PYA Perspectives – Physician Recruitment Arrangements – On Paper and in Practice

July 26, 2022

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Overview

- Current trends and pitfalls
- Regulatory and compliance implications
- Evolving role of provider needs assessments for both compliance and strategic planning
- Key processes for maximizing an effective physician recruitment arrangement
- Don’t forget about advanced practice providers (APPs)!
  - Outside the scope of this presentation, but a worthwhile tip

Current Trends

- Covid-19 pandemic fueled and continues to impact recruitment trends
  - Hospital recruitment: (26% in 2020 and 33% in 2021)
  - Medical group recruitment: (28% in 2020 and 29% in 2021)
  - Academic medical center recruitment (18% in 2020 and 20% in 2021)
- Top recruited specialties
  - Primary care: Family medicine, obstetrics/gynecology
  - Specialties: Anesthesiology, cardiology, dermatology, endocrinology, gastroenterology, hematology/oncology, neurology, psychiatry, orthopedic surgery, pulmonology/critical care, radiology, rheumatology, urology

Sources: Physicians Thrive *Physician Compensation Report 2022* and Merritt Hawkins *2022 Review of Physician and Advanced Practitioner Recruiting Incentives*

Current Trends (continued)

- Physician shortages
  - Aging population
  - Overall population growth
  - Large number of physicians nearing retirement age
  - Health status of the population
  - Geographic maldistribution
- Growth of APPs

Pitfalls

- Provision of support that’s more than reasonably necessary
- Excluding income from other sources in support amount calculation
- Physician practice guarantee of repayment
- Identification and tracking of expenses
- Lack of identified and/or supportable community need

Regulatory Overview and Compliance Considerations

- Recruitment arrangements can offer significant benefits
  - Part of broader hospital mission to serve the community
  - Plug gaps in medical staff and needed specialties
- Recruitment arrangements can also be a minefield of compliance challenges
  - Multiple potential legal implications – Stark Law, Anti-Kickback Statute, 501(c)(3) considerations
  - What makes them so tricky?
    - Recruited physician might not work out
    - Numerous technical requirements to meet

Regulatory Overview and Compliance Considerations

- Federal Physician Self-Referral Law (Stark Law) Basic Requirements
- Remuneration **induces** a physician to:
  - **Relocate**
  - To the hospital's **geographic area**
  - Become a **member** of the hospital's medical staff
- Arrangement is set out in writing, signed by both parties
- Arrangement is **not conditioned** on the physician's referral of patients to the hospital
- Remuneration is not determined in a manner that takes into account the volume/value of referrals or other business generated
- Physician is allowed to establish staff privileges at other hospitals and refer business to other entities (except as permissibly restricted under 42 CFR 411.354(d)(4))

Regulatory Overview and Compliance Considerations

- What is the **geographic area** served by the hospital?
  - Area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients
    - Some additional flexibility for rural hospitals
- What does it mean to **relocate**?
  - Physician moves their medical practice at least 25 miles into the geographic area
  - Physician's new practice derives at least 75% of its revenues from professional services furnished to patients not seen by the physician at their prior practice during the preceding three years
  - Exceptions
    - Resident or physician in practice 1 year or less OR
    - Employed on a full-time basis for at least two years immediately prior to the recruitment by certain government agencies

Regulatory Overview – Considerations and Pitfalls

- **Additional Stark Law Requirements – Physician Joining Existing Practice**
- Key requirements include:
- Physician practice may need to sign if receiving a financial benefit, not just passing the remuneration through to the physician (we typically see 3 party agreements)
- Except for actual costs incurred by the practice in recruiting, remuneration is passed through or remains with the recruited physician
- In the case of an income guarantee, costs allocated by the practice to the physician do not exceed the "actual additional **incremental** costs" attributable to the recruited physician
  - Devil is in the details

Regulatory Overview and Compliance Considerations

- Federal Anti-Kickback Statute safe harbor
- Similar, but narrower and not identical, to Stark Law exception
- Applies to physician in practice less than one year, or other practitioners to relocate to a Health Professional Shortage Area (HPSA)
- Benefits are provided for a period of no more than three years
- At least 75 percent of the revenues of the new practice must be generated from patients residing in a HPSA or a Medically Underserved Area (MUA) or who are part of a Medically Underserved Population (MUP)

Regulatory Overview and Compliance Considerations

- Common Issues/Questions (in addition to pitfalls already identified)
  - Recruiting into a large, well-funded group
  - “Side by side” recruiting
  - Options when the recruit isn’t “working out”
  - Amending recruitment agreements

Provider Needs Assessments

- Directional analysis intended to inform relative provider need by specialty
- Results guide determination of which provider arrangements are needed and/or which relationships to further pursue
- Different from a Community Health Needs Assessment
- Supports compliant provider recruitment activities under applicable federal and state laws and requirements
- Important component of the strategic planning process

Provider Needs Assessments

- Determine the provider complement required in a defined service area by estimating provider supply and demand, by specialty, for a population
- Current year and incremental year estimates
- Includes consideration of APPs in the defined service area
- Incorporates both quantitative and qualitative analyses

Provider Needs Assessments

- Provider demand based on various approaches including the use of industry accepted physician-to-population ratios and consideration of patient panel size
- Assumptions regarding provider supply are based on detailed analyses with input from facility and include assumptions based on provider type, practice location, age, clinical practice percentage, etc.
- Considerations:
  - Population shifts
  - Geography
  - Local health conditions
  - Use of APPs

Provider Needs Assessments

- Demand for a particular service is documented by lack of available services and long waiting periods
- Designated as a HPSA
- Designated as a MUA and/or MUP
- In an isolated rural area or an economically depressed inner-city area
- Demonstrated reluctance of physicians to relocate due to physical location
- Documented inability to retain medical residents in the state after they complete their training

Provider Needs Assessments

- Reduction in the number of physicians serving the community can be reasonably expected as a result of anticipated retirements
- Documented lack of physicians serving indigent or Medicaid patients in the community
- Patient travel patterns show a need for more physicians in a particular specialty
- Need for a minimum number of qualified physicians to assure access and quality in particular programs (particularly specialized or critical programs)

Provider Needs Assessments

- Age
- Multiple office locations
- APPs
- Telemedicine
- Academic medicine (faculty, residents)
- Community service board
- Other
  - Providers not accepting new patients
  - Volume of clinic or office encounters' claims data

Key Processes

- Determine need
- Identify recruitment support type
- Define amount and duration of support (including clear methodology for payments; reconciliation of agreement terms; consequences for breach)
- Board approval
- Determine and implement compliance process
  - Recruitment policy?
  - Use of template agreement?
- Continually evaluate and monitor

How can we HELP?