surgeon ER coverage at hospitals of comparable size with the same trauma service designation. It turned out that similar hospitals are generally paying \$900 to \$1,200 a night for trauma surgeon on-call coverage — about \$330,000 to \$440,000 per year. Paying almost double could have been a kickback risk for the hospital. "The hospital went back to the physicians with the survey results and said 'we checked this out against rates in our region and nationally, and we can't do it. We will offer \$1,000 a day.'" The trauma surgeons counteroffered with \$400,000 a year, and the deal was done.

◆ A critical access hospital in the South wanted to recruit the services of a gastroenterologist to an underserved rural area, but it had to provide some perk for the specialist to schlep to the boondocks to treat patients — without running afoul of the fraud and abuse laws. Since the Benefits Improvement and Protection Act of 2000 provided a 15% increase in payments for physician services at critical access hospitals — small facilities serving rural areas — why not spread the wealth? Under the terms of a new productivity-based contract, the hospital, which bills for the gastroenterologist's services, pays him a fee for every service provided based on the Medicare fee schedule, plus 15% more for every endoscopy, sigmoidoscopy and other gastrointestinal procedure.

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