Incentive compensation is permissible, BUT:

1. **Total compensation must be reasonable.**

   The total amount paid to the physician (base salary plus incentive compensation) must be reasonable, that is, reflect the fair market value of the services rendered. One or more of the published physician compensation surveys should be used to determine whether the physician's compensation is in line with what other physicians in that specialty are receiving. This should be documented and authorized pursuant to a board approved compensation plan that references third-party surveys or other evidence of what comparable organizations pay.

2. **No tie to utilization or costs of hospital services.**

   In addition to the requirement that compensation to the physicians be at fair market value, the compensation paid to the physicians cannot be based on the volume or value of business referred to the hospital by the physician. This does not preclude incentive compensation in appropriate instances that is based on the professional fees generated by the physician. Rather, it precludes the hospital from directly tying the physician's compensation to revenues generated for the hospital by virtue of the physician's utilization of hospital services.

   Conversely, per the recent Special Advisory Bulletin on "gainsharing" from the OIG, physician compensation cannot be based on the reduction of services or costs of the same rendered by a hospital. Therefore, any link between incentive compensation and things like utilization rates, lengths of stay, or cost per case should be eliminated.

3. **Incentive compensation must be capped.**

   Compensation paid to the physician must not only be reasonable, it must be subject to some ultimate limitation. The hospital, as a tax-exempt organization, is prohibited from entering into any open-ended "profit-sharing" or "revenue-sharing" arrangements with physicians on its medical staff. This does not mean that a physician cannot be paid more for increased productivity or for additional services. But, the physician's compensation cannot be directly tied to the hospital's bottom line, allowing the physician to share on an open-ended basis any "profits" or "excess revenues" generated by the hospital.

   There are four ways to approach this and still stay within the bounds of what the IRS would find acceptable. First, incentive compensation can be limited to a real dollar amount. Second, the cap can be expressed as a percentage of the physician's base salary. In either case, the total available compensation (base + incentive) must fall within the "reasonableness" parameters discussed above.

   A different alternative which should pass regulatory muster would be to pay incentive compensation pursuant to a formula directly tied to productivity. So long as the amount paid per unit of productivity can be documented as reasonable, the total payment will be acceptable to the IRS, even if the total amount received exceeds the base amounts in third-party surveys. For example, total salary and bonus payments could be limited to an amount equal to
1. the 90th percentile of compensation for physicians in the specialty in question in the Physician Compensation and Production Survey published by Medical Group Management Association (MGMA), or other reliable third-party compensation survey, divided by

2. the 90th percentile of total RBRVS units for physicians in the specialty in question as published in the MGMA (or other reliable third-party compensation survey), multiplied by

3. the total number of RBRVS units actually performed by the physician in question during the period.

(The RBRVS units form the basis for Medicare's physician compensation system and are universally used to record services performed by physicians in all specialties. Thus, they are the most reliable unit to measure relative physician productivity.)

By allowing the salary cap to vary based on the number of units of service performed by the physician, physicians who are very productive will not be disadvantaged by a static salary cap that arbitrarily limits their compensation without reference to personal productivity. On the other hand, the actual amount paid to the physician for services performed will still, by definition, be reasonable, since it will always be benchmarked against an amount per unit of productivity supported by reliable independent third-party surveys.

To see how this formula would work, assume that an internist performed 8,500 RBRVS units of service in a given year. The 90th percentile of compensation for internists in the 1998 MGMA survey is $205,087. The 90th percentile for RBRVS units is 7,704. The maximum amount of compensation that this physician could earn in a year (salary plus bonus) would be $226,227, that is: $205,087 ÷ 7,704 x 8,500. Even though this amount is greater than the 90th percentile listed in the MGMA, it is still reasonable since it was the result of the physician being busier than most other physicians.

The IRS has also recently given its blessing to compensation formulae that are expressed as a percentage of net revenue generated by the physician for professional services, without a cap, so long as the percentage deducted for overhead expenses can be defended as reasonable.

An example of how this would work, using the 1998 MGMA Survey data, is as follows: The survey indicates that the 90th percentile of compensation to gross charges in Internal Medicine was 67%. Thus, if this limitation methodology were applied, the overhead percentage that would be applied to an internist's gross charges in order to calculate compensation due during a given period would have to be at least equal 33%. By way of further illustration, assume that a physician's charges in a given year equaled $300,000. If the physician's compensation was based on productivity, the lowest overhead percentage that could be used would be 33%. The most the physician could earn would be $200,000. This would still be in line with amounts reflected in published surveys.

**4. Don't Discourage Indigent Care.**

If a charitable, tax-exempt hospital or one of its affiliates is involved, physician-employees should be required to provide services to anyone regardless of their insurance status or ability to pay. The physician should also be required to participate in Medicare, Medicaid and any other third-party reimbursement program covering a significant number of patients in the service area. Moreover, a Continuing Professional Education publication by the IRS in September 1999 went even further. It suggested that physician incentive compensation should not provide the physician with a disincentive to provide charity care. For instance, if the incentive compensation formula is based in whole or in part on a percentage of the
physician's collections, a factor should be added to the base against which the percentage is calculated to reflect a reasonable bad debt/charity care allowance. Although this would result in the physician receiving more money, and thus seem counter-intuitive to the other rules discussed above, it will discourage physicians from favoring patients with more lucrative insurance coverage when scheduling.

5. Make Sure Patient Satisfaction and Quality Indicators Are Taken into Account Too.

The IRS CPE text mentioned above strongly recommends that physician incentive compensation be tied to patient satisfaction and quality of care benchmarks as well as financial indicators. This makes sense not only from a tax exemption standpoint, but to minimize malpractice liability as well. If physicians "eat what they kill" without any incentive to provide better quality care, they and their hospital employers will eventually be consumed by a more ferocious breed of shark known as plaintiff's attorneys, who will easily convince a jury that treatment decisions which went awry were based on financial motives rather than what was in the patient's best interest. In fact, such a catch would be so easy, it could hardly be said to be sporting.

6. The Incentive Must Fit Within the Stark Law

In order for productivity incentives to work, they must also fit within an exception to the Stark Law's prohibition against physicians referring patients for "designated health services" to entities with which the physician has a financial relationship. There are three ways to accomplish this.

(a) The Productivity Payment Does Not Take Referrals Into Account

As long as the physician's compensation does not take into account the volume or value of referrals from the physician to the employer, it will fit within the Stark exception for "bona fide employment relationships" set forth at 42 C.F.R. §411.357(c). Thus, incentive compensation paid based on the achievement of quality or community service objectives that are not volume driven would not violate Stark.

(b) The Physician is Paid for "Personally Performed" Services

The Stark employment exception also allows employed physicians to be paid productivity bonuses for services that they or an immediate family member "personally perform." §411.357 (c)(4). If a physician personally performs a service, there is no referral covered by Stark, even if the service in question was a designated health service. However, distribution of technical component revenue generated by a designated health service personally performed by a physician can only be distributed within a group practice, pursuant to the rules set forth below.

(c) The Physician is Part of a "Group Practice"

The Stark regulations provide maximum flexibility with respect to productivity bonuses to physicians who are part of "group practices." To take advantage of this flexibility, the entity through which the physician practices has to (i) meet the definition of a "group practice" under Stark; (ii) comply with the rules governing distribution of revenues derived from designated health services; and (iii) keep detailed records of any such distribution.

(i) Group Practice Definition

To be a "group practice" for the purposes of the Stark Law, a practice entity must meet all of the following criteria. It is important to note that in the Preamble to the Phase II Stark regulations issued on March 26, 2004, CMS made it very clear that physicians employed by a hospital would not be considered to be part of a group practice. It is therefore necessary to move any such physicians into the employ of a non-hospital
entity that meets the group practice definition if any part of their compensation is derived from designated health services that they do not personally perform.

(a) Single legal entity. The group practice must consist of a single legal entity operating primarily for the purpose of being a physician group practice in any organizational form recognized by the State in which the group practice achieves its legal status, including, but not limited to, a partnership, professional corporation, limited liability company, foundation, not-for-profit corporation, faculty practice plan, or similar association. The single legal entity may be organized by any party or parties, including, but not limited to, physicians, health care facilities, or other persons or entities (including, but not limited to, physicians individually incorporated as professional corporations). The single legal entity may be organized or owned (in whole or in part) by another medical practice, provided that the other medical practice is not an operating physician practice (and regardless of whether the medical practice meets the conditions for a group practice under this section). For purposes of this subpart, a single legal entity does not include informal affiliations of physicians formed substantially to share profits from referrals, or separate group practices under common ownership or control through a physician practice management company, hospital, health system, or other entity or organization. A group practice that is otherwise a single legal entity may itself own subsidiary entities. A group practice operating in more than one State will be considered to be a single legal entity notwithstanding that it is composed of multiple legal entities, provided that —

(1) The States in which the group practice is operating are contiguous (although each State need not be contiguous to every other State);

(2) The legal entities are absolutely identical as to ownership, governance, and operation; and

(3) Organization of the group practice into multiple entities is necessary to comply with jurisdictional licensing laws of the States in which the group practice operates.

(b) Physicians. The group practice must have at least two physicians who are members of the group (whether employees or direct or indirect owners), as defined in §411.351.

(c) Range of care. Each physician who is a member of the group, as defined in §411.351, must furnish substantially the full range of patient care services that the physician routinely furnishes, including medical care, consultation, diagnosis, and treatment, through the joint use of shared office space, facilities, equipment, and personnel.

(d) Services furnished by group practice members. (1) Except as otherwise provided in paragraphs (d)(3), (d)(4), (d)(5), and (d)(6) of this section, substantially all of the patient care services of the physicians who are members of the group (that is, at least 75 percent of the total patient care services of the group practice members) must be furnished through the group and billed under a billing number assigned to the group, and the amounts received must be treated as receipts of the group. "Patient care services" must be measured by one of the following:

(i) The total time each member spends on patient care services documented by any reasonable means (including, but not limited to, time cards, appointment schedules, or personal diaries). (For example, if a physician practices 40 hours a week and spends 30 hours a week on patient care services for a group practice, the physician has spent 75 percent of his or her time providing patient care services for the group.)
(ii) Any alternative measure that is reasonable, fixed in advance of the performance of the services being measured, uniformly applied over time, verifiable, and documented.

(2) The data used to calculate compliance with this "substantially all test" and related supportive documentation must be made available to the Secretary upon request.

(3) The "substantially all test" set forth in paragraph (d)(1) of this section does not apply to any group practice that is located solely in an HPSA, as defined in §411.351.

(4) For a group practice located outside of an HPSA (as defined in §411.351), any time spent by a group practice member providing services in an HPSA should not be used to calculate whether the group has met the "substantially all test," regardless of whether the member's time in the HPSA is spent in a group practice, clinic, or office setting.

(5) During the "start up" period (not to exceed 12 months) that begins on the date of the initial formation of a new group practice, a group practice must make a reasonable, good faith effort to ensure that the group practice complies with the "substantially all" test requirement set forth in paragraph (d)(1) of this section as soon as practicable, but no later than 12 months from the date of the initial formation of the group practice. This paragraph (d)(5) does not apply when an existing group practice admits a new member or reorganizes.

(6)(i) If the addition to an existing group practice of a new member who would be considered to have relocated his or her practice under §411.457(e)(2) would result in the existing group practice not meeting the "substantially all" test set forth in paragraph (d)(1) of this section, the group practice will have 12 months following the addition of the new member to come back into full compliance, provided that —

(A) For the 12-month period the group practice is fully compliant with the "substantially all" test if the new member is not counted as a member of the group for purposes of §411.352; and

(B) The new member's employment with, or ownership interest in, the group practice is documented in writing no later than the beginning of his or her new employment, ownership, or investment.

(ii) This paragraph (d)(6) does not apply when an existing group practice reorganizes or admits a new member who is not relocating his or her practice.

(e) Distribution of expenses and income. The overhead expenses of, and income from, the practice must be distributed according to methods that are determined before the receipt of payment for the services giving rise to the overhead expense or producing the income. Nothing in this section prevents a group practice from adjusting its compensation methodology prospectively, subject to restrictions on the distribution of revenue from DHS under §411.352(i).

(f) Unified business. (1) The group practice must be a unified business having at least the following features:

(i) Centralized decision-making by a body representative of the group practice that maintains effective control over the group's assets and liabilities (including, but not limited to, budgets, compensation, and salaries); and

(ii) Consolidated billing, accounting, and financial reporting.
(2) Location and specialty-based compensation practices are permitted with respect to revenues derived from services that are not DHS and may be permitted with respect to revenues derived from DHS under §411.352(i).

(g) **Volume or value of referrals.** No physician who is a member of the group practice directly or indirectly receives compensation based on the volume or value of referrals by the physician, except as provided in §411.352(i).

(h) **Physician-patient encounters.** Members of the group must personally conduct no less than 75 percent of the physician-patient encounters of the group practice.

(ii) **Permissible Ways to Divide DHS Revenue**

Physicians who are members of a group practice meeting the above definition may be paid a bonus that reflects the overall revenue of the group, including revenue from designated health services, if the following rules are complied with:

(i) **Special rule for productivity bonuses and profit shares.** (1) A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services that he or she has personally performed (including services "incident to" those personally performed services as defined in §411.351), provided that the share or bonus is not determined in any manner that is directly related to the volume or value of referrals of DHS by the physician.

(2) Overall profits means the group's entire profits derived from DHS payable by Medicare or Medicaid or the profits derived from DHS payable by Medicare or Medicaid of any component of the group practice that consists of at least five physicians. Overall profits should be divided in a reasonable and verifiable manner that is not directly related to the volume or value of the physician's referrals of DHS. The share of overall profits will be deemed not to relate directly to the volume or value of referrals of DHS if one of the following conditions is met:

(i) The group's profits are divided per capita (for example, per member of the group or per physician in the group).

(ii) Revenues derived from DHS are distributed based on the distribution of the group practice's revenues attributed to services that are not DHS payable by any Federal health care program or private payer.

(iii) Revenues derived from DHS constitute less than 5 percent of the group practice's total revenues, and the allocated portion of those revenues to each physician in the group practice constitutes 5 percent or less of his or her total compensation from the group.

(3) A productivity bonus should be calculated in a reasonable and verifiable manner that is not directly related to the volume or value of the physician's referrals of DHS. A productivity bonus will be deemed not to relate directly to the volume or value of referrals of DHS if one of the following conditions is met:

(i) The bonus is based on the physician's total patient encounters or relative value units (RVUs). (The methodology for establishing RVUs is set forth in §414.22 of this chapter.)

(ii) The bonus is based on the allocation of the physician's compensation attributable to services that are not DHS payable by any Federal health care program or private payer.
(iii) Revenues derived from DHS are less than 5 percent of the group practice's total revenues, and the allocated portion of those revenues to each physician in the group practice constitutes 5 percent or less of his or her total compensation from the group practice.

(iii) Record Keeping Rules

Group practices wishing to take advantage of the productivity bonuses described above must maintain supporting documentation verifying the method used to calculate the profit share or productivity bonus and the resulting amount paid, and make this documentation available to HHS upon request.