Physician Multispecialty Group Practices: Key Legal Considerations

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Compensation Systems for Multi-Specialty Groups

• Purpose of a compensation system is to incentivize behavior and reward desired performance
• It’s hard to keep physicians happy in a single-specialty group – multi-specialty groups just add more complications
  – The more diverse the specialties, the more the complexity
• Variations in reimbursement or payment
  – Procedures vs. Cognitive (E&M)
  – Payer and patient mix can have wide variations
  – Capitation and cost-saving programs cause divergent interests
Variations in consumption of resources

- Overhead needs are different for primary care office-based specialists and proceduralists
- Overhead needs can be inverse of reimbursement levels
- Subsidizing others’ incomes
Common Factors Looked at in Compensation Systems

• Industry surveys of compensation and work RVU’s (wRVU’s) by specialty
• Historic production
• Equality of effect and participation
• Personal productivity and incentives
• Overhead allocations
• Quality/Outcome measures
• Citizenship
• Ancillary Services
Stark Rules for Physician Group Practices

Generally:

• Overhead expenses of and income from the practice must be distributed pursuant to a prospective methodology.

• Centralized decision-making on budget, compensation and salaries.

• Location and specialty based compensation are permitted for non-DHS revenues.

• No physician may be compensated in any manner that is based, directly or indirectly on the volume or value of his or her referrals.
Stark Rules for Physician Group Practices, cont’d

• A physician may be paid a share of the practice’s overall profits from DHS
• A physician may be paid a productivity bonus for services personally performed or for services incident to personally performed services
• So long as the bonus or share is not determined in any manner that is directly related to the volume or value of the physician’s referrals for DHS
Overall Profits

• The Group’s total profits from DHS
  or
• The profits from DHS from any component of the group that consists of at least 5 physicians
• Must be a verifiable and reasonable methodology for the division that is not related to the volume or value of DHS referrals
• Three “safe harbors”
  (1) A per capita division of profits
  (2) Proportionate to Group’s revenue that is not from DHS payable by either a federal program or a private payer
  (3) Revenues from DHS are less than 5% of Group’s total revenue and each physician’s allocation is less than 5% of his or her total compensation
Productivity Bonus

• Personal services or services incident to the physician’s services
• Calculated using a reasonable and verifiable methodology not related to the volume or value of DHS referrals
• 3 “safe harbors”
  (1) RVU based or by patient encounters
  (2) allocated by compensation from services that are not DHS payable by a federal program or private payer
  (3) Revenues from DHS are less than 5% of Group’s total revenues and each physician’s allocation is less than 5% of his/her total compensation
Examples of Compensation Systems for Multi-Specialty Practices

- Fixed salaries
  - Eliminates uncertainty for physician
  - Puts all risk on group for overhead, insufficient production or reduced reimbursement
  - Have to have periodic recalculation, based on actual revenues or productivity
  - More common in very large groups
Examples of Compensation Systems for Multi-Specialty Practices, cont’d

• Classic “Eat What You Kill” compensation
  • Collected revenues for physician’s services less allocated overhead
• Methodology of allocating overhead becomes the focus
  • Fixed vs. variable
  • Per capital division
  • Productivity division
Examples of Compensation Systems

• Base salary with productivity incentive
  • Most common approach for multi-specialty groups
  • Base salary derived from historic revenue production or compensation surveys
    • Median to 60th Percentile as base
  • Incentive calculated from production in excess of the standards used for the base salary
Examples of Compensation Systems, cont’d

• Equality: “Everyone Contributes”
  • Some Groups will set aside a portion of revenue for equal division
  • Probably only minority

• Ancillary services profits
  • Surveys have indicated that most multi-specialty groups use profit from ancillaries to lower general overhead, and do not use as individual compensation
  • “Incident to” ancillaries can be key piece of some specialists’ compensation (e.g., drug infusion profits)
Productivity Measures

• Collections: all the bad incentives of FFS Payments

• wRVU’s:
  • Generally seen as fair among specialties, but somewhat arbitrary
  • Still subject to negotiation on dollars
  • Not necessarily representative of the Group’s goals for incentives and performance
Productivity Measures, cont’d

• Quality/Outcomes
  • Set targets and reward physicians
  • Pool set aside for this (2-7%), percent of salary or assign wRVU’s
  • Minority of Groups have used this measure in compensation system, though growing number adopting

• Outreach/Leadership
  • Stipends for participation or assign wRVU’s
No Perfect System

• Every Group will have own solution
• Need to review on regular basis
• Hospital employment of physicians is bringing new creativity to the problem
  • Doctors usually have no easy exit and little control, so want better system
  • Incorporating concepts from Medical Directorships and Co-Management into compensation plan
  • Assigning value to the management contributions doctors bring to the table when full-time employees
Planning for Future

• ACO’s: “shared savings” probably not enough incentive to change behavior or compensation systems

• Risk sharing through global payments or capitation from private payers or government will force Groups to rethink compensation
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