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# Physicians and Other Healthcare Providers: Beware "Eat What You Kill" Compensation Models

**Insight — March 31, 2023**

Physicians and other healthcare providers often structure their group compensation formulas on an “eat what you kill” basis, *i.e.,* a provider is paid based on the services he or she performs in addition to items or services they order, prescribe, refer, sell, *etc*. Such formulas must be reviewed, structured, or revised appropriately to ensure compliance with federal fraud and abuse laws, including Stark, the Anti-Kickback Statute (AKS), and the Eliminating Kickbacks in Recovery Act (EKRA).

**1. Ethics in Patient Referrals Act (“Stark”).** Under the federal Stark law, if a physician has a financial arrangement with another entity, the physician may not refer certain designated health services[1] (DHS) payable by Medicare or Medicaid to that other entity and that entity may not bill Medicare or Medicaid for improperly referred services unless the arrangement fits within a regulatory safe harbor.[2] Importantly, Stark is a strict liability statute: there is no “good faith” compliance; either the arrangement satisfies Stark or there can be no prohibited referrals. Stark violations may result in costly repayments, significant civil and administrative penalties, and False Claims Act liability.[3] A physician's ownership interest in or contract with a group creates a financial relationship triggering Stark; accordingly, if the group provides any DHS, the physician's ownership or compensation arrangement with the group must be structured to comply with one of the following regulatory safe harbors.

> **a. Employees.** If the physician is an employee, the bona fide employee safe harbor may apply.[4] To fit within that safe harbor, however, the compensation may not be determined in any manner that takes into account the volume or value of DHS ordered, prescribed or referred by the referring physician.[5] An employer may pay the physician based on services the physician personally performs,[6] but under this safe harbor, the physician cannot be paid based on the physician's referrals for DHS performed or provided by others. Thus, any compensation formula that pays or rewards the physician based on DHS the physician orders or refers would fall outside the safe harbor. Physician employees may, however, be paid based on referrals for non-DHS under this safe harbor. This safe harbor would not apply to remuneration that a physician may receive as an owner of a group; instead, owners would need to satisfy either the rural provider or group practice safe harbor described below.

**b. Independent Contractors.** If the physician is an independent contractor, the arrangement may be structured to fit within either the personal services or fair market value safe harbor.[7] Again, however, both of these safe harbors require that the compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties.[8] Like the employee safe harbor, a group may pay a physician contractor based on services the physician personally performs, but it may not pay the physician based on the physician's referrals, prescriptions, or orders for any items or services performed or provided by others, including DHS and non-DHS. Like the employee safe harbor, these safe harbors would not apply to remuneration that a physician may receive as an owner of a group; instead, owners would generally need to satisfy either the rural provider or group practice safe harbor described below.

**c. Rural Providers.** If the referring physician is an owner of a group or other entity that qualifies as a "rural provider," the physician owner may make referrals to such entity and be compensated in any manner.[9] A "rural provider" is an entity that furnishes substantially all (not less than 75%) of the DHS that it furnishes to residents of a rural area, *i.e.,* an area outside a metropolitan statistical area.[10] The rural provider safe harbor would not apply to compensation paid to non-owner employees or contractors.

**d. Group Practices.** Aside from rural providers, physician groups providing DHS will generally need to satisfy the physician services or ancillary services safe harbors—the safe harbors that allow group members to refer DHS to others within their group, including ancillary services that constitute DHS.[11] However, if the group includes more than one physician, to fit within these safe harbors the physician group must qualify as a "group practice" under Stark.[12] In addition to other requirements designed to ensure the group functions as a single entity with shared resources, the group must satisfy the following:

> **(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 paragraph (i) of this section.
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> …
>
> **(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 his or her referrals, except as provided in paragraph (i) of this section.[13]

Thus, “eat what you kill” compensation formulas would likely fail the group practice requirements if and to the extent they are based in whole or part on the physician's referrals for DHS. Failure to qualify as a group means that the owners cannot satisfy the physician services and in-office ancillary services exceptions and, accordingly, would be prohibited from billing Medicare or Medicaid for DHS referred by group members unless the rural provider, employee, or contractor safe harbors described above were satisfied. However, the group practice definition does contain three important compensation methodologies that are deemed to be permissible, *i.e.*, they are deemed not to take into account the volume or value of referrals:

> **(1) Overall profits.**
>
> > (i) Notwithstanding paragraph (g) of this section, a physician in the group may be paid a share of overall profits that is not directly related to the volume or value of the physician's referrals.
> >
> > (ii) Overall profits means the profits derived from all the designated health services of any component of the group that consists of at least five physicians, which may include all physicians in the group. If there are fewer than five physicians in the group, overall profits means the profits derived from all the designated health services of the group.
> >
> > (iii) Overall profits must be divided in a reasonable and verifiable manner. The share of overall profits will be deemed not to directly relate to the volume or value of referrals if one of the following conditions is met:
> >
> > > (A) Overall profits are divided per capita (for example, per member of the group or per physician in the group).
> > >
> > > (B) Overall profits are distributed based on the distribution of the group's revenues attributed to services that are not designated health services and would not be considered designated health

services if they were payable by Medicare.

(C) Revenues derived from designated health services constitute less than 5 percent of the group's total revenues, and the portion of those revenues distributed to each physician in the group constitutes 5 percent or less of his or her total compensation from the group.

**(2) Productivity bonuses.**

(i) Notwithstanding paragraph (g) of this section, a physician in the group may be paid a productivity bonus based on services that he or she has personally performed, or services “incident to” such personally performed services, that is not directly related to the volume or value of the physician's referrals (except that the bonus may directly relate to the volume or value of the physician's referrals if the referrals are for services “incident to” the physician's personally performed services).

(ii) A productivity bonus must be calculated in a reasonable and verifiable manner. A productivity bonus will be deemed not to relate directly to the volume or value of referrals if one of the following conditions is met:

(A) The productivity bonus is based on the physician's total patient encounters or the relative value units (RVUs) personally performed by the physician.

(B) The services on which the productivity bonus is based are not designated health services and would not be considered designated health services if they were payable by Medicare.

(C) Revenues derived from designated health services constitute less than 5 percent of the group's total revenues, and the

portion of those revenues distributed to each physician in the group constitutes 5 percent or less of his or her total compensation from the group.

**(3) Value-based enterprise participation.** Notwithstanding paragraph (g) of this section, profits from designated health services that are directly attributable to a physician's participation in a value-based enterprise, as defined at § 411.351, may be distributed to the participating physician.[14]

Importantly, a group is not obligated to comply with any of these three specific options, but if it does not, the group would need to ensure that "[n]o physician who is a member of the group practice directly or indirectly receives compensation based on the volume or value of his or her referrals."[15] Most groups will want to make sure their compensation structure satisfies the "overall profits" or "productivity bonus" methodology if they intend to bill Medicare or Medicaid for DHS.

**2. Anti-Kickback Statute (AKS).** Stark only applies to referrals by physicians; other providers need not worry about Stark. However, all providers participating in federal healthcare programs—physicians as well as other provider types—will need to ensure their compensation arrangements satisfy the federal AKS if and to the extent they participate in federal healthcare programs. The AKS generally prohibits knowingly and willfully offering, paying, soliciting or receiving any remuneration in order to induce or reward referrals for items or services payable by federal healthcare programs unless the arrangement is structured to fit within a statutory or regulatory exception.[16] AKS violations are felonies, automatic False Claims Act violations, and otherwise subject the violator to prison terms and criminal fines as well as civil and administrative penalties.[17] Unlike Stark, the AKS is an intent-based statute so it is not essential that a provider fit within an AKS safe harbor, but if they do not, the test for liability is whether "one purpose" of the compensation was to induce referrals.[18] That is a difficult standard to defend against in an "eat what you kill" compensation formula; accordingly, physician groups will want to try to structure their compensation arrangements to fit within one or more of the following AKS safe harbors if possible.

**a. Employees.** The AKS contains a broad exception for bona fide employment contracts.[19] Unlike other safe harbors discussed in this memo, the safe harbor does not prohibit compensation based on the volume or value of referrals. Accordingly, under the AKS, an employer may likely pay employees based on the volume or value of their referrals.[20] Of course, to the extent applicable, Stark, EKRA, or state laws may prohibit same. Also, the employment safe harbor would not protect referrals by owners.

**b. Independent Contractors.** Like Stark, the AKS safe harbor

applicable to contractors requires that the compensation "is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs."[21] Thus, like Stark, the AKS would likely allow a group to pay a contractor based on services the provider personally performed, but would presumably prohibit the group from paying the contractor based items or services the provider referred to or ordered from others when such items or services were payable by federal programs.

**c. Group Practices.** Like Stark, the AKS contains a "group practice" safe harbor that applies to an owner's income from the group practice.[22] Among other things, the safe harbor requires that the practice must:

> (i) Meet the definition of "group practice" in [Stark]; and
>
> (ii) Be a unified business with centralized decision-making, pooling of expenses and revenues, and a compensation/profit distribution system that is not based on satellite offices operating substantially as if they were separate enterprises or profit centers.[23]

Thus, at least for physician groups, the AKS safe harbor incorporates the Stark requirements discussed above. Again, because the AKS is an intent-based statute, it is not essential that the group practice comply with the Stark "group practice" requirements, but, if not, group owners would need to ensure their compensation structure does not otherwise improperly induce or reward referrals for items or services payable by federal healthcare programs by, *e.g.*, pooling such revenue. As a practical matter, it does not appear that the OIG has actively pursued claims against group practice owners based simply on their return on investment, but practice owners should at least consider the AKS risks when structuring their compensation formulas.

**3. Eliminating Kickbacks in Recovery Act.** EKRA was passed in response to the opioid epidemic and parallels the AKS: it prohibits knowingly and willfully offering, paying, soliciting or receiving remuneration in return for referring or using a recovery home, clinical treatment facility, or laboratory.[24] Recovery homes[25] and clinical treatment facilities[26] are generally limited to those providing care or treatment for substance use disorders; however, "laboratory" is defined broadly to include any facility providing lab services on humans.[27] Accordingly, any healthcare provider, group, or facility providing lab services must beware EKRA. Violations may result in a $200,000 criminal fine and/or 10 years in prison.[28] Unlike the AKS, EKRA applies to paying or rewarding referrals for private pay business as well as federal program business.[29] EKRA contains a limited

number of safe harbors, including the following:

**a. Employees.** EKRA permits payments to employees so long as the compensation structure is not determined by or does not vary by:

> (A) the number of individuals referred to a particular recovery home, clinical treatment facility, or laboratory;
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> (B) the number of tests or procedures performed; or
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> (C) the amount billed to or received from, in part or in whole, the health care benefit program from the individuals referred to a particular recovery home, clinical treatment facility, or laboratory.[30]

Thus, the EKRA safe harbor for employees is narrower than the AKS: while the AKS would allow employers to pay bona fide employees based on their referrals, EKRA does not. Employers providing lab services must beware any "eat what you kill" compensation structure that includes labs, whether or not such labs are payable by private or government payers.

**b. Contractors.** EKRA also has two safe harbors applicable for payments to contractors. To satisfy the first, the compensation structure must meet the standards described above for employees, *i.e.,* the compensation structure may not vary with:

> (A) the number of individuals referred to a particular recovery home, clinical treatment facility, or laboratory;
>
> (B) the number of tests or procedures performed; or
>
> (C) the amount billed to or received from, in part or in whole, the health care benefit program from the individuals referred to a particular recovery home, clinical treatment facility, or laboratory.[31]

Alternatively, EKRA incorporates the AKS "personal services" safe harbor.[32] As discussed above, to satisfy that safe harbor, the compensation structure may not be "determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs."[33] Again, providers offering lab services must beware any contractor compensation structure that is based on the volume or value of lab services.

**c. Owners.** Unlike Stark or the AKS, EKRA does not have any

specific safe harbor applicable to income to group owners or general group compensation structures.[34] It is possible that such arrangements may be addressed in future regulations, but no such regulations have issued yet. Until then, it is unlikely that the DOJ would target group practice owners based solely on their income from the group, but owners should consider the risks when structuring "eat what you kill" compensation methodologies and may want to avoid compensating group practice members directly based on their referrals for labs; instead, pooling of lab revenue consistent with Stark or the AKS would likely be safer.

**D. Conclusion.** "Eat what you kill" and other compensation formulas that pay referring providers based on items or services performed or provided by others potentially implicate Stark, the AKS, and EKRA. Physicians must ensure their group compensation structures comply with Stark if and to the extent they provide DHS payable by Medicare or Medicaid. All providers (including physicians) must ensure they comply with the AKS if and to the extent they participate in any federal healthcare programs. And those providing labs must ensure compliance with EKRA regardless of whether the lab services are payable by government or private payers. Providers should also check their own state laws, which may impose additional requirements. Noncompliant compensation structures may result in serious financial and criminal penalties.

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*Endnotes:*

[1] "Designated health services" are defined as (i) clinical laboratory services.; (ii) physical therapy, occupational therapy, and outpatient speech-language pathology services; (iii) radiology and certain other imaging services; (iv) radiation therapy services and supplies; (v) durable medical equipment and supplies; (vi) parenteral and enteral nutrients, equipment, and supplies; (vii) prosthetics, orthotics, and prosthetic devices and supplies; (viii) home health services; (ix) outpatient prescription drugs; and (x) inpatient and outpatient hospital services. (42 CFR § 411.351).

[2] 42 USC § 1395nn; 42 CFR § 411.353.

[3] *See* Stanger, "Beware Laws Affecting Healthcare Transactions," at https://www.hollandhart.com/beware-laws-affecting-healthcare-transactions.

[4] 42 CFR § 411.357(c).

[5] *Id.* at § 411.357(c)(2)(ii).

[6] Stark defines "referral" to exclude services personally performed by the physician. (42 CFR § 411.351).

[7] 45 CFR § 411.357(d) and (l).

[8] 42 CFR § 411.357(d)(1)(v) and (l)(3).

[9] 42 CFR § 411.356(c)(1).

[10] *Id.; see also* 42 CFR § 411.351.

[11] 42 CFR § 411.355(a) and (b).

[12] *Id.; see also* 42 CFR § 411.352.

[13] 42 CFR § 411.352(e) and (g).

[14] 42 CFR § 411.352(i).

[15] 42 CFR § 411.352(g).

[16] 42 USC § 1320a-7b(b).

[17] *See* Stanger, "Beware Laws Affecting Healthcare Transactions," at https://www.hollandhart.com/beware-laws-affecting-healthcare-transactions.

[18] *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985).

[19] 42 CFR § 1001.952(i).

[20] *See* Stanger, "Paying Employees for Referring Healthcare Business," at https://www.hollandhart.com/paying-employees-for-referring-healthcare-business.

[21] 42 CFR § 1001.952(d)(1)(iv).

[22] 42 CFR § 1001.952(p).

[23] *Id.* at § 1001.952(p)(3).

[24] 18 USC § 220(a).

[25] "'[R]ecovery home' means a shared living environment that is, or purports to be, free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders." (18 USC § 220(e)(5)).

[26] "'[C]linical treatment facility' means a medical setting, other than a hospital, that provides detoxification, risk reduction, outpatient treatment

and care, residential treatment, or rehabilitation for substance use, pursuant to licensure or certification under State law." (18 USC § 220(e)(2)).

[27] For purposes of EKRA, a "laboratory" is defined as "a facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings." (42 USC § 263a; *see* 18 USC § 220(e)(4)).

[28] 18 USC § 220(a).

[29] EKRA applies to services offered by any health care benefit program, which in turn is defined as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract." (18 USC § 24b(b); *see id.* at § 220(e)(3)).

[30] 18 USC § 220(b)(2).

[31] *Id.*

[32] 18 USC § 220(b)(4).

[33] 42 CFR § 1001.952(d)(iv).

[34] *See* 42 USC § 220(b).

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