HealthLeaders Media
A Division of hcPro

Physician Compensation Report

September 2007
Vol. 8 No. 9

INSIDE

A *HealthLeaders* Media publication

Proposed Stark changes may limit entrepreneurship

The Stark self-referral law is arguably one the most important federal regulations when it comes to physician compensation, and proposed changes attached to the 2008 Medicare Physician Fee Schedule may make complying with the regulation a little more difficult.

The third phase in the final Stark ruling—known as Stark II, Phase III—was originally scheduled to be released March 26, but CMS extended the timetable for the final release by one year, and it is now due in the spring of 2008. However, the agency has included some major revisions in the latest fee schedule that, if passed, would go into effect just a few months before the final ruling.

The major areas of Stark that CMS is either proposing to change or seeking feedback about include:

» **The anti-markup rule.** The changes related to the anti-markup provision are directed at pod laboratories and other diagnostic tests performed by outside suppliers and billed to Medicare by a different entity, says **David Harlow,** principal at The Harlow Group, LLC, a healthcare law and consulting firm based in Newton, MA. CMS currently prohibits the markup of the technical component for certain diagnostic tests performed in these scenarios, and the new proposal would expand that limitation to the professional component as well. "It's really sort of tightening things up and not something radically new," Harlow says. "These rules have been in place for a while, and this is the next stage of evolution of this particular rule."

The proposal would also require groups to include equipment and fees in the net charge for a service, meaning the entity performing the service will also handle billing. Currently, a physician group can perform the technical component of a radiology test and purchase the professional component from an interpretive radiology group. "If the proposal goes through, [the physician group] would no longer by able to profit from the purchase of that professional component," says **Robert A. Wade, Esq.,** a partner with Baker and Daniels, LLP, in South Bend, IN.

> "This is the sort of thing that makes physicians throw up their hands. It is yet another factor that would lead many physicians to lean more toward work as an employee rather than as an entrepreneur."
>
> —*David Harlow*

» **In-office ancillary services exception.** CMS hasn't proposed specific changes to the in-office ancillary exception—the safe harbor that allows practices to set up ancillary service lines—but is seeking feedback and will likely make changes to the exception when the Stark II, Phase III ruling is released. CMS is soliciting feedback about the following:

– *Whether certain services should be excluded from the in-office ancillary services exception.* CMS is investigating whether it should limit the types of services that are protected by the exception. The proposal specifically singles out therapy services not

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Stark changes

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provided on an incident-to basis, services "not needed at the time of service to assist the physician in his or her diagnosis," and complex laboratory services.

"Right now it's a very broad application; it can apply to basically any medical procedure. Now they want to see whether or not there should be exceptions to the exception," says Wade.

– *Whether the definitions of "same building" or "centralized building" should change.* CMS has proposed changing the definition of "centralized building"—a key requirement for a service to qualify for the exception—to require a minimum of 350 square feet.

– *Whether nonspecialist physicians should be able to use the in-office ancillary services exception to refer patients for specialized services involving the use of equipment owned by the nonspecialists.* Under the current law, a 10-physician group consisting of one surgeon and nine internists could share profits equally, Wade says. CMS is questioning whether the surgeon's services are ancillary to the services performed by the internists. If CMS decides to change the current structure, it could severely hinder multispecialty practices, particularly those with primary care doctors, he adds.

If CMS decides to drastically redefine what constitutes an ancillary service or where one can be performed, it may have a significant impact on certain specialties, Harlow says.

"This is a way for physicians to supplement practice incomes and if this opportunity for revenue is going to be cut off or limited significantly, that's pretty serious."

» **Per-click payments.** CMS is looking to tighten restrictions on per-click, or unit-of-service, payments for space and equipment leases in certain situations. For example, arrangements in which a physician leases equipment he or she owns to a hospital and receives a per-click fee each time a patient is referred to the hospital are "inherently susceptible to abuse," according to CMS. Regulators are also concerned about the reverse—when a physician rents equipment from a hospital and financially benefits from the referral arrangements.

The per-click restrictions apply only when the physician group that owns the equipment refers patients to the hospital. The group can still receive per-click compensation when other independent groups use the leased equipment. "The theory here is that the more [patients] the physician group that owns the equipment refers to the hospital, the more volume they'll have and the more they would be paid on a per-click arrangement. The fear is overutilization," says Wade.

» **Percentage-based compensation arrangements.** Prior to the release of Phase II of Stark, there was debate about whether percentage-based compensation arrangements met the Stark requirement for "set in advance" compensation. CMS decided to permit percentage-based compensation, but it is now seeking to limit those arrangements only to professional-services revenue generated directly by the physician, Harlow says.

"It has come to our attention that percentage compensation arrangements are being used for the provision of other services and items, such as equipment and office space that is leased on the basis of a percentage of the revenues raised by the equipment or in the medical office space. We are concerned that percentage compensation arrangements in the context of equipment and office space rentals are potentially abusive," CMS noted in the proposal released in the July 12 *Federal Register.* The restrictions on percentage-based compensation will primarily affect arrangements between physicians and hospitals for services, Wade says.

» **"Stand in the shoes" rule.** When analyzing contracts for Stark applicability and compliance, one entity can "stand in the shoes" of another, creating an indirect financial relationship rather than a direct one. For example, a hospital

would stand in the shoes of a medical foundation that it owns or controls when it contracts a physician to provide services at a clinic owned by the medical foundation and would be deemed to have a direct compensation relationship with the contractor physician.

"We believe that it is necessary to collapse the type of relationship discussed above to safeguard against program abuse by parties who endeavor to avoid the application of the physician self-referral requirements by simply inserting an entity or contract into a chain of financial relationships linking a designated health services (DHS) entity and a referring physician," CMS wrote in the proposal.

CMS is still soliciting comments about how to handle a stand-in-the-shoes approach between various entities, but it is already prepared to finalize a provision that treats physicians as standing in the shoes of their group practice.

» Under arrangements. The elimination of under arrangements, if the proposal goes through, may be the most significant change to Stark in the fee schedule, Wade says. The target is physician-hospital joint ventures that allow physicians performing a service, typically on an outpatient basis, to receive higher reimbursement by contracting with a hospital to bill for the service. For example, a group of orthopedic surgeons can contract with a hospital to bill for services it provides in an ambulatory surgery center (ASC), and because the hospital is submitting the claim, it is reimbursed at a higher rate than if the group received the ASC payment rate.

This has been allowed because the definition of a DHS—the services subject to Stark law—is based on the entity that bills, rather than the one that performs, a service. CMS plans on closing this loophole by expanding the definition to include both entities—the facility that bills as well as the facility that performs a services—in its new definition, making an under arrangement referral a violation of Stark.

What the changes mean

As of now, the changes are only proposed and may be altered when CMS releases the final rule later in the fall. Some of the proposals will be final, but many are "test balloons" CMS is releasing to gauge providers' reactions and gather feedback before releasing the final Phase III ruling, Wade says.

With the fee schedule proposals and the scheduled Phase III clarifications, CMS is headed in the general direction of closing loopholes and tightening the restrictions around self-referrals. The end result, Harlow says, will be fewer income opportunities and bigger headaches for physician entrepreneurs who have to work with the self-referral law.

"This is the sort of thing that makes physicians throw up their hands. It is yet another factor that would lead many physicians to lean more toward work as an employee rather than as an entrepreneur, because the potential benefits of being an entrepreneur are being severely limited," says Harlow.

PCR *sources*

David Harlow, principal, The Harlow Group, LLC, 31 Olde Field Road, Newton, MA 02459, 617/965-9732; *healthblawg.typepad.com.*

Robert Wade, partner, Baker & Daniels, LLP, First Bank Building, Suite 250, 205 West Jefferson Boulevard, South Bend, IN 46601, 574/239-1906; *bob.wade@bakerd.com.*

CRNA compensation rivals some physician salaries

Certified registered nurse anesthetists (CRNA) aren't physicians, but for many facilities they're as valuable as physicians and compensated as highly as some.

CRNAs earned a median compensation of $131,400 in 2005, according to the 2006 *MGMA Physician Compen-sation and Production Survey.* But physician recruiters such as **Marc Bowles, CPC-PRC, CMSR, FMSD,** chief marketing officer of The Delta Companies, have recently seen CRNA salaries in the $250,000 range.

Although this is significantly less than the median of $359,699 earned by anesthesiologists, CRNAs are the highest-paid nonphysician practitioner and in many cases can earn as much as or more than primary care physicians.

The appeal of CRNAs for a facility is straightforward. They perform many of the same anesthesia services as an anesthesiologist but earn a fraction of the compensation. In some markets, this has led RNs and MDs to compete for contracts in ambulatory surgery centers (ASC) or a physician office, for example.

But for the most part, the two groups have a symbiotic relationship, says **Terry C. Wicks, CRNA,** former president of American Association of Nurse Anesthetists and staff CRNA at Catawba Valley Medical Center in Hickory, NC.

It's very common for CRNAs and anesthesiologists to work in the same groups and earn from the same revenue pool, he says. "There's been enough increase in demand that neither group is in a position to feel threatened by the other because there's so much work to do that all of us can't get it all done," he adds.

Anesthesia providers face similar pressures as other practitioners (i.e., aging baby boomers are using more services), but there's also a significant financial component driving the demand.

Anesthesia services are often viewed as a profitable addition for hospitals and other facilities—not only do they provide services for high-paying surgical procedures, but they can also improve OR efficiency and boost bottom lines in other ways.

The demand and profitability is paying off for doctors and RNs alike. Median compensation for anesthesiologists jumped more than it did for any other specialty in 2005, climbing 10.34%, according to the 2006 *MGMA Physician Compensation and Production Survey.*

CRNA compensation has also jumped sharply, though in very specific settings, such as locum tenens positions and rural areas.

Temping is tempting

The proliferation of ASCs, specialty clinics, and other outpatient facilities has spread the work force over a larger area, and combined with an increase in surgeries, this has opened up avenues other than permanent placement for CRNAs and anesthesiologists alike, says **Travis Singleton,** vice president of marketing at Merritt, Hawkins & Associates.

The locum tenens industry has become a major player in the anesthesia services market, he says. Anesthesiologists and CRNAs accounted for one-quarter of locum tenens placements made in 2005 by Staff Care, Inc., a locum tenens search firm associated with Merritt, Hawkins, and Associates. And 60% of CRNAs and 44% of anesthesiologists have worked on a temporary basis, according to an annual survey conducted by LocumTenens.com.

The sometimes higher locum tenens salaries and the rising demand for services have altered the field. More CRNAs are willing to shop around for the right job, whether that involves seeking higher salaries or looking for more work-life balance.

"You see CRNAs move a lot for signing bonuses or move a lot for structured call work," Singleton says. "You can often see a CRNA go out and make a better living and control [his or her] quality of life better as a 'locums' physician."

Rural settings pay more

The highest demand for CRNAs—and subsequently the highest pay—is usually in rural settings, where average compensation approaches $200,000 per year and a CRNA can earn 10% more than his or her urban counterparts.

The average salary in rural areas was $196,194, compared to $170,952 in suburban areas and $170,698 in metropolitan areas, according to the 2007 *CRNA Compensation and Employment Survey* by LocumTenens.com.

CRNA median compensation trends

Compensation survey	2006+	2005+	2004+	% chg 2005–2006	% chg 2004–2005
AMGA Medical Group Compensation and Financial Survey	$140,396	$130,567	$127,262	7.5%	2.6%
Merritt, Hawkins & Associates review of physician and CRNA recruiting incentives (mean data)	$156,000	$150,000	$145,000	4.0%	3.4%
*MGMA Physician Compensation and Production Survey**	$131,400	$127,054	$123,166	3.4%	3.2%
*SCA Physician Compensation and Productivity Survey**	$135,256	$135,200	$124,800	0.0%	8.3%

* Designated as a safe-harbor survey for calculating fair market value under Stark II.
+ Survey results are based on the previous year's data.

Source: Data excerpted from American Medical Group Association, Merritt, Hawkins & Associates, Medical Group Management Association, and Sullivan Cotter & Associates compensation surveys. Reprinted with permission.

Rural CRNA salaries tend to be higher because there are fewer anesthesiologists in rural hospitals and other facilities, and CRNAs often shoulder a large portion of the workload. "CRNAs are the primary anesthesia providers in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100% of the rural hospitals," the AANA says on its Web site.

Although about 80% of CRNAs nationwide practice alongside an anesthesiologist, the remaining 20% typically serve as the sole anesthesia provider, often in a rural setting, working with a surgeon or another physician.

More CRNAs being trained

The CRNA field has seen robust growth in recent years as the providers attempt to keep pace with demand. The number of nurse anesthesia programs across the country has grown from 86 to 106 in the past five years, Wicks says.

The graduation rate has also increased. Five years ago, roughly 800 CRNAs graduated from accredited nurse anesthesia training programs, whereas this year Wicks expects that number to be in the 1,850–2,000 range.

It takes a minimum of seven calendar years, start-to-finish, to become a qualified CRNA. Accredited nurse anesthesia educational programs typically last two or three years and are only available to RNs with a baccalaureate degree and at least one year's experience in an acute-care setting. Anesthesiologists, on the other hand, train for much longer, making it a little easier for CRNAs to increase supply in order to meet the rising demand for anesthesia services.

Wicks says the AANA has increased the training programs to meet demand for anesthesia services and will continue to do so in the future. "The demand is big and is going to stay strong, but we have taken important steps to address the shortage, he says.

PCR *sources*

Marc Bowles, CPC-PRC, CMSR, FMSD, chief marketing officer, The Delta Companies, Four Hickory Centre, 1755 Wittington Place, Suite 800, Dallas, TX 75234, 800/521-5060; *mbowles@thedeltadifference.com.*

Travis Singleton, vice president of marketing, Merritt, Hawkins & Associates, 5001 Statesman Drive, Irving, TX 75063, 800/876-0500; *www.mhagroup.com.*

Terry C. Wicks, CRNA, former president, American Association of Nurse Anesthetists, staff CRNA, Catawba Valley Medical Center, 810 Fairgrove Church Road SE, Hickory, NC 28602, 828/326-3000; *www.aana.com.*

New wRVU values skew certain compensation plans

by Max Reiboldt, CPA

One of the most popular models hospitals use when employing physicians is an income distribution plan (IDP) based upon work relative value units (wRVU). Even in private groups, wRVUs are a good way to "level the playing field" by helping compare one physician's production to another's.

In most settings, the wRVU model is used primarily to derive compensation in conjunction with a multiplier, also known as a conversion factor. For the model to be successful, the key is to derive a fair and accurate conversion factor. In a private group, wRVUs are also important because of the total value that each wRVU carries, commensurate with its associated CPT code. Compensation is derived by multiplying the CMS-issued wRVU levels with the group-determined conversion factor, so if either of those variables change, it can affect the final compensation amount. CMS recently made such changes to wRVU values, and practices that haven't adjusted their conversion factors may be operating with an inaccurate compensation formula.

New wRVU values

As of January 1, CMS increased the wRVUs associated with several CPT codes. Although overall reimbursement increased for these codes, it did not increase at the same rate as the wRVU values.

The effect of these changes, assuming the conversion factor remains the same, is that the wRVU credit and resultant compensation within many IDPs increased, even if there was no actual additional work performed. Without question, the increase in compensation outpaced the increase in reimbursement, and many compensation plans automatically became "too rich."

The most significant changes were assigned to the E/M codes frequently used by primary care physicians. (See the table below for more information.)

Some of these codes changed dramatically. For example, 99213, the code for an office/outpatient visit with an established patient, increased 37.31% in its wRVU value. Total RVUs—which are comprised of wRVUs as well as practice expense and malpractice RVU calculations—increased as

Changes to wRVUs for E/M codes

CPT code	Description	wRVU		wRVU change	% change
		2006	2007		
99201	Office/outpatient visit, new	0.45	0.45	0.00	0
99202	Office/outpatient visit, new	0.88	0.88	0.00	0
99203	Office/outpatient visit, new	1.34	1.34	0.00	0
99204	Office/outpatient visit, new	2.00	2.30	0.30	15%
99205	Office/outpatient visit, new	2.67	3.00	0.33	12.36%
99211	Office/outpatient visit, est.	0.17	0.17	0.00	0
99212	Office/outpatient visit, est.	0.45	0.45	0.00	0
99213	Office/outpatient visit, est.	0.67	0.92	0.25	37.31%
99214	Office/outpatient visit, est.	1.10	1.42	0.32	29.09%
99215	Office/outpatient visit, est.	1.77	2.00	0.23	12.99%

Source: Centers for Medicare and Medicaid Services.

well, but to a lesser extent. For example, the 99213 RVU increased by 19.42%—from 1.39 to 1.66 total RVUs. Within that, 0.25 (or 93% of the change) was attributable strictly to the work component.

Reimbursement is tied to total RVU values, so although wRVUs increased significantly, the total RVU value (and thus the reimbursement) was not as significant.

For an example of how this affects compensation, consider the following scenario:

- Conversion factor: $35.00
- 2006 wRVUs: 5,000
- 2006 compensation: $175,000 (5,000 x $35)
- 2007 wRVUs: 8,000 (5,000 baseline + 1,800 increase in productivity + 1,200 change in rate)
- 36% of growth due to genuine increase in productivity
- 24% of growth due to CMS wRVU changes
- 2007 compensation: $280,000 (8,000 x $35)

The physician in the example receives an additional $63,000, or a 36% increase in compensation, due to a genuine increase in productivity. But he or she also receives an additional $42,000, or a 24% increase in compensation, for no (or little) additional work.

It is difficult for any IDP to successfully sustain such an increase in wRVU values with a constant conversion factor. The conversion factor was developed—and the pro forma models of the IDP were tested—based on prior (i.e., lower) RVU values and will now skew the amount of compensation calculated.

Benchmark source adjustments

As a result of the CMS changes, many of the benchmark sources used to derive conversion factor values are not entirely accurate. This is through no fault of the organizations conducting the benchmark surveys; it is a genuine result of the changes in the values, as discussed above.

Some of the most prominent and widely used survey/benchmark sources are those compiled by the MGMA. Like most surveys, their compilations are based on a previous year's data. For example, the new compensation survey scheduled to be published in fall 2007 will be based upon 2006 survey data. Obviously, this is prior to the CMS-invoked changes in RVU values, so the conversion factors that will be published by MGMA in its new 2007 survey will not reflect these changes. In all likelihood, their conversion factors will be overstated.

It is difficult for any IDP to successfully sustain such an increase in wRVU values with a constant conversion factor. The conversion factor was developed—and the pro forma models of the IDP were tested—based on prior (i.e., lower) RVU values and will now skew the amount of compensation calculated.

MGMA is working to address this issue. They will provide adjustment tools that will be used to readjust the conversion factors consistent with the terms and conditions noted above. Any organization—private practice or hospital—that uses wRVUs (or full RVUs) as a component of its compensation plan has three possible alternatives to update its compensation formulas:

- **Scenario one**—use the 2006 Medicare physician fee schedule instead of the 2007 version
- **Scenario two**—adjust wRVU tier levels upward
- **Scenario three**—adjust conversion factors downward

Of these three alternatives, option three is the most tenable; that is, to complete further analyses and adjust conversion factors downward. When utilizing an RVU- (especially a wRVU-) based model for an IDP, it is incumbent upon the practice and/or hospital network/employer to continually monitor the changes in RVU values per CPT code and include a stipulation in all physician contracts that the conversion factors may be adjusted yearly, based upon a fair and objective analysis.

Without such adjustments in the above-noted situation, it could entail significantly greater increases in compensation for what one might argue to be no (or very little) additional work on the part of the physician.

Editor's note: For more information concerning the above situation, contact Max Reiboldt, CPA, managing partner/CEO, The Coker Group, at 678/832-2000 or via e-mail at mreiboldt@cokergroup.com.

The earning curve: How production, comp change over time

Physician productivity—and as a result, compensation—isn't uniform throughout a career. So if a practice loses a physician in his or her prime, finding a replacement contains certain risks. Will the new physician be less productive? Will he or she drag down the practice's overall profitability?

Depending on the specialty, one way of answering those questions is to look at how long the physician has been practicing medicine.

As an aggregate, physicians' median collections tend to follow a curve—collections start low, rise over time, and then begin to decline toward the end of a physician's career, says **David N. Gans, FACMPE,** vice president of practice management resources with MGMA. See the graph on p. 9 for examples.

Because collections typically have a direct relationship with compensation in private practices, compensation follows a similar curve.

However, it isn't the same for every specialty. Surgeons' compensation and collections tend to rise faster and decline earlier than cognitive-based specialties, such as primary care, which may have a steeper learning curve but in which compensation and collections decline later.

Inexperienced physicians

A physician just out of residency will typically have lower collections until he or she has learned some of the business and productivity skills necessary to build a practice. For example, a new surgeon may take more time in the OR than a veteran, Gans says.

"They have yet to learn how to multitask; they tend to be much more sequential, and they may not have their surgical planning down as well as someone who's done thousands of surgeries." But surgeons come out of residency well trained, so the main obstacles are learning to become efficient and building a patient base. If a practice can help a surgeon in these areas, it may boost collections at an earlier stage.

Primary care physicians must learn similar business skills, but cognitive-based specialists also may take a while to build solid diagnostic skills, Gans says.

"When you're evaluating the patient, it takes a while to build your diagnostic skills, but once you build them you keep them forever."

Marc Bowles, CPC-PRC, CMSR, FMSD, chief marketing officer of The Delta Companies in Dallas, has seen similar trends when recruiting physicians fresh out of residency programs. "When a physician is coming out of training, they don't have the history to really know what to do in every situation," he says. "As you get more experience, you've seen things before."

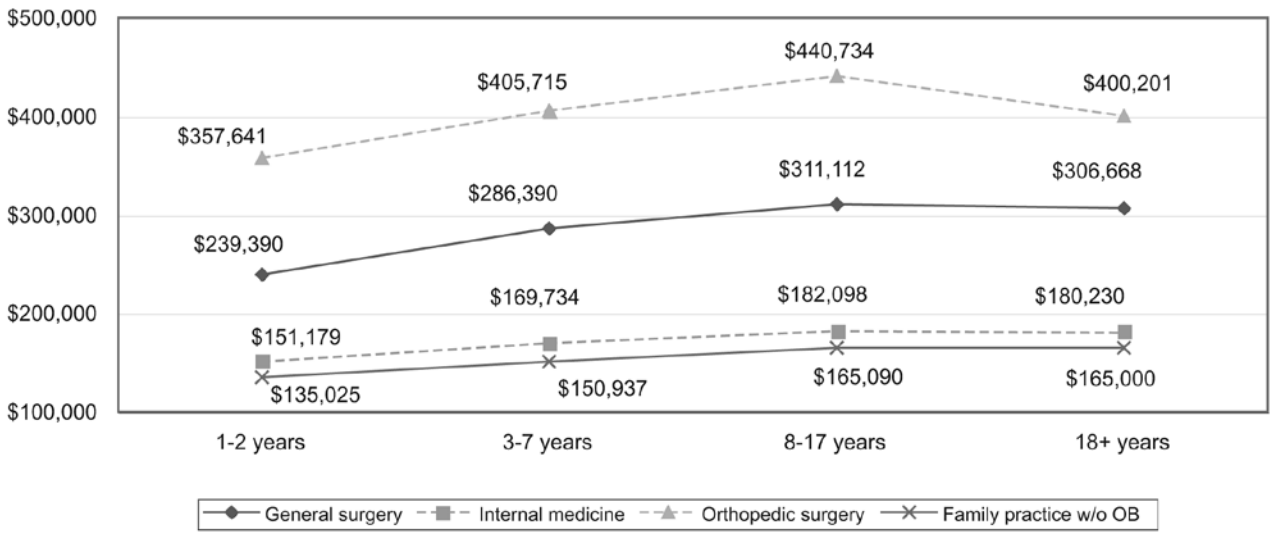
Experienced physicians

There are two primary reasons why physicians' productivity and compensation decline after they have been practicing for more than 20 years.

Some physicians, particularly specialists, may lose some of the skills they need to perform procedures that bring in high revenues.

Whereas a primary care physician likely will retain and sharpen his or her diagnostic skills until the end of his or her career, surgeons, for example, may lose some of the motor skills, depth perception, and coordination they need to perform complex surgeries.

Physician compensation by years in specialty



Source: 2006 MGMA Physician Compensation and Production Survey.

"A surgeon may have arthritis in his or her fingers, so they will reduce the complexity of the surgery. As they reduce the complexity of their surgery, revenue goes down." says Gans. "Contrast that with what happens to diagnostic skills. Those doctors continue to learn every year, so general internists or rheumatologists, for example, continue to hone their diagnostic skills over time so they may have 35 years of experience, but they're actually probably a better doctor now."

The second reason production declines is simply because physicians tend to reduce the number of hours they work toward the end of their careers. Even without scaling back to practicing part-time, physicians can reduce their productivity by negotiating to get out of call coverage duties or taking more vacation time.

Many physicians' careers go in eight-year cycles, Bowles says. "The first eight years after medical school you're digging yourself out of debt; for the next eight you're living your life; and the final eight or 10 years you're putting money away," he says.

Physicians in the final phase may already have a strong portfolio, so the financial incentive to work aggressively and productively may not be as strong, he adds.

Why does it matter?

Most practices don't put too much weight into the correlation between experience and compensation/production when looking to bring on a new physician. When all is said and done, the experience curve is a minor factor in a physician's overall value to a group and the ultimate decision to recruit a doctor.

However, it is one piece of the puzzle that can still play a role, depending on the group's goals. If the practice needs a long-term commitment and is considering bringing on a physician with several years of experience, the leaders should flesh out in the interview process what the physician's goals are and evaluate whether there's a chance his or her production will decline.

Bowles recommends doing a little extra research if there are concerns about experience-related productivity. For example, facilities often ask a physician to verify his or her caseload volumes at a previous practice.

PCR *sources*

Marc Bowles, CPC-PRC, CMSR, FMSD, chief marketing officer, The Delta Companies, Four Hickory Centre, 1755 Wittington Place, Suite 800, Dallas, TX 75234, 800/521-5060; *mbowles@thedeltadifference.com.*

David N. Gans, FACMPE, vice president of practice management resources, MGMA, 104 Inverness Terrace East, Englewood, CO 80112, 303/799-1111, Ext. 1270; *dng@mgma.com.*

News in brief

CMS seeks data on hospital-physician financial relationships

To obtain a more complete assessment of the amount of physician investment in specialty hospitals, CMS will begin this month to require hospitals to report information about their financial relationships with physicians.

CMS will initially select 500 hospitals to send a mandatory "Disclosure of Financial Relationships Report," which must be filled out and submitted within 45 days. This financial reporting has become a requirement, because many hospitals were unresponsive when CMS initially tried to get these data voluntarily.

Hospitals that don't disclose their information to CMS in a timely fashion may be subject to civil monetary penalties of up to $10,000 for each day beyond the deadline.

House votes to eliminate 9.9% pay cut

The House of Representatives voted 225–204 to approve H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007, which includes provisions that eliminate the scheduled 9.9% Medicare physician payment reduction for 2008 and the 5% reduction for 2009. Instead, the bill includes a 0.5% payment increase for physicians in each of these years.

In addition, the legislation repeals the sustainable growth rate formula on which Medicare reimbursement is based and provides six service categories, each targeting growth rates.

After being passed in the House, the bill proceeded to a conference with the Senate-passed State Children's Health Insurance Program bill, which does not now contain any provisions relative to Medicare physician payment. The differences between the two bills must be reconciled and both the House and the Senate must approve a conference agreement before the legislation will go into effect.

CMS unveils PQRI tool kit

CMS has developed a tool kit to help providers report necessary data when participating in the 2007 Physician Quality Reporting Initiative (PQRI). The tool kit consists of existing educational resources plus new measure-specific worksheets designed to walk the user step by step through reporting for each measure, including the following:

- **2007 PQRI physician quality measures**—a numerical listing of all measures included in the 2007 PQRI
- ***2007 Coding for Quality Handbook***—a handbook that delineates coding and reporting principles and provides implementation guidelines for how to successfully report measures using clinical scenarios
- **2007 Code Master**—a numerical listing of all codes included in PQRI intended for incorporation into billing software
- ***MLN Matters* article 5640, Coding & Reporting Principles**—a publication that introduces the coding and reporting principles underlying successful PQRI reporting
- **Data collection worksheets**—measure-specific worksheets that walk the user step by step through reporting for each measure
- **2007 PQRI Measure Finder Tool**—a tool designed to help eligible professionals and their coding/billing staff quickly search for applicable measures and their detailed specifications

To access the tool kit, visit, *www.cms.hhs.gov/PQRI*, and scroll down to the "PQRI Tool Kit" tab. The tool kit will be expanded as new educational resources become available.

CMS revamps ASC payment system

CMS has issued a final rule revising the payment system for services furnished to Medicare beneficiaries in ambulatory surgery centers (ASC) in hopes of better aligning payments for similar services furnished in a hospital outpatient department or a physician's office.

The final rule adds about 790 procedures for ASC payment beginning in 2008. The new ASC payment system is based on the Outpatient Prospective Payment System (OPPS), using relative payment weights for Ambulatory Payment Classifications (APC) as a guideline. ASCs will receive 65% of the OPPS rates under the proposed OPPS/ASC payment system, or 67% of the corresponding payment rates for the APCs, which is slightly higher than the originally proposed 62%, according to CMS' press release.

The final rule's payment rates will be published as part of the 2008 OPPS/ASC final rule later this year and will be transitioned in over a four-year period.

Review deferred comp plans for compliance with new regs

Congress' attempts to crack down on potentially abusive deferred compensation strategies, made notorious by Enron and other high-profile corporate scandals, will make compliance more difficult for physician groups that have implemented or plan to incorporate a nonqualified deferred compensation plan.

Many practices currently offer nonqualified deferred compensation for a variety of reasons, including recruiting and retaining physicians. These plans come in several forms and are commonly found in buyout or buy-in arrangements in medical practices.

In many cases, the deferred compensation agreement is somehow tied to accounts receivable. Nonqualified deferred compensation is also commonly incorporated into retirement plans, providing a more effective funding option for high-income physicians by essentially allowing the physician to defer from taxes up to 100% of compensation each year until retirement.

These plans can benefit both the physician and the practice—the physician can better fund his or her retirement and pay lower annual income taxes; the practice can deduct the payments from its own taxes as well.

However, new legislative changes can make deferred compensation subject to tax, as well as fines and penalties, if the arrangements are not properly set up.

Section 409A

In 2004, Congress passed the American Jobs Creation Act, which added Section 409A to the Internal Revenue Code and significantly changed the rules relating to nonqualified deferred compensation plans. However, the IRS has extended the good faith compliance period multiple times, and the final deadline for documentation compliance has been pushed to December 31 of this year.

Unlike Stark and other healthcare-specific regulations, these changes were not targeted specifically at physicians and practices, says **Steven M. Harris,** partner at the Chicago office of the law firm McDonald Hopkins, LLC.

"The typical physician contracts that have a payout of deferred compensation were not meant to be swept up in the regulations. This is one of those cases where the legislators passed these mandates and there's collateral damage," he says.

Nevertheless, any practice with an existing deferred compensation plan or considering implementing one should evaluate the Section 409A regulations with a tax attorney.

"At a minimum, it complicates the process of creating any form of deferred compensation for doctors or anybody else," says **Ellen Messing,** partner at Messing, Rudavsky & Weliky, PC, a Boston-based law firm.

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Questions? Comments? Ideas?

Contact Associate Editor Elyas Bakhtiari

Telephone: **781/639-1872, Ext. 3273**

E-mail: ***ebakhtiari@hcpro.com***

Deferred compensation

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Any violation of Section 409A makes the amounts immediately taxable and subject to an additional 20% penalty tax, plus interest and fines. In addition, noncompliance with respect to one payment or benefit may taint other payments and subject them to penalties as well.

For example, if your practice has $1 million of accounts receivable subject to deferred compensation payment obligations, even an inadvertent violation could result in taxes, interest, and penalties exceeding $700,000, according to Harris.

Scheduled payments

The major change included in Section 409A is a prohibition on accelerating scheduled payments under the plan. The legislation was passed in part because of abuses by high-profile corporate executives who accelerated their payments under a nonqualified plan, knowing bankruptcy or other company financial problems loomed, to incur smaller economic losses than those incurred by rank-and-file participants in qualified plans holding stock without the option to accelerate payments.

Under the new law, payment dates and amounts must be objectively determined in advance using a "nondiscretionary formula and methodology," Harris says. This doesn't mean you have to set specific times for payouts, but you must establish the conditions in the agreement. For example, you can identify key trigger events, which should be included in all contracts, such as retirement, death, disability, or separation from the practice.

Other key provisions in Section 409A include:

- A decision to defer compensation earned during a calendar year generally must be made before the beginning of that year, although there are special rules in the case of the first year of eligibility and for performance-based compensation.
- A decision to defer performance-based compensation earned over a period of at least 12 months may be made at any time up to six months before the end of the performance period, provided that the pre-established performance criteria have not been met at the time of the election
- Once an amount has been deferred, there are significant restrictions on the ability to change the timing and form of payment

Grandfathered practices

The IRS has allowed room for previously existing plans to be grandfathered in, Harris says. Any plan that was in existence as of December 31, 2004, and has not been materially modified is considered grandfathered, but there are exceptions to this rule, so it won't apply to many organizations.

For example, if the amount payable under the deferred compensation plan has the potential to increase due to external factors (e.g., if it's tied to accounts receivable), then it no longer benefits from grandfather protection.

The best advice, Harris and Messing say, is to review all plans, regardless of when they were drafted.

PCR *sources*

Steven M. Harris, partner, McDonald Hopkins, LLC, 640 North LaSalle Street, Suite 590, Chicago, IL 60610, 312/280-0111; *sharris@mcdonaldhopkins.com.*

Ellen Messing, partner, Messing, Rudavsky & Weliky, PC, 50 Congress Street, Suite 1000, Boston, MA 02109, 617/742-0004; *mail@mrwemploymentlaw.com.*

Physician Compensation Report (ISSN:1530-342X) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA, 01945, 781/639-1872, *www.hcmarketplace.com.*