At Presstime
Medicare Proposes New Rules
The Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule that would require most Medicare-participating providers and suppliers to give Medicare beneficiaries written notice about their right to contact a Medicare quality improvement organization (QIO) with concerns about the quality of care they receive under the Medicare program.

Under current rules, only beneficiaries admitted to hospitals as inpatients are required to receive information about contacting their state QIO regarding quality of care issues. CMS’s proposed rule would require that in order to participate in the Medicare program, providers and suppliers would need to inform beneficiaries of their right to complain to a QIO about quality of care, as well as how to contact their local QIO.

In all, the following care settings are impacted by this proposal: clinics, rehabilitation agencies, and public health agencies that provide outpatient physical therapy and speech-language-pathology services; comprehensive outpatient rehabilitation facilities; critical access hospitals; home health agencies; hospices; hospitals; long-term care facilities; ambulatory surgical centers; portable x-ray services; and rural health clinics and federally qualified health centers.

Taking Control of the CMS Managed Care Audit Process

Rita Isnar

The creation of the Medicare Parts C & D programs require managed care organizations to develop and implement effective compliance programs. There are a number of criteria that organizations must consider in ensuring that their compliance programs are effective:

• the seven elements of an effective compliance program as set forth by the Department of Health and Human Services (HHS) Office of Inspector General (OIG);
• the requirements outlined in the United States Sentencing Commission’s Sentencing Guidelines; and
• the requirements outlined by the Centers for Medicare & Medicaid Services (CMS), including 42 CFR §422.503(b)(vi), 42 CFR §423.504(b)(4)(vi), and Chapter 9 of the CMS Prescription

Employees Value Wellness Programs, but Opportunities Exist for Employers to Do Even More

There is an old adage that says, “A happy employee is a healthy employee.” In recent years, it seems that adage has been expanded to include, “A happy (and healthy) employee is also a productive employee.” Employers know this all too well, which is why an increasing number are placing greater emphasis on health and wellness programs in the workplace. Have these efforts, however, resonated with employees?

A recent survey conducted by OptumHealth and GfK Roper Public Affairs and Corporate Communications examines the
National Briefs

Even with Coverage, Vulnerable Seniors Still More Likely to End Up in ER: Despite having insurance coverage through Medicare, dual eligible patients are twice as likely to end up in the emergency room than Medicare-only patients, according to new analysis conducted by Avalere Health LLC for The SCAN Foundation. Dual eligibles with five or more chronic conditions spent $54,199 Medicare dollars while Medicare-only beneficiaries with the same number of chronic conditions spent $38,675 Medicare dollars per capita in 2008. They are among the sickest and costliest patients in the system; they are more costly than Medicare-only beneficiaries and are more likely to use health services across a number of provider settings.

HealthMedia Creates Specialized Health Coaching Program: HealthMedia, Inc. has contracted with the Hazelden Foundation to customize a digital health coaching program, originally developed for Hazelden’s Addiction Treatment patients, to be provided to the U.S. Navy. HealthMedia® had already been offering its digital health coaching programs as part of Hazelden’s comprehensive MORE® (My Ongoing Recovery Experience) program. The new program, called Navy MORE, will be offered through the Department of Navy Substance Abuse and Rehabilitation Services and is part of a comprehensive effort to support military personnel, family members, and retirees in their long-term recovery from substance abuse and related behavioral health issues.

Routine Osteoporosis Screening Recommended for Women over 65: The U.S. Preventive Services Task Force (USPSTF) now recommends that all women ages 65 and older be routinely screened for osteoporosis. This is the first final recommendation statement to be published since the USPSTF implemented a new process in July 2010 in which all of its draft recommendation statements are posted for public comment on the USPSTF Web site prior to being issued in final form. The USPSTF also recommends that younger women with increased risk factors for osteoporosis be screened if their fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.

Study Finds MRSA Screening Saves Hospitals Money: Screening patients in the intensive care unit (ICU) for methicillin-resistant Staphylococcus aureus (MRSA) produces cost savings for the whole hospital, according to a recent study. Conducted by a team of researchers at the Minneapolis Veterans Affairs Medical Center, the study found that even under the most conservative assumptions the screening would be cost-neutral if early detection of MRSA would lead to a reduced rate of infection and transmission within the hospital. Under optimal assumptions, screening could result in savings of almost $500 per hospital admission.

**Why Worry?**
For years, the OIG and, more recently, the U.S. Government Accountability Office (GAO) repeatedly have identified significant gaps in both CMS enforcement of these standards and the industry’s noncompliance with applicable requirements outlined above. CMS generally has agreed with these findings but cited budgetary constraints and limited resources as reasons for not pursuing industry audits and enforcement.

In 2010, CMS commenced conducting audits of managed care plans, including a number of compliance areas. These audits were conducted by Medicare drug integrity contractors (MEDICs). The results of audits conducted by MEDICs were significant. In fact, these audits led to a number of terminations and sanctions against audited plans. Given the results found in 2010, CMS has stated that the same or similar results will continue in 2011. Therefore, managed care organizations are well advised to prepare for the real possibility of being audited by CMS in 2011.

**How to Prepare?**
There are a number of criteria that CMS considers in conducting these audits. As previously published in the February 15, 2011 issue of Managed Care Outlook, James Cottos’ article “Are You Prepared to Pass a CMS Managed Care Audit?” indicates that “the audits focused on whether the plans developed a comprehensive standalone fraud, waste, and abuse compliance program that included CMS’s core requirements.” The following summarizes the core compliance areas published by CMS that have been the subject of the audits:

- Registration/Enrollment and Premium Billing
- Marketing/Agent Broker
- Appeals and Grievances
- Part D Formulary Administration
- Compliance Plans/Programs

As a result, managed care organizations must be prepared to evidence that their programs are designed to effectively comply with applicable standards with the objective of protecting the integrity of Medicare funds by preventing fraud, waste, and abuse. Organizations will have only days to submit a document response to CMS once an engagement letter has been sent to the managed care organization by the MEDIC. Therefore, not only must the managed care organization have documentation well organized and ready to submit to the MEDIC at any given time, but it also must have an established strategy in place.

First, it is strongly recommended that managed care organizations conduct a review, either internally or by engaging a third party, to review all compliance areas listed above. This will enable your organization to identify any gaps in compliance or operations.

Second, once gaps are identified, immediately start the remediation process. Develop policies and procedures; implement training as soon as practicable. While engaging in the remediation process, ensure that your efforts are adequately evidenced.

Third, commence risk assessment and auditing and monitoring activities to ensure that remediation efforts have been implemented appropriately. Lastly, while engaging in the above noted activities to prepare for a CMS audit, your organization should concurrently prepare a package and presentation for the MEDIC. Managed care organizations will have an opportunity at the beginning of the site visit to “present” — use that opportunity to:

- clearly describe the overall organizational structure;
- identify who within the organization is responsible for various activities and how your organization effectively addresses each

(See Taking Control of the CMS… page 5)
CDPHP® Launches New Effort to Combat Childhood Obesity: In a continued effort to develop programs and services that address the growing problem of childhood obesity, CDPHP® has announced a collaboration with the Alliance for a Healthier Generation’s Alliance Healthcare Initiative to provide comprehensive health benefits for the prevention, assessment, and treatment of childhood obesity. The new collaboration will better enable CDPHP families to work with their primary care physicians (PCPs) and registered dietitians to ensure their children achieve lifelong health.

Blue Cross Embeds Weight Coaching into Stop-Smoking Support Program: Smokers who resolved to quit in 2011 but were worried about the side effect of weight gain now have more support to succeed. Blue Cross and Blue Shield of Minnesota has added a new weight maintenance coaching feature at no additional cost to members who use its Stop-Smoking Support program. Blue Cross is offering members who participate in the Stop-Smoking Support program up to three optional coaching calls with a weight coach to address their weight gain concerns as they quit tobacco.

BCBS of Tenn. Rolls Out New Technology: As part of its patient-centered medical home strategy, BlueCross BlueShield of Tennessee is partnering with local health care provider groups and hospitals to roll out technology designed to positively impact the quality of patient care once that person leaves the hospital. Holston Medical Group in Kingsport is the first to incorporate Smart Transitions from Performance Clinical Systems in its hospital discharge workflows. Performance Clinical’s Smart Transitions is a “cloud-based” interactive clinical checklist system, accessible anywhere through a secure Internet connection, which provides active guidance for clinicians to consider as they make their patient discharge plans. The system makes those plans instantly available via a computer to primary care physicians for proactive follow up with their patients. All steps are captured electronically in a database for ongoing analysis to support quality and performance improvement goals.

Physician House Calls Make Return to Seattle Area: When a physician’s office is closed or an urgent care facility is not available, many people in need of non-emergency medical care turn to the emergency room of the closest hospital. There they may face long waits while life-threatening conditions take precedence. Premera Blue Cross is continuing to reduce unneeded ER visits with the launch of The Premera Home Visit Program, one component of a strategic approach to improve service and improve health care affordability. The Home Visit Program — in addition to Premera’s 24-Hour NurseLine and the increased visibility of urgent care facilities in members’ local neighborhoods — is another option now available to qualified Premera members.

Health Net, Sutter Health Expand Network Selection in Sacramento Area: Health Net of California, Inc. and Sutter Health have created a new health maintenance organization (HMO) network providing lower-cost premiums for employers when their employees access medical care nearly exclusively through the Sutter Health system of hospitals, primary care physicians, and specialists. The PremierCare HMO network is available to Health Net members living or working in Sacramento, Solano, Yolo, and parts of Placer and El Dorado counties whose health care coverage is through employers with more than 50 employees. In El Dorado County, medical services are provided through Health Net’s direct network of HMO physicians and Marshall Hospital in Placerville.
Taking Control of the CMS …
(from p. 3)

of the seven elements of the compliance program;
• identify any established executive-level compliance committees, their objectives, how frequently they meet, and their accomplishments; and
• describe who and how each of the compliance areas described above are handled by the organization; identify examples of auditing and monitoring that you have conducted within these areas, such as an audit work plan with the approval of legal counsel.

This is your limited opportunity to take control of the audit process. Consider developing a PowerPoint presentation to keep auditors focused and engaged. Further, we strongly recommend that auditors are furnished the following information either as part of your document request response or during the site visit:

1. General background information on your organization — for example:
   • size;
   • number of lives covered;
   • number of employees, products, and services provided;
   • history of the organization; and
   • background information on executive-level team, including resumes.

2. Oversight and management:
   • Board of directors composition/membership, bylaws, charter, and meeting minutes evidencing board actions in relation to compliance — If the board has a board audit subcommittee, provide the same information for the subcommittee.
   • Formal position descriptions and resumes for the chief compliance officer (CCO) and key compliance personnel.
   • Organizational chart, compliance organizational chart, and operational organizational chart — This should include detailed legend or description of each department’s responsibilities. The organizational chart also should indicate the reporting relationship between the CCO and the chief executive officer (CEO) and the board.
   • Copies of reports and presentations, made to the board and its subcommittees by the CCO.
   • A document depicting key working committees (e.g., special investigations units, et cetera) and the reporting structure of these committees also should be furnished. This organizational chart should be accompanied with the charter for each working committee, membership, meeting minutes, and overall description of how they interrelate if there is more than one committee to prevent fraud, waste, and abuse.
   • Consider providing an example of your organization’s compliance program budgets.

3. Written compliance guidance:
   • A list and copies of compliance policies and procedures related to the infrastructure of the compliance program.
   • All applicable operational policies and procedures.
   • Code of conduct and evidence of how the code is distributed to all affected parties.
   • Employee handbook.

4. Education and training:
   • Copies of both specialized and general training curriculum.
   • Evidence of how training is tracked.
   • Examples of new hire training.

5. Effective lines of communication:
   • Evidence of how your organization publicizes the code of conduct, hotline, and compliance program throughout the organization.
   • Hotline operations manual or policies and procedures.
   • Methodology and evidence used to track compliance issues to resolution.
   • Sample hotline call or complaint form.

6. Enforcement of written standards:
   • Employment application form.
   • Annual employee appraisal form.
   • Disciplinary or corrective action standards and enforcement process.
   • Sanction screening process and evidencing related to employees, contractors, and vendors.
   • Process related to background investigations.
7. Auditing and monitoring:
   • Compliance audit work plans.
   • Information on monitoring activities related to each of the operational areas provided in policy and procedure section above.
   • Risk assessment process and results (consider consulting with counsel if providing audit result reports).

8. Response to detected offenses and corrective action:
   • Evidence of voluntary disclosures, if any, made to government agencies or entities.

This information should be clearly organized and tabbed for auditors. Further, your compliance staff should be prepared to answer specific questions about each of the operational areas listed above (see items 1 through 6) and answer questions about auditing and monitoring activities conducted by the compliance program in relation to these compliance areas.

Remember, the harder an auditor has to work to understand who you are and what you are doing, the less likely it is that they will develop a positive impression of your organization.

Endnotes:

Rita Isnar, JD, MPA, is senior vice president for Strategic Management, LLC. She spends much of her time managing and conducting IRO engagements for the firm’s clients. Her clients include a variety of health care entities including health systems, hospitals, pharmacies, pharmaceuticals, managed care organizations, and other entities. She frequently speaks on topics of health care fraud, compliance, and quality. She can be reached at 315/252-4615 or by email at risnar@strategicm.com.

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Employees Value …
(from p. 1)

role of health and wellness programs in the workplace from the employee perspective and explores how health-focused companies can reinforce employee loyalty through these programs. Interestingly, the survey reveals that employees, in general, are supportive of employers encouraging healthful behaviors at work; nevertheless, a sizable gap remains between which wellness programs employers offer and which programs employees believe are actually available.

“The research shows that companies that deploy health and wellness programs and take the approach of building an overall culture of health have a stronger commitment to those values,” explains Laura Karkula, vice president of Wellness Products at OptumHealth. “They make it part of the thread of their environment, and that leads to greater employee loyalty, according to our research, which shows that 82 percent of employees working at companies that place importance on employee health say health and wellness programs would encourage them to stay longer at the company.”

Despite a growing number of employers offering health and wellness programs, a noticeable gap remains between what the employer offers and what the employee thinks is offered. In addition to this survey, which focuses more on the employees’ perspective, OptumHealth and Gilmore Research Group conducted a survey last year aimed more at the employers’ perspective. In that survey, 66 percent of large companies said they offer a health risk assessment; in the survey just conducted, however, only 14 percent of employees at those large companies said they were offered health risk assessments. (See Figure 1) A comparison of these two surveys shows the divide between the employers’ perspective and the employees’ perspective.

“We have to figure out a way to take more of the principles of not just health promotion but truly health marketing into the workplace and
into the lives of our employees,” says Karkula. “Those of us in the health care industry understand the jargon and the acronyms. We know what a disease management program is or an EAP or a health risk assessment, but do the employees have the same understanding? As we see more and more employers working to engage employees at the employee level in a way that is relevant and tangible to them, we will see some of that gap begin to shrink.”

It is more than just health marketing, however, says Karkula. Even if individuals understand that they have a health and wellness program available to them, do they know how to access that benefit, because that is critical to success.

“The Holy Grail for a lot of us in this industry is, how do we create a less sizable gap? Because employers are paying for those programs, they have a lot at stake. They can also drive so much more value through their populations — not only in terms of the traditional measures (i.e., through medical cost reductions or productivity savings) but also in terms of loyalty and engagement,” stresses Karkula.

The important thing to remember is that there is no one-size-fits-all approach, says Karkula. Employers have to assess their existing culture and look at how other benefit designs have been delivered to see what works for their specific employee population.

Generally speaking, employees are okay with employers encouraging them to take steps to be healthy. According to the survey, 87 percent believe it is appropriate for employers to do so. More than eight in 10 (84 percent) believe that workplace programs show an employer cares about its employees and would increase productivity (73 percent).

The survey also shows that employees believe strongly in linking insurance premium reductions
to participation in wellness programs. In fact, over half of those surveyed said that premium reductions would increase their participation rate in wellness programs. The one caveat to that, however, says Karkula, is employee choice. Allowing employees to choose which aspects of the program they want to participate in helps minimize any angst in the population related to this type of incentive approach.

“The general population understands that they can benefit from living a healthy lifestyle,” notes Karkula, “and they want the tools and the resources to help them do that. You have to give them the opportunity, however, to make their own choices. Some employers have begun deploying more of a points-based approach to premium reductions. This is one way to give employees that choice.”

Interestingly enough, the survey shows that only about one-third of employed respondents feel they have a lot of control over maintaining a healthy lifestyle while at work (36 percent). When asked what barriers stand in the way of maintaining a healthier lifestyle at work, almost half of the employed respondents say the top obstacle is that they have too little time (46 percent). More than one-third say that they have too much stress at work (36 percent), and four in 10 (41 percent) say that a lack of discipline on their part is a top challenge. (See Figure 2)

“One of the positive things that came out of this broader survey we did with Roper is that individuals do believe that health is primarily determined by lifestyle choice and not genes,” says Karkula. “That is a shift we have seen in our industry in the last few years in particular. People were quick to point to their parents or grandparents or some other factor outside of their own lifestyle choices in the past, but we see that changing. Seventy percent responded that lifestyle choices were the drivers of their health status. I think people do feel that they have a role and a personal responsibility; the tricky part is helping them change their behaviors, which we all know can be difficult.”

![Figure 2: Stress, Time-Pressure, and Temptations Are Challenges to Employees](image-url)
As an industry, all stakeholders must continue to look for ways to focus on the tangible value of health and wellness, continues Karkula. “Employers have a lot of complexities to manage when it comes to the health of their employees, but they are not alone. Health plans can join them in this effort, by a) continuing to support the employer on how to maximize the use of these programs, b) continuing to support the employer in strategies to drive this health marketing approach, and c) connecting with consumers at multiple touch points.”

**Accountable Care Organizations: A Look at the Risks and Opportunities for What Lies Ahead**

Even though the regulations governing accountable care organizations (ACOs) are still a work in progress, providers and payers would be wise to begin their journey of understanding not only the risks but also the opportunities inherent with ACOs in the coming years. KPMG Healthcare recently issued a report, *The Evolution of Accountable Care: Accelerating the Transformation of U.S. Healthcare*, that focuses on many of these risks and opportunities. In this article, KPMG Partner and Healthcare Advisory Leader Brad Benton provides additional insight on the topic.

“In the United States today, we have a striking mandate within the context of our health care system to figure out how to do more with less,” notes Benton. “When you look at the growth of health care spend in terms of gross domestic product (GDP), you can see why we are tasked with this mandate. Currently, health care spend is rising above 17 percent of GDP, which is a real challenge economically. Equally striking is how we compare to the rest of the industrialized world — in terms of unreasonable or unnecessary health care spend as well as more broadly stated quality measures, such as mortality indices, infant mortality, and a number of other data points that would suggest that the quality we get for what we spend is not what it should be.”

Accountable care as an idea provides an opportunity to begin to moderate the growth of those health care expenditures and get more in terms of quality output for every one of those health care dollars spent, stresses Benton. “It gives us the opportunity to get our arms around an issue that some would say is seemingly out of control; at best, it is something that threatens our ability to be globally competitive when you think about our country’s dedication of national resources to health care.”

The difficult part is knowing what will work from one organization to the next, says Benton. There is no one-size-fits-all solution, but with the right kinds of clinical integration, right kinds of care models, and the right kind of oversight, the opportunity to have meaningful impact is achievable.

To date, there are no federal regulations governing ACOs. That leaves the door wide open for interpretation, says Benton. “In the context of health plan thinking, it is up to these plans to figure out what the market is telling them. It requires a very candid self evaluation of not only their relationships with providers but also how those relationships should evolve as the market evolves.”

That includes everything from patient-centered medical home initiatives to health status objectives to clinical integration objectives and “get closer to our members” objectives.

“It is a recognition of what the market is telling you in terms of evolution,” stresses Benton. “It is a transparent and candid review of your own business plan and some of the threats to that business plan and then having an execution plan that flows from that review.”

There are a number of risks inherent in an undertaking of this size and magnitude, says Benton. From a health plan or payer perspective,
the biggest risk is the belief that the status quo is sustainable. The second risk is not quickly obtaining a much deeper understanding of the provider networks — specifically, what the challenges are and how to engage with those providers to help in a collaborative fashion to resolve some of those challenges. The third risk area involves what Benton calls “change leadership.”

“It is remarkable what these health care organizations face as they work to drive a greater level of clinical integration and a greater level of shared alignment, which includes economic alignment as we move from fee-for-service medicine to episodic-based care,” notes Benton. “This may just be the single biggest change management mandate we’ve seen in a quarter of a century. Maybe even since the inception of Medicare. We’ve certainly got our work cut out for us.”

In terms of financial implications, perhaps it is easier to think about the future state of health care and then back up, says Benton. “Right now, we are at something like a $2.5 trillion overall health care spend in this country. There is a lot of good data that says roughly $700 billion of that overall spend is unnecessary, much of which the data would imply is related to overutilization. At the end of the day, it’s the health plans that are on the back end of that overutilization. Doesn’t it make sense that they would welcome opportunities to get higher quality, reduced utilization, and happier members while enjoying a more collaborative relationship with their provider networks?”

In the near term, the financial implications are more investment related, notes Benton. That is because breaking away from the status quo requires investment. How are you going to establish new provider relationships without investment? How can you launch a patient-centered medical home initiative without investment?

There are also a number of important implications from the provider perspective. First, with the fee-for-service model, doctors get paid for treating more sick people. That is the way the U.S. health care system has been built, acknowledges Benton. It is critical to understand, he adds, that the transition for providers from generally being reimbursed on a fee-for-service basis to one that is built on bundled or episodic payments is a dramatic transition. Second is the issue of cost shifting to commercial payers. Medicare and Medicaid generally pay at levels that do not provide for positive operating margins, he continues. The folks who have provided for positive operating margins are the commercial payers, and that dynamic is very important to understand.

**Incentive-Based Physician Compensation Strategies**

*Randal L. Schultz*

Health care reform and reimbursement issues are causing the private sector to create alliances between hospitals and physicians to deliver efficient patient services and to allocate bundled payments and bonus payments tied to shared savings. Many physicians believe they cannot remain in the private practice of medicine due to complicated regulations and diminishing reimbursement. Hospitals are attempting to acquire physician practices as a means of garnering new populations of patients.

To attract the physicians, hospitals are developing ways to reward innovation and productivity. Designing an incentive-based compensation strategy is usually the best way to reward a hard working physician. The design of the incentive-based compensation arrangement will depend upon whether the physician is working for a hospital or for a group practice. If a physician is employed directly by a hospital, the ability of the physician to receive incentive compensation is directly tied to the personal production of that physician. If the physician is employed by a group practice, the physician can be paid not only based upon his or her own personal productivity but also the productivity of the
group practice and the revenue generated from ancillary services.

Based on the foregoing, hospitals are forming subsidiaries that constitute group practices and hire new physician employees through the new subsidiary. As long as the subsidiary is structured as a “group practice” under the federal Stark regulations, the hospital can offer compensation packages that are similar to those offered through a physician’s private group practice.

The key to a successful incentive compensation program is to assign values to the efforts given by the physician that relate to direct patient care, administrative services, teaching obligations (where applicable), and practice development activities. Typically, relative value units (RVUs) are assigned to the specific activities performed by the employee. The wise designer of an incentive-based compensation program carefully evaluates the nature of the physician’s practice and ties the various types of services performed to an RVU value. The designer should create (make up) RVU values for each activity even if some activities are not typically assigned RVU values. Various sources exist to determine the appropriate RVU value to assign to patient-related services.

The federal Stark legislation precludes physicians from being paid on a direct production basis for the “designated health services” that physicians order for their patients. Designated health services are various types of ancillary services reimbursable by Medicare such as x-rays, labs, physical therapy, durable medical equipment, and a variety of other items specifically articulated in the federal regulations.

The value of these ancillaries, however, can be indirectly allocated to the physician based upon the percentage of professional services the physician renders as the ratio of professional services rendered by all other physician employees within the physician’s group practice. There are also a number of other techniques that can be used to allocate these ancillary revenues. To the extent the ancillaries are not reimbursable by Medicare, those ancillaries can be allocated on a production basis unless there is some type of state regulatory prohibition or contractual prohibition that would preclude such an allocation.

Physicians also can be paid a bonus relating to the overall profitability of the group practice. Clearly, if every dollar generated by the group practice is specifically allocated to a provider on a production basis, there will be no excess profit to allocate as a bonus. Often, a group practice setting will be designed to generate an unallocated profit so that a discretionary bonus can be made to employees of the group practice who have contributed in ways beyond simply the numbers.

Medical director agreements also have become a fashionable technique for providing physicians additional compensation. Hospitals must pay fair market value for medical director services rendered, and the time specifically incurred by the physician must be carefully documented. Although the government carefully reviews compensation paid through medical director agreements and similar types of management services agreements, such agreements have become widely used for physician compensation strategies.

Physicians also generate revenues through performing expert witness services, speaking engagements, publishing revenues, and honorariums they may receive for other services. Frequently, employers, whether hospitals or group practices, try to include these amounts in the overall physician compensation calculation subject to an aggregate compensation limit. Physicians who engage in these types of activities try to separate them from the overall compensation arrangement so that they can receive all fees directly associated with these activities.

Deferred compensation programs are also a powerful addition to a total compensation package. Deferred compensation programs can be in the form of qualified retirement plans (IRC § 401(a) and 403(b)) as well as other types of nonqualified deferred compensation arrangements that kick in upon separation from service with the employer. Although all of these deferred
Compensation arrangements are beyond the scope of this article, they are just as important as the underlying compensation arrangement.

Compensation strategies cannot simply define the revenue side of compensation formulas. What kind of expenses will be deducted from the revenues under a production-based formula? To the extent various expenses can be excluded from the formula, the more money will be available for physician compensation. For example, do any employee benefits costs reduce the revenue side of the production formula? What about direct expenses such as malpractice insurance, continuing medical education activities, and various fees associated with licenses and association dues? The actual development of a fully integrated production-based compensation formula can become very complicated.

Finally, multiple issues associated with the overall employment agreement can impact the ultimate compensation formula. Is there an automatic cost of living adjustment placed into the agreement; is there a cap on various types of expenses allocated to the production formula; will expanding the geographic scope of the practice or the specialties associated with the practice impact the compensation formula? Is there a value assigned to an exclusive right to provide a certain type of service for the hospital or the first opportunity to provide services at a new location developed by or for the group practice?

There are a number of issues that must be carefully evaluated when designing an incentive-based compensation strategy. This article provides only a taste of those issues. Understanding the basic legal framework that maximizes the flexibility in designing the compensation program as well as understanding limitations imposed by federal and state law are critical to creating the most beneficial compensation arrangement.

Randal L. Schultz, Esq., is the vice chair of Polsinelli Shughart’s national Health Care Law practice group. He can be reached at rschultz@polsinelli.com.