How to Use and Not Abuse MGMA and Other Survey Data in FMV Compliance Programs: Why Flawed Data Usage Leads to Increased Compliance Risk

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This program is a general discussion of legal and business issues; it should not be relied upon as legal, valuation, business, financial, or other professional advice.

The panelists will provide their own views and not those of their current or past employers or clients.

Not all slides will be covered in detail. Some are for reference only.

The slides are the result of the collaboration of the panelists and reflect their individual and collective thoughts and observations.

This presentation may include a discussion of hypothetical scenarios. Any hypothetical scenarios are intended to elicit thoughtful and lively discussion, but do not represent actual events.

This program may include a discussion of certain ongoing or settled *qui tam* or other lawsuits. The discussion is based on publicly available documents and allegations in the lawsuits. We wish to remind participants that allegations are allegations only. We also wish to remind participants that the list of cases and related issues we discuss may not be comprehensive.

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Session Overview

Part I: Regulatory/Enforcement Context

Part II: Examining Industry Usage of Survey Data

Part III: The Reality of the Data

Part IV: Appropriate Data Use and Solutions

Part V: Question and Answer

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Part I: Regulatory/Enforcement Context

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Regulatory/Enforcement Context

2005 OIG Compliance Guidance.

*Is the determination of FMV based upon a **reasonable methodology** that is uniformly applied and properly documented?*

Applicable Guidance (From the Stark Commentary).

Phase I (2001) – Flexible Methods: *To establish the FMV of a transaction that involves compensation paid for assets or services, we intend to accept **any method that is commercially reasonable and provides us with evidence that the compensation is comparable to what is ordinarily paid for an item or service in the location at issue**, by parties in arm's-length transactions who are not in a position to refer to one another.*

Phase I (2001) – Internal vs. Independent Surveys: *We agree that there is no requirement that parties use an independent valuation consultant for any given arrangement when other appropriate valuation methods are available. However, while **internally generated surveys** can be appropriate as a method of establishing FMV in some circumstances, due to their susceptibility to manipulation and absent independent verification, **such surveys do not have strong evidentiary value** and, therefore, may be subject to more intensive scrutiny than an **independent survey**.*

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Regulatory/Enforcement Context

Applicable Guidance (From the Stark Commentary).

Phase II (2004) - No Bright Line Standard: *We appreciate the commenter's desire for clear "bright line" guidance [for determining FMV]. However, **the statute covers such a wide range of potential transactions that it is not possible to verify and list appropriate benchmarks or objective measures for each**. Moreover, the definition of FMV in the statute and regulation is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies.*

Phase III (2007) – Reliance on Salary Surveys: *We emphasize, however, that we will continue to scrutinize the FMV of arrangements as FMV is an essential element of many exceptions. **Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating FMV**. Ultimately, the appropriate method for determining FMV for purposes of the physician self-referral law will **depend on the nature of the transaction, its location, and other factors**.*

Phase III (2007) – Burden of Documenting FMV: *The statute and regulations provide a definition of FMV for purposes of section 1877 of the Act. **The parties to a transaction or an arrangement are in the best position to ensure that the remuneration is at FMV and to document it contemporaneously**. If questioned by the government, the burden would be on the parties to explain how the transaction meets the FMV compensation exception requirements.*

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Regulatory/Enforcement Context

Recent Enforcement Actions Involving Physician Compensation

New York Heart Center	**$1.33 million**
Infirmary Health System	$24.5 million
All Children's Health System	$7 million
Halifax Hospital	$85 million
King's Daughters Medical Center	$40.9 million
Tuomey Healthcare System	$72.4 million
Adventist Health System	$115 million
North Broward Hospital District	$69.5 million
Columbus Regional Health	$35 million
Dr. Andrew Pippas	$425 thousand
Westchester Medical Center	$18.8 million
Citizens Medical Center	$21.8 million

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Regulatory/Enforcement Context

Reference to survey data is prominent in enforcement cases

- Government's expert in the *Tuomey* and *Halifax* cases
- Tuomey's expert in the *Tuomey* case
- *Citizens' Medical Center* Case
  - Citizens' argued physicians made around national median; thus FMV
  - Judge ruled against motion to dismiss, concluding practice losses and pay increases created doubt about FMV, regardless of survey benchmarking
- Benchmarking above 75th and 90th percentiles mentioned frequently in whistleblower complaints as evidence of compensation paid for referrals

Citing practice losses is becoming the leading economic indicator of compensation exceeding FMV in recent enforcement cases

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Part II: Examining Industry Usage of Survey Data

Examining Industry Usage of Survey Data

Using survey data to define the US market

- Thinking the survey data fully represents all US physicians
- Thinking the survey data fully represents a specific local market based on national or regional data

Using specific percentiles of survey data to set floors and ceilings for physician compensation

- Defining market compensation based on specific percentiles

Assuming wRVUs (or collections) are the definitive driver of physician compensation

- One-to-one relationship based on reported percentiles
- Median rate x wRVUs = market compensation

Basing FMV solely on survey data using one or two production-based methods

Note: this presentation will critique the above usage.

Examining Industry Usage of Survey Data

Using survey data to define the US marketplace

- Physician employment by health systems
  - Citing MGMA percentage of reporting physicians employed by health systems
  - Used by media outlets, industry presentations, etc.
- Specific percentiles as national rates
  - Survey median as US national median
  - Over the 90th percentile as "most highly paid in the US"
  - Used by qui tam relators, industry presentations, DOJ
- Respondent characteristics
  - ACO participation, value-based payments, etc.
  - Industry searching for data; surveys provide such data on respondents

Note: this presentation will critique the above usage.

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Examining Industry Usage of Survey Data

Selection of specific percentiles for FMV

- Medians
  - "It's going to take the median to hire a replacement physician."
  - "Any physician should be able to move somewhere and make the median compensation per wRVU rate."
- Specific percentiles or range of percentiles
  - "FMV is up to the 75th percentile."
  - "Physicians over the 90th percentile are not FMV."
  - "FMV is the 25th to the 75th percentile."
  - "FMV is the median to 75th percentile."
- Support for selecting percentiles
  - "This is how everybody does it."
  - "This is what we see in our practice."
  - "I heard it at a conference or webinar so it must be true."

Note: this presentation will critique the above usage.

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Examining Industry Usage of Survey Data

Matching compensation and production

- Percentile matching: total compensation
  - Total compensation should match with the benchmarked level of production
    - Example: physician at the 65th percentile for wRVU production should be paid the 65th percentile total compensation
  - Stacking analysis: problem if total comp from all elements (clinical, call, admin) benchmark higher than production
    - Example: total comp at 85th percentile, but production at 65th
- Percentile matching: compensation rate
  - Compensation rate (per wRVU or collections %) should match with the benchmarked level of production
  - Example: physician at the at the 65th percentile for wRVU production should be paid the 65th percentile compensation per wRVU rate

Note: this presentation will critique the above usage.

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Part III: The Reality of the Data

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Primer on Statistics

Inferential statistics

- Sample of a population is analyzed
- Characteristics of sample are extrapolated to the population: sample reflects the population
- Requires a representative sample of the population
- Requires randomized or other sampling techniques to provide for a representative sample

Descriptive statistics

- Description of a given data set
- Presents analysis of a given data
- Sample not developed as an "academic, statistically significant" representation of a population

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Primer on Statistics

Surveys are a description of a nonrandom sample of U.S. physicians

- Voluntary participation
- Trade associations or client relationships
- Concentrations in characteristics of respondents
  - Large multispecialty groups and health system practices
  - MGMA provides filters for reporting data based on specific characteristics

Implications for using survey data

- Not based on randomized or representative sampling methods
- Not an "academic, statistically significant" representation of the U.S. physician marketplace
- Provides a broad picture of the range of compensation and production for responding physicians who are a part of the U.S. physician market
- Requires informed use and judgment in making inferences and conclusions about specific physicians relative to survey data

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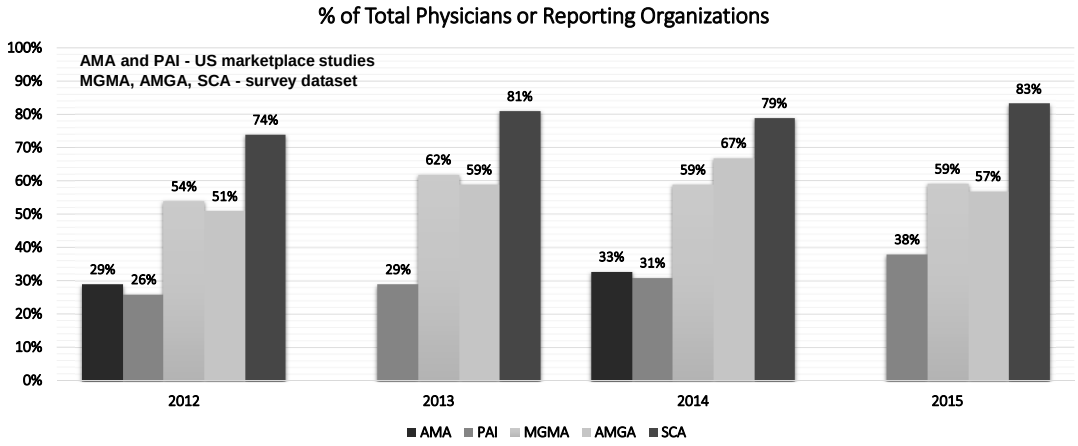
Physicians Employed by Health Systems



AMA and PAI - % of US physicians
MGMA – based on % of reporting providers
AMGA and SCA – based on reporting organizations
***This analysis is based on the data year and not the year of publication**

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Implications of Survey Sample Analysis

Limits "truth claims" made based solely on survey data

- Survey percentiles as US marketplace benchmarks
- Ranges of compensation and production may be different
- Patterns and relationships between compensation and production may be different
- Limitations in making inferences about all US markets, local markets, and specific physicians
- Characteristic trends
- Alternative payment model trends

Improper usage leads to an inaccurate market analysis

- Misinformed FMV or CR analysis based on *only* survey trends

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Survey Data Tables

Total Compensation

Specialty	10th %tile	25th %tile	Median	75th %tile	90th %tile
Cardiology: Electrophysiology	$350,449	$429,826	$541,271	$684,299	$814,667
Cardiology: Invasive	$297,040	$392,511	$484,485	$624,697	$770,674
Cardiology: Invasive-Interventional	$349,742	$455,449	$560,000	$686,310	$854,651
Cardiology: Noninvasive	$252,000	$338,036	$426,295	$533,818	$636,982

Work RVUs

Specialty	10th %tile	25th %tile	Median	75th %tile	90th %tile
Electrophysiology	5,110	6,620	8,690	11,858	14,619
Cardiology: Invasive	4,113	5,937	7,946	9,693	12,533
Cardiology: Invasive-Interventional	5,181	6,742	8,680	11,464	14,723
Cardiology: Noninvasive	3,840	5,274	7,070	9,212	12,020

Compensation to Work RVUs Ratio

Specialty	10th %tile	25th %tile	Median	75th %tile	90th %tile
Electrophysiology	$35.99	$45.49	$57.20	$76.95	$98.05
Cardiology: Invasive	$37.19	$50.26	$59.73	$74.33	$111.06
Cardiology: Invasive-Interventional	$39.28	$49.86	$60.79	$79.92	$98.87
Cardiology: Noninvasive	$36.12	$46.45	$60.30	$79.82	$101.97

Source: MGMA DataDive Provider Compensation 2013

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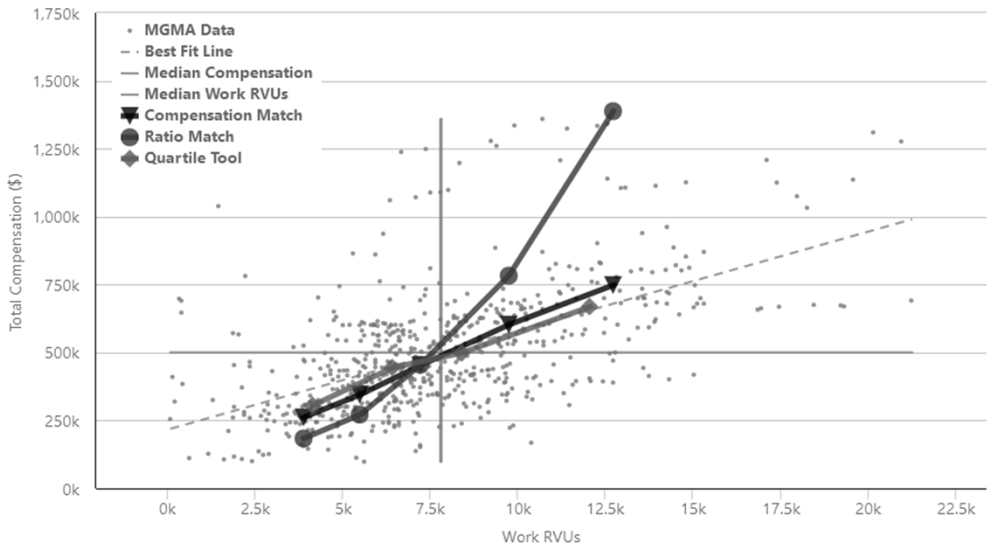
Cardiology: Noninvasive Compensation and Work RVUs



Source: MGMA DataDive Provider Compensation 2016 Pay to Production Plotter

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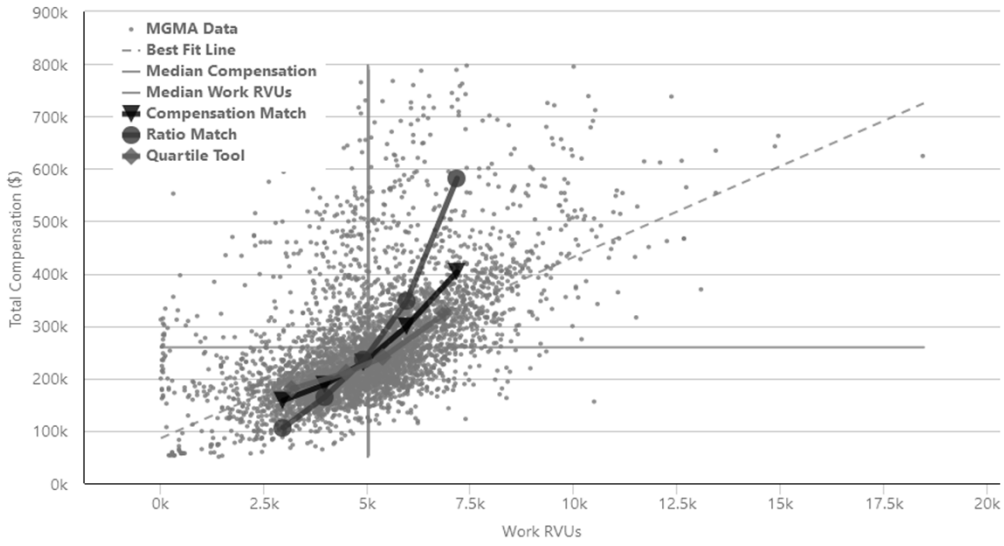
Family Medicine (without OB) Compensation and Work RVUs



Source: MGMA DataDive Provider Compensation 2016 Pay to Production Plotter

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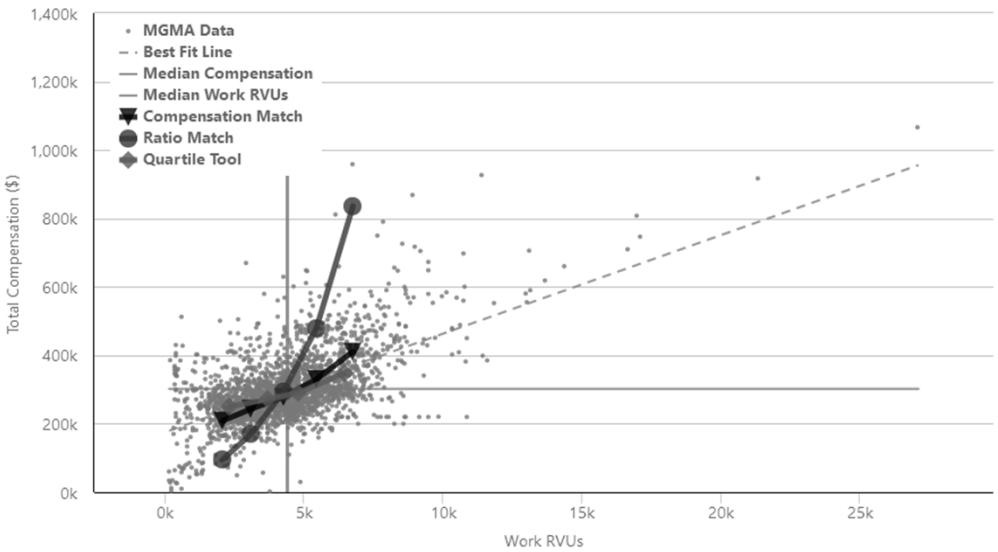
Hospitalist: Internal Medicine Compensation and Work RVUs



Source: MGMA DataDive Provider Compensation 2016 Pay to Production Plotter

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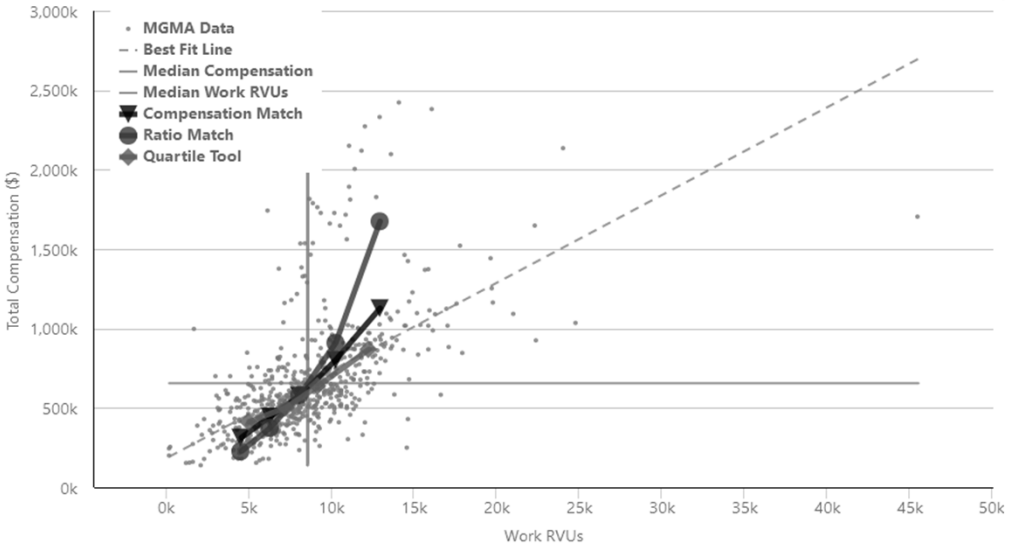
Orthopedic Surgery: General Compensation and Work RVUs



Source: MGMA DataDive Provider Compensation 2016 Pay to Production Plotter

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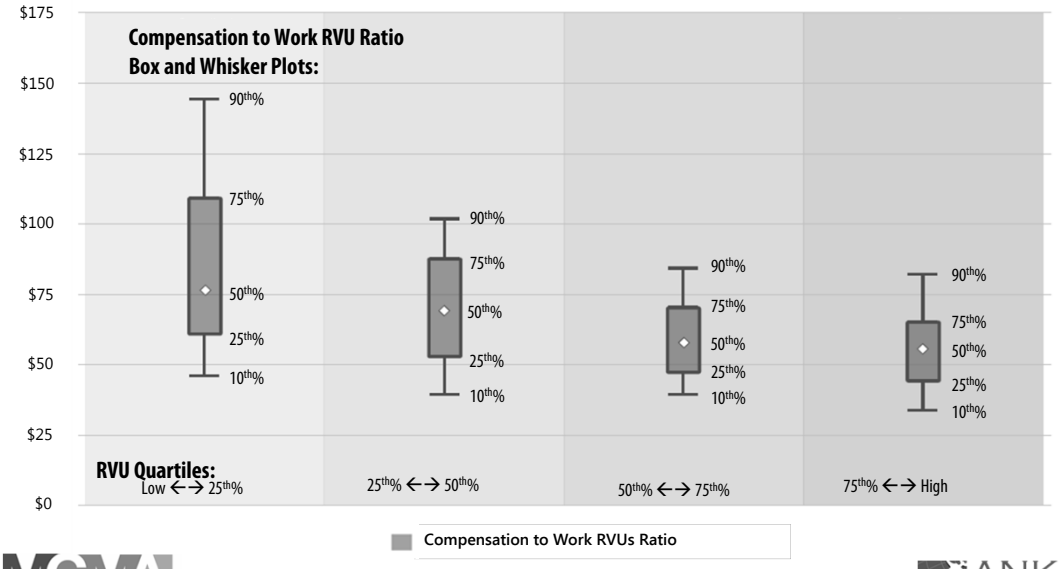
Quartile Report



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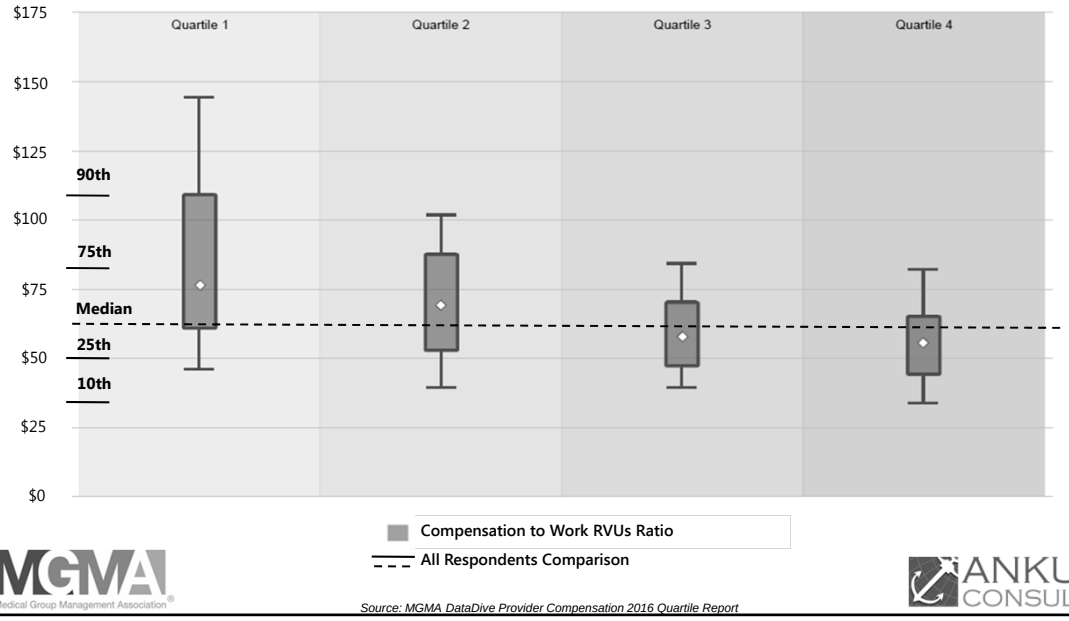
Cardiology: Noninvasive Grouped by Work RVU Quartiles



Source: MGMA DataDive Provider Compensation 2016 Quartile Report

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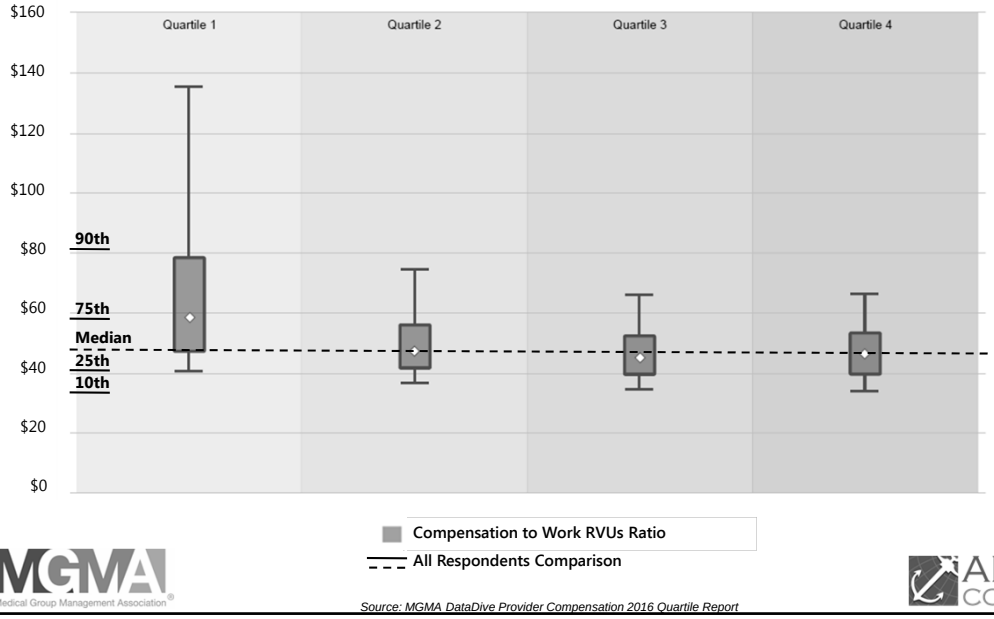
Family Medicine (without OB) grouped by Work RVU Quartiles



Source: MGMA DataDive Provider Compensation 2016 Quartile Report

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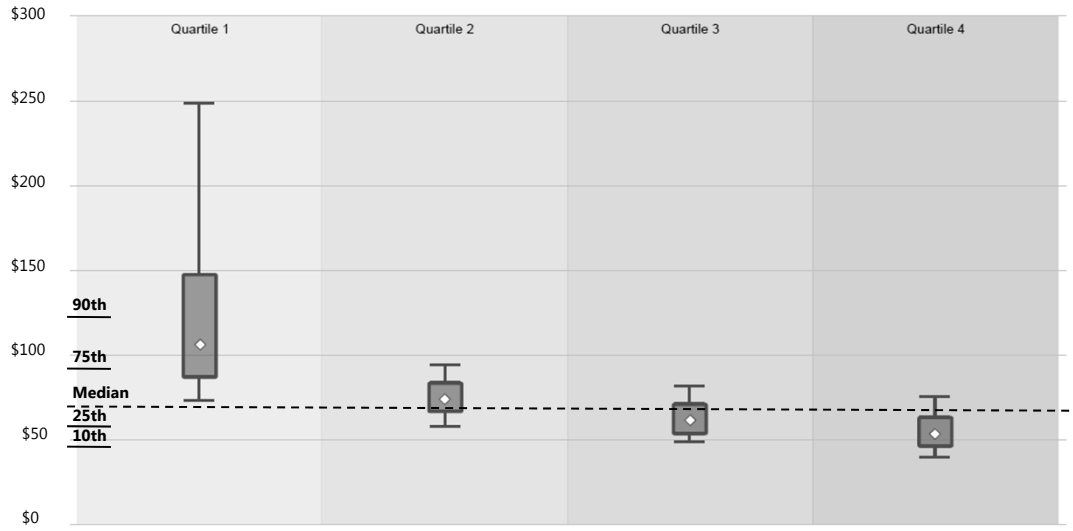
Hospitalist: Internal Medicine grouped by Work RVU Quartiles



Source: MGMA DataDive Provider Compensation 2016 Quartile Report

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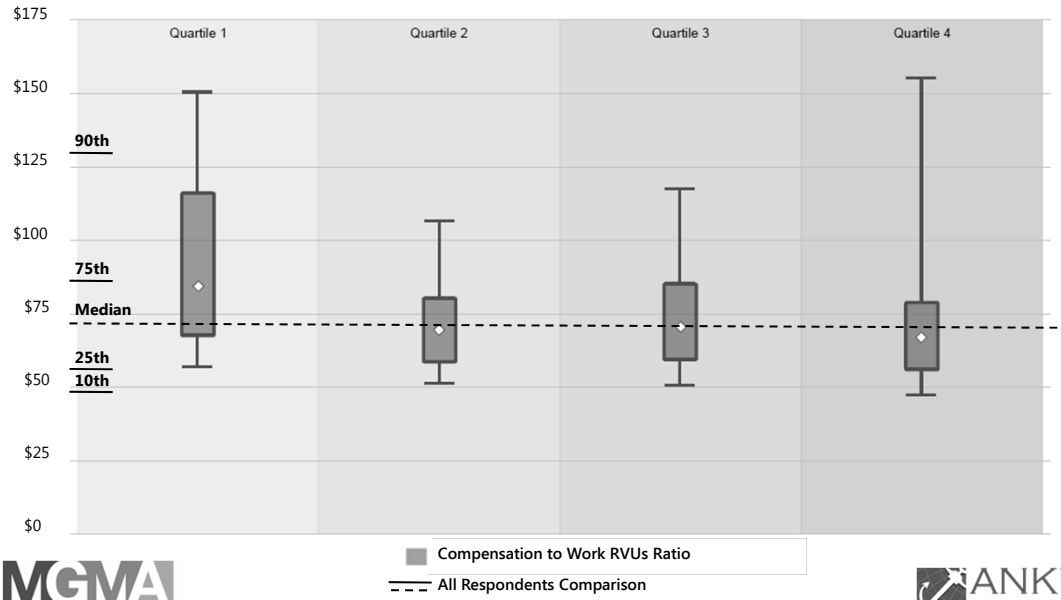
Orthopedic Surgery: General grouped by Work RVU Quartiles



Source: MGMA DataDive Provider Compensation 2016 Quartile Report

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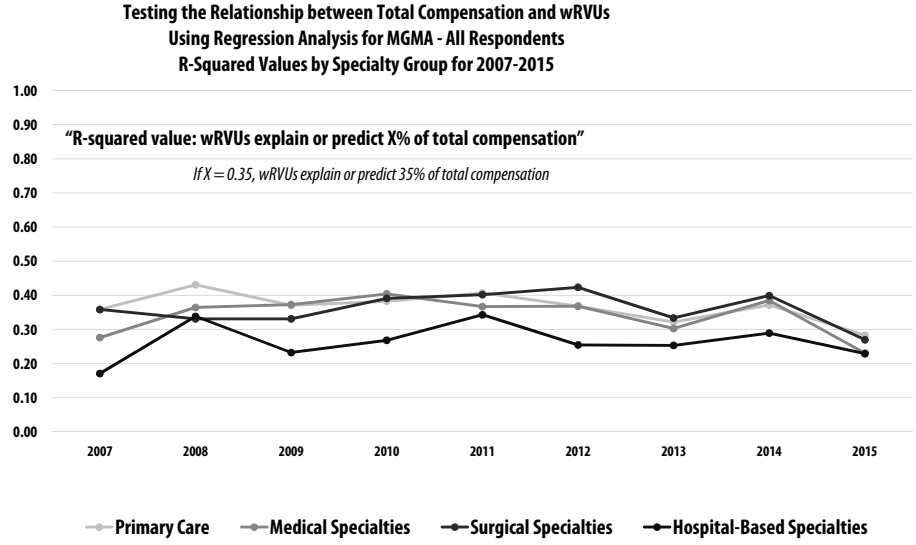
The Reality of the Data



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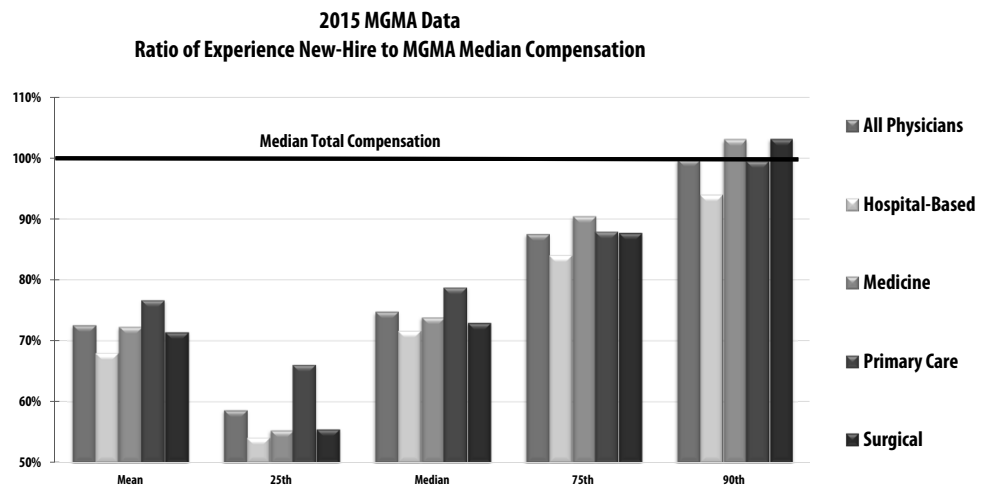
The Reality of the Data



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The Reality of the Data

Wide dispersion of compensation levels relative to production

- Wide range of compensation per wRVU at any given level of production
- Median compensation rate varies by level of production
- Percentile matching is not supported by the data
- Selecting percentiles as universal rates of FMV does not comport with the dispersion of the data
- Most newly hired physicians don't make the median total compensation as a starting salary
- wRVU production does not explain or predict the majority of total compensation for all respondents without appropriate parameters in place
  - May explain more for certain subgroups

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The Reality of the Data

Factors driving wide dispersion of compensation levels relative to production

- Local market commercial payer rates
- Payer mix
- Service mix
  - Ancillaries
  - Nonproduction services: call coverage, administrative
- Profits on nonphysician providers
- Cost efficiency

Ignoring these other factors in using survey data can lead to ***practice losses***

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Part IV: Appropriate Data Use and Solutions

Avoid Common Misuses of MGMA Data

Inappropriate use of MGMA Data includes:

- Using total compensation as a benchmark, and adding on-call, incentives, etc. on top
- Defaulting to high percentile benchmarks when not appropriate to the situation
- Not applying data filters when applicable
- Dividing across tables to get ratios
- Matching productivity percentiles to ratio percentiles
- Using total compensation for newly hired physicians

Best Practices for Survey Usage

Remember to:

- Pay attention to survey data definitions
- Use survey data as a guide, and use multiple sources
- Use the median as the central point of a dataset; not the mean/average
- Start with current practice realities and level-set physician expectations
- Apply necessary filters to specific scenarios
- Utilize the Pay to Production Plotter and Quartile Tool for both data applications and education
- If in doubt, contact Data Solutions for data clarification

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FMV Usage and Solutions

Valuation is not based on prescribed formulas

- IRS Revenue Ruling 59-60 (influential valuation text)
  - "No formula can be devised that will be generally applicable to the multitude of different valuation issues…" (§ 3.01)
  - "Because valuations cannot be made on the basis of a prescribed formula…" (§ 7)

Key to the market approach is comparability of the subject to the market data

- Comparable services
- Comparable conditions and markets
- Independent parties (without referral relationships)

Comparability of survey data

- Respondent characteristics
- Definitions of reported metrics

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FMV Usage and Solutions

Benchmarking and robust multifactor economic analysis to evaluate comparability

- Multiple metrics: production, revenue, cost
  - *Physician compensation is not singularly determined by wRVUs*
  - Multiple factors affect physician compensation and economics of physician practices
- Every physician and practice is not supposed to be at the median
  - By definition, most will not be!
  - *The median is neither a floor nor a ceiling!*
- High or low benchmarking in and of itself is not determinative of operational or compliance issues
- Do you understand the key economic drivers of the subject physician's practice relative to survey data?
- *Do you know why your health system's practices lose money?*
- Rigorous economic analysis is needed

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FMV Usage and Solutions

Standard appraisal methodology

- Consideration of three approaches to value
  - *But, current healthcare compensation valuation practice ignores the cost and income approaches*
- Outside of healthcare, the rest of the valuation world uses market data along with the cost and income approaches
  - See IRS Reasonable Compensation Job Aid
  - Value of professional services = net earnings generated
  - Tax court cases using the independent investor test

Use the cost and income approaches too

- Earnings-based compensation with adjustments
- RBRVS model – every dollar collected has a job
  - Proportion for work = physician comp and benefits
  - Proportion for practice expense + malpractice = overhead
  - *It's CMS' own payment allocation methodology!*

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FMV Usage and Solutions

Misnomers about cost and income approaches

- Involves valuing referrals - *Not True!*
  - Income approach values each service separately – must estimate each earnings stream individually and stack them
  - Survey data includes profits on ancillaries – it's baked into the compensation levels at undetermined levels

Misuse of survey data can lead to practice losses

Become informed data users not abusers

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Question and Answer

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