Riding Out the Storm - 10 Potential Solutions to Stabilize Physician Resources During the COVID-19 Pandemic

On March 13, Department of Health and Human Services Secretary Alex Azar formally invoked his authority under Section 1135 of the Social Security Act to waive specific Medicare and Medicaid program requirements. Under this order, the Centers for Medicare & Medicaid Services (CMS) was authorized to waive sanctions under the Stark Law “in such circumstances as the [agency] determines appropriate.”

By letter dated March 19, the American Hospital Association (AHA) urged CMS, the Office of Inspector General (OIG), and the Department of Justice to suspend enforcement of the Stark Law and the Anti-Kickback Statute “to enable hospitals to efficiently meet the demands of the public health crisis and compensate referring physicians and their family members.” AHA also asked CMS to “adopt an exception to the definition of ‘compensation arrangement’ under [the Stark Law] for any compensation paid to a physician or a physician’s immediate family member in return for a service necessary to the hospital’s response to the COVID-19 public health crisis.”

To date, CMS has issued several blanket waivers suspending specific program requirements that apply to all impacted providers, but these do not currently include a Stark Law blanket waiver. According to CMS guidance regarding Section 1135 waivers:

> In past emergencies, [Stark Law] waivers were granted only upon request and on a case-by-case basis and required specific details concerning the actual or proposed financial relationship between the referring physician(s) and the referred-to entity. Unless and until a “Stark waiver” is granted to the requesting party(ies), such party(ies) must comply with all physician self-referral (Stark) rules.

While appreciating each hospital faces unique challenges with its medical staff during this COVID-19 emergency, we have identified 10 potential solutions a hospital may consider to stabilize physician resources. Depending on specific facts and circumstances, some may be implemented within current Stark Law requirements, while others may require a hospital to pursue an individual waiver.

1. For those impacted by the postponement of elective procedures, consider converting employed surgical and procedural specialists, or those contracted under personal service agreements (PSA), to a fixed salary to stabilize their income. This salary should not be intended to “make them
whole" with their maximum earning capacity, but might be set near their base compensation or
an amount approximating the median (if the physician’s base or total compensation historically
was above the median) according to published benchmark compensation surveys such as that
published by the Medical Group Management Association (MGMA).
2. If training and credentials permit so, consider redeploying employed surgical and procedural
specialists to provide services in the intensive care unit (ICU) or emergency department (ED) to
help triage patients and treat those with less serious injuries. They could be compensated for
these services at their contracted rate per work relative value unit (wRVU) to help support their
earning capacity, or potentially at a higher rate if the individual circumstances warranted such
compensation. For example, a family practice physician who traditionally works in an outpatient
setting but agrees to help in the ED may be eligible for rates closer to ED compensation rates,
versus family practice rates.
3. Employed advanced practice providers (APP) who have scheduling capacity might be redeployed
into the ICU or ED in order to assist in the management of these key areas during this crisis. They
could be compensated on a fixed salary at their current rate of pay, or potentially higher
compensation if the circumstances (i.e., patient acuity, shortage of providers, etc.) warrant such
compensation.
4. Underutilized (or retired) community physicians could be contracted as independent contractors
(IC) to assist in the ICU or ED to triage patients. The hospital could pay them an hourly rate
potentially inclusive of an allowance for benefits and malpractice insurance expenses. Any ability
to bill for these services would then be assigned to the hospital.
5. If a physician-owned distributor (POD) has supplies—such as personal protective equipment (PPE),
ventilators, nebulizers, etc.—specifically needed to treat COVID-19 patients, the hospital could
enter into purchase agreements if the POD has inventory. The hospital would want to ensure it
pays for these items at rates comparable to other similar purchase agreements the hospital has in
place.
6. Engage underutilized employed medical staff to serve in an administrative capacity to address
crisis management, so the physicians needed on the front lines to treat patients could focus on
clinical practice only. These underutilized physicians could be paid an hourly rate for their time,
which would help stabilize their income until elective procedures recommence.
7. If impacted community physicians rent office space in hospital-owned medical office buildings
(MOB), the hospital could defer rent until after the crisis passes. This deferred rent could be
captured over a period of time once the healthcare system stabilizes.
8. If impacted community physicians find themselves in the unenviable position of needing to reduce
practice staff, the hospital could lease the clinical staff (e.g., nurses and technicians) temporarily
to assist with care of COVID-19 patients. However, consideration should be given to the
Coronavirus Aid, Relief and Economic Security Act (CARES) in final form once, or if, passed.
9. If employed or community physicians are self-quarantined, redeploy them to provide telehealth
services in their area of specialty or any area where they possess the training and credentials. In
the absence of ability to bill for this, the hospital might consider compensating the physician on
an hourly basis and, for community physicians, have the billing assigned to the hospital in the
event it becomes billable.
10. Hospitals may need to consider (or help identify institutions, including potential governmental
resources, who are willing to make) short-term loans to community physicians to help stabilize the
practice to avoid lay-offs of valuable medical resources in the community. The hospital would need
to ensure a market-based rate of interest is included. The hospital could consider deferring any
re-payments of these amounts until after the crisis. With appropriate legal guidance, the hospital
may be able to consider forgiving some of the repayments dependent upon the physician and
practice remaining in the community for a specified period of time.

These proposed solutions are intended only to stimulate discussion within your organization. Any solution you pursue should be developed based on specific facts and circumstances and subject to proper legal review. These solutions are only some options to consider—we are sure there are many more. In fact, we will be continuing to brainstorm as well as study the onslaught of new and proposed COVID-19 relief regulations and guidance. Join us in this conversation to identify various ways to help health systems navigate these difficult times.

If you have any questions regarding these matters, or require assistance in developing a specific waiver request, contact one of our PYA executives below at (800) 270-9629.

Disclaimer: To the best of our knowledge, this information was correct at the time of publication. Given the fluid situation, and with rapidly changing new guidance issued daily, be aware that some or all of this information may no longer apply. Please visit our COVID-19 hub frequently for the latest updates, as we are working diligently to put forth the most relevant helpful guidance as it becomes available.