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Advanced Fair Market Value: Complex Hospital-Physician Compensation Arrangements

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Overview

- Ensuring your hospital has a defensible fair market value analysis process;
- Must organizations start to focus on commercial reasonableness when analyzing fair market value?
- How will organizations address fair market value in the move from volume to value?
- Specific case study discussions of documenting fair market value for physician supervision/collaboration, administrative services, team based models of care, and more.

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Defensible Fair Market Value Analysis Process

- Organizations should establish a vibrant fair market value documentation process.
 Departments involved include:
 - Compliance
 - Legal
 - Finance
 - Operations
 - Audit

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Defensible Fair Market Value Analysis Process

➤ Typical pathway for physician compensation arrangements include:

1. **Operations** identifying needed physician financial arrangement.
2. Consultation with the **Finance** Department regarding
 - a) proposed financial terms, b) fair market value documentation issues, and c) analyzing the commercial reasonableness of i) proposed financial arrangement from an operations perspective, and ii) compensation terms.

Defensible Fair Market Value Analysis Process

3. Consultation with **Legal** Department regarding a) legal structure of compensation arrangement to comply with the Anti-Kickback Statute and Stark Law, and b) fair market value/commercial reasonableness analysis.
4. **Compliance** oversight of the operational and legal requirements in 1. and 2. above.
5. **Audit** structure for oversight of the compensation arrangement.
6. Approval by Physician Arrangements Review **Committee** of FMV and Commercial Reasonableness.

Defensible Fair Market Value Analysis Process

Typical third party surveys include:

- **Sullivan, Cotter & Associates, Inc.** - Physician Compensation and Productivity Survey
- **HayGroup** - Physicians Compensation Survey
- **Hospital and Healthcare Compensation Service** - Physician Salary Survey Report
- **Medical Group Management Association** - Physician Compensation and Productivity Survey
- **ECS Watson Wyatt** - Hospital and Health Care Management Compensation Report
- **William M. Mercer** - Integrated Health Networks Compensation Survey



Defensible Fair Market Value Analysis Process

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Defensible Fair Market Value Analysis Process

Data Example 1:

- Single Tier Model with a Guaranteed Cash Compensation of \$175,000 with additional incentive compensation of \$40 per RVU above 4,500 RVUs work.
- Base Compensation, RVU production and compensation per RVU all benchmarked at 50th percentile.

Percentile	Cash Compensation	RVUs	Compensation per RVUs
25	125,000	3,500	\$35
50	175,000	4,500	\$40
75	225,000	5,500	\$41
90	300,000	6,500	\$46

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Defensible Fair Market Value Analysis Process

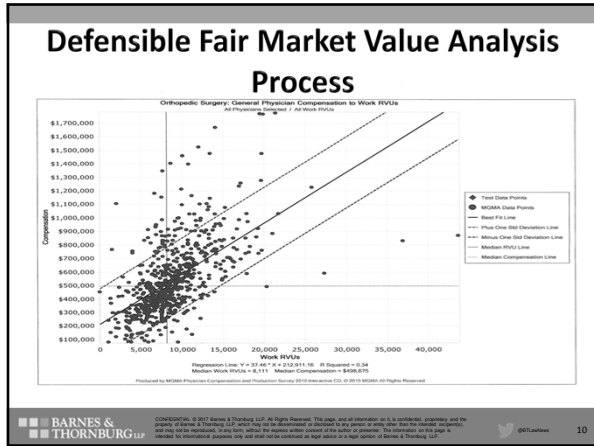
Data Example 2:

- Multiple Tiered Model
- 100% RVU Production

RVUs worked	Compensation per RVU
4,500 and below	\$30
4,501 – 5,500	\$35
5,501 – 6,500	\$40
6,501 and above	\$42

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Defensible Fair Market Value Analysis Process

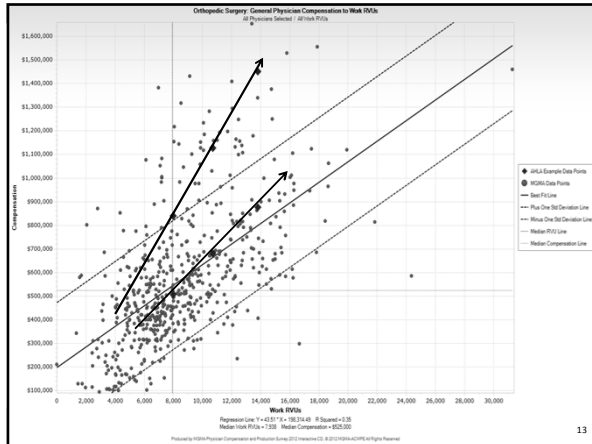
- Be careful with the compensation per wRVU benchmark data.
 - 90th percentile physicians, based upon productivity, do not earn compensation per wRVU at the 90th percentile.
 - For most specialties, compensation per wRVU should remain approximately at the 50th percentile.

Defensible Fair Market Value Analysis Process

Specialty: Orthopedic Surgery


	50 th	75 th	90 th
wRVUs*	7,981	10,723	13,795
x \$63.54(50 th)*	\$507,113	\$681,339	\$876,534
x \$105.18 (90 th) *	\$839,442	\$1,127,845	\$1,450,958
Benchmark Range*	\$520,119	\$682,541	\$943,059


* Based upon 2012 Physician Compensation and Production Survey from the Medical Group Management Association




Defensible Fair Market Value Analysis Process

- Fair market value is based upon the specific financial arrangement being entered into by the parties. Factors that can cause compensation to exceed 90th percentile include:
 - Extremely high productivity
 - High demand/low supply for specialty
 - Thought leader in specialty
 - Historic compensation above 90th percentile for personally performed services (do not include revenue from ancillary services or midlevel providers)
 - Super sub-specialization or multi-specialty
 - Nationally renowned program






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Defensible Fair Market Value Analysis Process


- Aggregate compensation versus each component of compensation.
- Benchmark data includes all sources of compensation from respondents
- When analyzing fair market value compensation, understand all sources of compensation.
- Can one physician really be more than a 1.0 FTE?
- Focus on number of hours worked by physician.



Employment
Research
On-Call
Medical Staff Officer
Medical Directorship



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FMV Process

- Contract Request and Document Management System
- Customized workflows for all contract types:
 - Physician Employment
 - Professional Service Agreements
 - Supply Chain
 - Real Estate
 - Design & Construction
 - Research
- No contract and no signature unless contract request submitted through database

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FMV Process

- Capturing all components of compensation:
 - Clinical
 - Call Pay
 - Administrative
 - Medical Director
 - Academic
 - Sign-on Bonus

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FMV Process

- Once survey is complete, the request routes for FMV review.
- FMV department performs an initial fair market value assessment to determine if we already have an FMV opinion that covers the proposed compensation arrangement.
- If no existing FMV, the FMV department reviews the proposal to determine if the proposed compensation is at or below the 60th percentile annual salary for the appropriate specialty according to national benchmark data.
- If the proposed compensation exceeds the 60th percentile compensation benchmark, then the proposed compensation is sent for an outside FMV/commercial reasonableness opinion.

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Commercial Reasonableness

Commercial Reasonableness Questionnaire
(from Halifax Health)

1. Is the compensation fair market value? Coordinate with the Finance Department for an FMV opinion if not already obtained.
(Yes or No) _____
2. What is the business purpose of this arrangement?
3. Does this arrangement further Halifax Health's mission and/or pursuit of strategic goals?
4. Justify the amount of services
5. Can the function be performed by a non-physician? If yes, discuss why you are seeking a physician.
6. If services are rendered on an hourly or part time basis, are there mechanisms in place to ensure the services are actually performed by the physician? If yes, please describe them. Otherwise, respond with "full time".
7. Is there a continued need for the services? If yes, please describe.
8. Are these services duplicated elsewhere? If so, does this new agreement create an excessive supply of services given our facility's need?

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Commercial Reasonableness

- Separate analysis from FMV
- Commercial reasonableness is more of a “qualitative” analysis than quantitative
- Many FMV reports specifically exclude comment or opinion regarding CR
- Who determines if the transaction is CR? – often nobody knows or is asking
- CR opinion provides a “pre-transaction” document demonstrating thought regarding CR
- Seeing more government activity in this area

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Commercial Reasonableness

- The following services may not be commercially reasonable:
 - Two medical directors over a department when only one is needed.
 - Paying the physician for questionable consulting services.
 - Renting a piece of equipment full-time when only used once a month (assuming rental for one day is less than full-time rental).
 - Purchase of physician's medical office building with no intention to use building.
 - Large net losses to the hospital.
 - Rate may be FMV, but fail CR test.

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**FMV With Transition
from Volume to Value**

Volume: The most commonly used productivity measures, in order, are the following: wRVUs, collections, net income, and patient visits.¹

2011 Physician Compensation and Productivity Survey by Sullivan, Cotter & Associates, Inc. Of those that use productivity based incentive measures, 74% use work RVUs.

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**FMV With Transition
from Volume to Value**

Health care organizations are placing a greater concentration, and thus a greater percentage of compensation, based upon **value** of medical services as opposed to traditional productivity compensation arrangements.

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**FMV With Transition
from Volume to Value**

➤ Areas of focus for value include:

- Quality
- Access
- Patient Panel Development/Maintenance


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FMV With Transition from Volume to Value

Quality:


- Education
- Meeting attendance
- Value Based Care
 - NGACO RAF, Medicaid peds RAF, Medicaid quality, Saturday Access
- Quality measures
 - Adult: BMI(G), HTN, CCS, BCS(G), Depr Screen(G), DM composite, Pneumovax(G)
 - Peds: Immun by 2(G); develop screen, asthma med control; depr screen(G); BMI(G); HTN screen(G)
- Innovation measures
 - Video visits, RIE, pediatric collaboratives


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FMV With Transition from Volume to Value

➤ Access compensation can include:

- Maintaining office hours outside of the traditional 8 am – 5 pm
- Managing practice to permit scheduling of appointment within two business days (i.e. maintaining a schedule so that 20% of the schedule is available two business days before requested appointment).
- Maintaining Saturday office hours.



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FMV With Transition from Volume to Value

An example of a Panel Incentive is as follows:

Age Adjusted Panel Size per clinical FTE	Incentive per clinical FTE
2,500	\$ 25,000
2,750	\$ 30,000
3,000	\$ 35,000
3,250	\$ 40,000
3,500	\$ 45,000
3,750	\$ 50,000
4,000	\$ 55,000
4,250	\$ 60,000

Age adjusted, by way of example, could include a 20% reduction for patients below the age of 18 and a 20% increase for patients above the age of 65.


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FMV With Transition from Volume to Value

➤ Examples of non-productivity quality indicators, based upon the percentage of patients receiving wellness services, based upon a percentage of the patient panel receiving such non-productivity services, is as follows:

- Breast cancer screening
- Rectal cancer screening
- Depression screen
- Pneumonia vaccination
- High blood pressure consultation
- Cholesterol screening
- Aspirin utilization for patients with coronary heart disease
- Childhood immunizations
- Tobacco use screening and cessation counseling

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FMV With Transition from Volume to Value

Fair market value in the **aggregate**, is still a requirement in non-productivity compensation models due to the requirements under the exceptions under the Stark Law and the safe harbors under the Anti-Kickback Statute.

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Case Studies

United States ex rel. Reilly v. North Broward Hospital District, et al.

➤ Allegations:

- The relator alleged that the compensation was excess of fair market value and commercially un-reasonable, because it was over the 90th percentile of total cash compensation as published in MGMA physician compensation surveys, and generated substantial practice "losses" for Broward
- Broward tracked and evaluated "inpatient contribution margins" and "outpatient contribution margins"

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Case Studies

North Broward Hospital District

- For instance: One orthopedic surgeon was alleged paid at least \$1,391,184.23 in 2008 and \$1,557,984.40 in 2009
- MGMA 90th percentile compensation for orthopedic surgeons in the Southern U.S. was \$1,209,569 in 2008
- After evaluating the net revenue and expenses of the practice, Broward faced a net loss of \$791,630
- However after tracking “inpatient contribution margins” and “outpatient contribution margins” this surgeon contribution margin was a profit of \$867,326

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Case Studies

North Broward Hospital District

- The physicians’ compensation was not financially self-sustaining from professional income alone, but would be self-sustaining if one added the value of facility fees, which Broward tracked
- The whistleblower argued that Broward’s “Contribution Margin Reports,” continually tracked referral profits and was used to **“take into account the volume and value of referrals”** when establishing compensation
- The complaint also alleged that Broward pressured physicians to limit charity care, even though Broward is a public entity, and to keep referrals in-house, even when physicians believed the patient’s care needs were better served by another facility

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Case Studies

North Broward Hospital District

- The settlement marked the largest ever reached without litigation under the Stark Law at the time
- Because of the settlement we don’t know DOJ’s thoughts on:
 - The propriety of compensation that, in combination with practice overhead expenses, is in excess of collections from the physician’s personally performed services
 - But we do know that a DOJ fair market value expert has asserted in litigation that physician arrangements, even for employed physicians, for departments that “lose” money are commercially un-reasonable while conceding that there is no statutory or regulatory basis for such an assertion
 - And the DOJ has asserted that hospitals that tolerate practice “losses” *because of* the value of the employed physician’s referrals to the hospital are suspect

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Case Studies

Adventist Health System

➤ Compensation Exceeded Fair Market Value:

- Compensation formulas based on “bottom line” by incorporating Part A and Part B revenues (DHS revenues) such that compensation varied based on volume or value of referrals. For example, oncologists were paid in part with chemotherapy revenues so that the more chemotherapy drugs a physician ordered, the more the physician was paid. This resulted in a high number of physicians exceeding the 90th percentile with some making over \$1 million/year.
- Bonus payments consisting of professional charges plus a significant portion, if not all, of the facility fee. The facility fee was paid outside of the contract language.
- Bonuses based on numbers of patients seen by the physician.

Case Studies

Adventist Health System

- Employment agreements included caps on compensation **that were not enforced**. One interesting example involved an oncologist whose total compensation was nearly \$2 million and by contract was not to be paid in excess of the 99th percentile. Other agreements required the physician not to be paid more than certain dollar figures or no more than the 90th percentile and none were enforced.
- The Dorsey *Qui Tam* complaint included an exhibit listing 167 physicians whose compensation arrangements involved alleged Stark violations, 85 of those exceeded the 90th percentile on MGMA
- Many physicians **paid in excess of 90th percentile** fell below the **50th percentile in work RVUs**

Case Studies

Adventist Health System

➤ Employed Physician Practices Consistently Lost Money But for Referrals:

- Contribution margin from inpatient and ancillary services referrals was tracked for each physician
- One example describes a pediatric urologist who wanted to work 3 days/month and was paid \$300,000/year based on the physician doing 80-85% of his surgeries at the hospital
- Physician debts were routinely forgiven
- Employment agreements included provisions requiring salary reductions if practice losses exceeded certain amounts that were not enforced

Case Studies

United States *ex rel. Drakeford v. Tuomey Healthcare System, Inc.*

- In 2003, several local specialty groups told Tuomey they planned to perform surgical procedures in-office instead of at Tuomey's 266-bed hospital
- To allegedly avoid a reduction in surgical case volume, Tuomey employed the 19 specialists as part-time employees
- Each of the 10-year employment contracts included essentially the same terms.
 - Physicians were required to perform outpatient procedures at a Tuomey hospital or facilities owned by Tuomey
 - Tuomey was responsible for billing and collections from patients and third-party payers, including Medicare and Medicaid
 - Tuomey compensated the physicians with annual base salaries that hinged on Tuomey's net cash collections for outpatient procedures
 - The physicians were also eligible for productivity bonuses equal to 80 percent of the net collections, along with an incentive bonus that could total up to 7 percent of the productivity bonus
 - Finally, the contracts also included a non-compete clause, prohibiting the specialists from competing with Tuomey during the 10-year term and two years after the contract expired

Case Studies

Tuomey Healthcare System, Inc.

- Tuomey claimed that it had acted in good faith and sought/relied on advice from various outside law firms and consultants in connection with the employment agreements – Legal Opinion “Shopping”
- Tuomey indicated that it believed the employment agreements were commercially reasonable and not in excess of fair market value given a shortage of physicians in the community
- However, the Government discovered additional consultant reports suggesting potentially conflicting opinions as to the regulatory risk of the employment agreements

Case Studies



Tuomey Healthcare System, Inc.

- The valuation Tuomey relied upon indicated productivity levels of the physicians were between the 50th and 75th percentiles
- Compensation levels exceeded the 90th percentile
- But, the valuation did not take into account any full time benefits provided
- In addition to this valuation, Tuomey sought out the expertise of a former Department of Health and Human Services attorney who had experience with the Stark Law and who advised them the physician contracts were problematic and the terms could potentially expose liability under the Stark Law

Case Studies

Tuomey Healthcare System, Inc.



- Shortly after, Tuomey terminated the representation and sought advice from a new attorney
- The new attorney was placed in the position of providing guidance to Tuomey regarding compliance with the Stark Law
- This new attorney allegedly advised Tuomey that given the facts above, the Stark Law did not apply to the physician contracts


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Case Studies

Volume or Value Analysis with Case Studies



- Cannot **take into account** volume or value.
- Four levels of volume and value:
 - i. Paying a doctor for each referral of designated health services. **Clearly prohibited.**
 - ii. Creation of a bonus pool that varies with either the gross revenue or net margin of a service line. Division of bonus pool based upon each physician's referrals of DHS. **Clearly prohibited.**
 - iii. Creation of a bonus pool that varies with either the gross revenue or net margin of a service line. Division of bonus pool based upon percentage of work RVUs in comparison with aggregate wRVUs of all applicable physicians. **Halifax case, but unlitigated.**
 - iv. Fixed bonus pool or bonus based upon overall success of AMC, both financially and based upon quality metrics. **Unlitigated.**


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Case Studies

Tuomey Healthcare System, Inc.

- Major Question regarding the volume or value of referrals:
 - Here is how the Fourth Circuit interpreted the compensation structure when remanding the case back to district court:
 - "It stands to reason that if a hospital provides fixed compensation to a physician that is **not based solely on the value of the services the physician is expected to perform**, but also takes into account additional revenue the hospital anticipates will result from the physician's referrals, that such compensation by necessity takes into account the volume or value of such referrals."
- Important Takeaways from Tuomey:
 - Virtually all FCA cases are resolved through settlement agreements due to potential ramifications of losing – unusual that this case went to trial
 - Physician employment does not necessarily insulate agreements from Stark liability
 - If a proposed arrangement appears to have been developed in response to the fear of losing a referral stream, the government may look closely at issues of commercial reasonableness
 - Long-term arrangements should be reviewed periodically for compliance
 - Providers cannot blindly follow a fair market value or commercial reasonableness determination, its important to look at the analysis from a legal perspective


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Case Studies

United States ex rel. Baklid-Kunz v. Halifax Hospital Medical Center, et al. Allegations:

- Lawsuit brought by the former Director of Physician Services at Halifax Health alleges that contracts with six (6) oncologists violated the Stark law and other relevant Medicare laws.
- The government alleged that the prohibited referrals resulted in the submission of 74,838 claims and overpayment of \$105,366,000.

Case Studies

Halifax Hospital Medical Center

- Executed contracts with six medical oncologists that included an incentive bonus that improperly included the value of prescription drugs and tests that the oncologists ordered and Halifax billed to Medicare.
 - Bonus Pool = 15% of Halifax Hospital's "operating margin" from outpatient medical oncology services (i.e., pool includes revenue from "designated health services" referred by oncologists)
 - Does not comply with Employment Exception (1) FMV and (2) Volume/Value referral prohibition
 - Share of pool paid to individual oncologists is based on each individual physician's personal productivity, not referrals
 - However, pool includes "profits" from services referred, but not personally performed by oncologists.

Case Studies

Halifax Hospital Medical Center

- Complaint alleged that Halifax paid three neurosurgeons more than fair market value for their work.
 - Bonus = 100% of collections after covering base salary, no expense sharing
 - Total Compensation = As much as double neurosurgeons at 90th percentile of FMV.

Case Studies

Halifax Hospital Medical Center

➤ Bonus = 100% of collections after covering base salary, no expense sharing

- Total Compensation = As much as double neurosurgeons at 90th percentile

AMGA 90 th	MGMA 90 th	Dr. R. K.	Dr. WK.	Dr. FMV.
\$844,703	\$1,200,051	\$1,725,302	1,160,163	1,897,524

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Case Studies

Halifax Hospital Medical Center

Practice/Specialty	Median Net Income (Loss) per FTE Physician w/ Financial Support 2012 MGMA Cost Survey Data	Net Income (Loss) per MD
Multispecialty Group (Hospital-Owned 10 FTE or less)	-\$332,177.00	
Multispecialty Group (Hospital-Owned 11 to 25 FTE)	-\$146,000.00	
Multispecialty Group (Hospital-Owned 26 to 50 FTE)	-\$138,674.00	
Multispecialty Group (Hospital-Owned 51 to 75 FTE)	-\$82,707.00	
Multispecialty Group (Hospital-Owned 76 to 100 FTE)	-\$97,171.00	
Multispecialty Group (Hospital-Owned 101 FTE or more)	-\$83,688.00	
Anesthesiology (All Practices)	\$37.00	
Cardiology (All Practices)	-\$166,739.00	
Cardiothoracic/Vascular (All Practices)	-\$141,377.00	
Family Medicine (Hospital-Owned 10 FTE or less)	-\$127,130.00	
Family Medicine (All Practices)	-\$1,125.00	
Geriatric Medicine (All Practices)	\$544.00	
Geriatric Neurology (All Practices)	-\$244,250.00	
Hospital Medicine (All Practices)	-\$23,264.00	
Infectious Disease (All Practices)	-\$97,107.00	
Internal Medicine (Hospital-Owned 10 FTE or less)	-\$182,009.00	
Internal Medicine (All Practices)	-\$174,802.00	
Neurology (All Practices)	-\$178,165.00	
OB/GYN (All Practices)	-\$111,178.00	
OB/GYN - Maternal/Fetal Medicine (All Practices)	-\$391,061.00	
Obstetrical Medicine (All Practices)	-\$14,540.00	
Ophthalmology (All Practices)	\$10,937.00	
Otolaryngology (All Practices)	\$0.00	
Orthopedic Surgery (All Practices)	-\$228.00	
Otolaryngology (All Practices)	-\$2,880.00	
Pediatrics (Hospital-Owned 10 FTE or less)	\$6,036.00	
Pediatrics (All Practices)	\$11,227.00	
Physiatry (All Practices)	-\$138,674.00	
Psychiatry (All Practices)	-\$88,040.00	
Psychiatry - Addiction (All Practices)	\$128.00	
Surgery - Cardiovascular (All Practices)	-\$152,117.00	
Surgery - General (All Practices)	-\$146,383.00	
Surgery - Neurological (All Practices)	-\$82,734.00	
Surgery - Plastic/Reconstructive (All Practices)	-\$210,414.00	
Surgery - Urology (All Practices)	-\$261,375.00	
Urology (All Practices)	\$0.00	
Average Practice Rate per FTE Physician	-\$148,141.72	

Halifax Hospital Medical Center

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Case Studies

Halifax Hospital Medical Center

➤ DOJ asserts that paying physicians more than the professional collections they generate exceeds FMV, is not commercially reasonable, and takes referrals into account:

"Given that each neurosurgeon was paid total compensation that **exceeded the collections received for neurosurgical physician services**, Defendants could not reasonably have concluded that the compensation arrangements in those contracts were fair market value for the neurosurgical services or were commercially reasonable."

➤ But, there is no requirement that providing physician services must be profitable:

- If compensation is FMV and is not adjusted for referrals, it should satisfy the Stark Law
- Some service lines have unprofitable payor mixes or low demand
- CMS recognizes the legitimacy of subsidizing physician compensation, e.g. in the E.D.
- Likewise, call coverage and hospitalist services often require subsidies

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Questions ?

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