OBJECTIVES

1. Identify regulatory structures requiring fair market value and commercial reasonableness

2. Explore common valuation methods and factors influencing fair market value

3. Discover practical strategies for assessing and documenting the compliance of physician compensation arrangements

4. Answer key compliance questions regarding the design of physician compensation plans
AGENDA

Setting the Stage

Common Hospital and Physician Relationships

Dollars and Sense

Staying Out of Trouble... “or at least trying to...”

Physicians
- Private practice becoming economically unsustainable
- Institutional “affiliation” is main option
- Often seek financial support / remuneration first
- More open attitude toward employment

Hospitals
- Must maintain stable medical staff / key service lines
- Mounting competitive pressures
- Hospital management and boards accepting reality
- New financial constraints looming

Government
- Always dubious of provider relationships
- Regulatory framework designed to prevent or penalize fraudulent activities
- Government elevating its enforcement efforts

Environment
Medicare
- Stark Law
- Anti-kickback Statute
- False Claims Act
- Civil Monetary Penalties

Internal Revenue Code
- Rules governing tax-exempt organizations

State Laws and Others
- Corporate Practice of Medicine
- “Mini Stark”
- Anti-Trust

Stark prohibits:
- Physicians from making referrals of designated health services to an entity with which the physician has a financial relationship.

The statute is so broad:
- It covers nearly any physician-hospital arrangement
- Intent doesn’t matter…strict liability
- Critical that the arrangement meets one of the Stark exceptions
Recent Enforcement Actions Involving Hospital-Physician

• Toumey
  – Part-time employment of surgeons
  – Whistle-blower case (physician)
  – Stark violations
  – Court decision (twice)
  – Fair market value and commercial reasonableness
    • Non-compete also
  – $44 million ($237 million pending)

• Lessons
  – Legal and valuation opinion shopping
  – Evolution of Stark Interpretation
  – Importance of commercial reasonableness

Recent enforcement (cont.)

• Sisters of Charity of Leavenworth – Montana
  – Employment arrangements – compensation administration
  – Self-disclosure as result of internal reviews
  – Technical Stark and AKS
  – Settlement
  – Fair Market Value
  – $3.9 million

• Lessons
  – Pay attention to the details
  – Disclosure can be a long process
Recent Enforcement (cont.)

- Halifax
  - Professional service arrangements with independent physicians
  - Whistle-blower (compliance personnel at hospital)
  - Stark and AKS
  - Pending
  - Commercial reasonableness

- Lessons (so far)
  - Physician arrangements must be prudent and make business sense (Commercial Reasonableness)

Enforcement (cont.)

- Countless other examples
  - Violations ranged from
    - Seemingly simple, but technical errors, to
    - Being overly aggressive (in response to competition), to
    - Complete disregard for the law

- IRS
  - Putting tax-exempt status at risk
  - Excess benefit
  - Fair market value...rebuttable presumption
It's a tough job...

Compliance
- No matter how hard you try...
- You can still screw it up
- Tremendous pressure to “get deals done”
- Business people pushing to satisfy physicians
- Physicians have leverage
- Legal and regulatory risks are real
- Impact can be greater than the deal itself...

POTENTIAL PROBLEM SOURCES

Contracts
- Unsigned
- Late signatures
- Missing
- Insufficient contract language
- Rogue contracts

Documentation
- Lack of or insufficient documentation
- Documentation not consistent with payment
- Clerical errors (wrong payee name, etc.)

Payments
- One-time or ongoing overpayment
- Payment not consistent with contract
- Payment for services not rendered
- Underpayments

Non-Monetary Compensation
- Items of value not accounted for
- Items of value exceeding the CMS annual limit
Common Physician Arrangements

- Hospital – Physician Arrangements are Varied and Evolving
  - Employment
  - Professional Service
  - Medical or Program Directorship
  - Emergency Call
  - Clinical Service
  - Co-Management
  - Joint Ventures
  - Independent Contractors
  - Management Service
  - Leases
  - Shared-Risk

More Arrangements

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<thead>
<tr>
<th>Traditional</th>
<th>Unique</th>
<th>Emerging</th>
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<tbody>
<tr>
<td>• Medical Staff Leadership</td>
<td>• Resident Preceptors</td>
<td>• Research</td>
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<td>• Mid-Level Supervision</td>
<td>• Income / Revenue Guarantees</td>
<td>• Meaningful Use / CPOE / EHR</td>
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<td>• State Indigent Care Programs</td>
<td>Champions...incentives</td>
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<td>• Key Opinion Leader</td>
<td>• Shared-savings and Bundled</td>
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<td>Payments</td>
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<td>• Accountable Care</td>
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Physician Arrangements

- How can we be consistent when every arrangement is a little different?

Never Going to have Perfect Information

- Do the contract terms capture the reality of the arrangement?

Compliance Must Rely on the Efforts of Business People

- Are they negotiating and designing compliant relationships?

Setting Policy and Establishing a Workable Process are Key

- What do we do about exceptions?

Know the answers to these questions

- Are physicians employed or independent contractors?
- Is there a contract approval process and who is involved? (board, legal, finance, compliance)
- Do the physicians have written agreements?
- Are the expectations of the arrangement outlined in the contract?
- How are physicians compensated (production, fixed rate, hourly, etc.)
- Was FMV and CR determined and documented? How?
- Does physician compensation consider ancillaries or only professional services?
- Do physicians complete time records for non-clinical time?
- Do contracts meet a Stark exception? AKS safe harbor?
- Is the POS billed correctly for physician services?
- Who is responsible for administering the arrangement?
- Does the administrator understand the arrangement terms?
Getting to Fair Market Value

• Required Financial Standards
  – Fair Market Value
  – Commercial Reasonableness

• Apply to:
  – Physician compensation and other financial relationships
  – Practice acquisitions and health care business transactions

Stark Law imposes limits on the valuation of certain income under compensation arrangements

  “Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”

  Stark further states that FMV may be determined by “any reasonable method.”

  Former Stark Safe Harbor sought to define FMV for hourly compensation arrangements. Ultimately, deemed impractical.


Valuation Approaches

- **Income Approach**
  - Value determined by reference to expected future income generated

- **Cost Approach (Asset)**
  - Value determined for an asset based economic principle of substitution

- **Market Approach**
  - Value derived from an analysis of comparable data / transactions

Valuation in Compensation Arrangements

- Market Approach is most prevalent
- Emerging perspectives among appraisers concerning the economic impact of physician arrangements

What you need to know?

- **Process**
  - Was FMV determined?
  - Who performed the valuation...qualifications?
  - Was a formal analysis or report issued?
  - Was the report reviewed / approved by business people / legal counsel?
  - Where is the report stored?

- **Substance**
  - Which valuation approach was used to determine FMV?
  - What assumptions / expectations / market factors were considered in the valuation?
    - Did the valuation exclude the volume and value of referrals?
  - Was the valuation consistent with others?
    - If not, why not?
Market Approach Examples

- Prevailing Compensation
  - Survey Data

- Productivity
  - Percent of Collections
  - WRVUs X Compensation per WRVU
    - Hybrid Cost and Market Approach

- Physician Job Dynamics
  - Clinical
  - Administrative
  - Call
  - Other

- Physician Compensation Survey Data
  - American Medical Group Association
  - Hay Group
  - Medical Group Management Association
  - Sullivan Cotter Associates
  - Others

- Comparative Metrics
  - Annual Compensation
  - Hourly or Shift Compensation
  - Compensation per WRVU
  - Signing Bonus, et al
  - Compensation per Call Shift
  - Operating Expenses per FTE physician
  - Operating Expenses as a percent of Collections
  - Compensation to Collections Ratios
  - Others

- Comparative Statistics
  - 10th, 25th, 50th, 75th, 90th percentiles

Time for a Quiz

Which survey is the best source of physician compensation data?

Is it OK to base FMV on only one survey?
  - If not, why not?

What can you do if data do not exist for a new specialty?

What is the big mistake some organizations make when paying physicians on a WRVU basis?

What percentile is the best for physician compensation?

At what level of compensation should we be concerned?
1. No survey is perfect. — Each has strengths and weaknesses, limitations and biases. The ones listed are generally deemed reliable by appraisers. Organizations should evaluate the various sources, understand their limitations and determine which best reflects their situation.

   — In some circumstances, other survey sources may be necessary to consider (i.e., academics, physician executives, pay for call, etc.)

2. Usually, no. — Because of the limitations of the individual surveys, as well as available government guidance (Stark II Safe Harbor), a blended survey approach is considered prudent for FMV determination.

   — Sometimes, multiple surveys will not possess the necessary data.

3. Tough question. Here are some suggestions.

   — Call the survey sources and see if they have any data that may be suppressed in their reports.

   — Contact specialty societies.

   — Check with your favorite consultant...chances are they have dealt with that specialty for someone else.

   — Do financial projections based on anticipated case volumes and professional fees.

   — Use the available data (e.g., compare IM and Hospitalist compensation to estimate a reasonable adjustment for Neuro-Hospitalists from General Neurology). Evaluate and be prepared to adjust after a year.

4. They align compensation per WRVU with actual WRVU production (percentiled).

   — Mathematically, this alignment usually results in excessive compensation for high producing physicians. For example, a physician producing WRVUs at the 75th percentile, being paid 75th percentile compensation per WRVU, will likely end up with total compensation above the 90th percentile.

5. This answer can depend on several factors, such as:

   — Prevailing local market conditions

   — Individual/physician productivity

   — Organizational mission and/or community need

   — Method of compensation and expectations

6. From a practical standpoint, compensation around the median doesn’t generally raise FMV concerns unless a physician is seriously underperforming.

   — Targeting a particular percentile range of compensation is best driven by an effective compensation plan design that seeks to balance compensation with physician contribution (collections, productivity, quality, etc.) and market conditions

   — Some organizations will set compensation thresholds around the 75th percentile to trigger an internal or external FMV review.

   — Other organizations may set a hard cap on physician compensation at the 90th percentile to avoid potential compliance risks and/or ensure that patient care doesn’t suffer due to aggressive physician work efforts.

Emergency Call

- Burden
- Type of Call – Unrestricted, Restricted or Blend
- Number of physicians in the rotation
- Intensity of Call – frequency and complexity
- Payer Mix
- Institutional and Community Need
- Trauma Status

- Expectations and Market Factors!
Factors (cont.)

Professional Service Arrangements

- Vary from group practice models to service line coverage (ED, anesthesia, ICU, etc.)
- High degree of complexity
- Value Considerations
  - Specialty
  - FTE physicians and mid-level provider staffing / coverage requirements...who makes the determination?
  - Overhead
  - Productivity
  - Administrative roles
  - May involve acquisition of certain assets (ancillaries)

Factors (cont.)

Service Line Co-Management

- Common in cardiology, emerging in surgery, hematology / oncology, orthopedics, and others
- Increasingly observed in CPM states
- Value Considerations
  - Administrative services
    - Typically, time-based
    - Quality and efficiency achievement
  - May be budget-driven or in relation to scope of management services
- See OIG Advisory Opinion 12-22
Compensation Misconceptions

- “So long as we do not exceed payment amounts above 90\textsuperscript{th} percentile of MGMA, we are OK.”
- “The doctor is a ‘high producer’, which is why base salary is set at the 75\textsuperscript{th} percentile.”
- “The physician is employed, thus, the Stark Law doesn’t apply.”
- “The other hospital in town pays $2,500/night, so that must be fair market value.”
- “The contract says the doctor is here for 10 hours per week, therefore, we pay him for 10 hours.”
- “We can pay the doctors for call; because if we don’t, they’ll go to the competing hospital.”
- “We can pay the doctor more than he was making because we are going to get all his referrals.”

Commercial Reasonableness

- Required, but not defined in Stark or AKS
- **CMS Definition**
  - An arrangement that appears to be a sensible, prudent business agreement, from the perspective of the parties involved, even in the absence of any potential referrals.
  
  “An arrangement will be considered ‘commercially reasonable’ in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS [Designated Health Services] referrals.”

- Heightened concern as a result of Toumey and Halifax cases.
CR and FMV

• “A payment term may be deemed to be fair market value, but may not be commercially reasonable.”
  – Examples: Compensation may be FMV, but...
    • Paying a physician for a medical directorship that the hospital doesn’t need, or for work that another physician is already performing.
    • Leasing 3,000 square feet from a physician-owned MOB when the hospital only needs 1,500 (and vice versa).
  – ...the arrangement doesn’t make business sense, and therefore, is not commercially reasonable

The CR Challenge Question

• Does it ever make business sense to enter into a financial arrangement with independent physicians that does not have a positive economic return for the hospital, when you exclude the value of referrals?
  – If so, when?
  – What about at group practice PSA?
1. What is the hospital’s specific purpose for contracting for the services or conducting the transaction?

2. Does the arrangement meet the need/demand for the services of the hospital and surrounding community? Is there any objective data available that indicates a hospital and community need for these specific services?

3. Absent patient referrals, what benefits do the hospital and community receive from the arrangement?

4. Does entering into the arrangement solve or prevent an identified business problem for the hospital?

5. Are the terms of the arrangement sensible and consistent with accepted business practices?
   - Factors to consider include: duration, renewal, termination, compensation review and other relevant contractual terms.

6. Is the arrangement explainable? In other words, on its face, is the arrangement clear and are the tasks, duties, and responsibility expectations clearly articulated and documented?

7. Absent patient referrals, does the agreement make economic sense for both parties?

8. Is the arrangement consistent with other arrangements of similar nature observed in the industry?
Medical Directorships

1. Is the scope of the directorship duties reasonable and consistent with other comparable directorships in the industry?

2. Is there thorough documentation of administrative and clinical responsibilities (percentage of time and amount of time expended for each)?

3. Are there internal review processes to assure/verify the director is performing the expected duties, tasks, and responsibilities?

4. Have you assured, prior to entering into the arrangement, that there will be no duplication of services or medical staff requirements as a result of the arrangement?

5. Are there multiple directorships and if so, are there policies/procedures to assure that there is no duplication of actual services provided?

6. Are the terms of the directorship agreement reasonable and consistent with business practices?
   - Factors to consider include: duration, renewal, termination, compensation review and other relevant contractual terms.

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Promoting Compliance in Physician Compensation

Role of the Compliance Officer in physician contracting

The Compliance Officer **should not** be directly involved in negotiating contracts with physicians in order to ensure independence of payment review throughout the contract term.

The Compliance Officer **should** ensure that the appropriate controls are in place to govern the physician contracting process.
Elements of a Compliant Physician Relationship

- Stark exception or AKS safe harbor is identified and followed
- Agreement in writing
- At least one-year term
- Compensation set in advance
- Compensation not tied to referrals (past, present or future)
- Compensation is fair market value and commercially reasonable

Ensure contract is current

Identify compensable activities described within the contract
  - Are the activities being performed?
  - Are related payments consistent with contract terms?

Review compensation methodology

Total from all sources (i.e., clinical pay, sign-on bonus, medical directorship, call, etc.)

Evaluate aggregate compensation

Are physicians being compensated for inappropriate revenue or activity?

Ensure total compensation is within FMV

Is documentation of FMV and commercial reasonableness included in the contract file?

Consider an FMV review trigger or compensation cap for highly compensated physicians, especially in connection with production-based compensation plans.
Spots Problems in Physician Compensation

Guaranteed Compensation Plans
- Guarantee set above 50th percentile (median)
- Is the physician's contribution sufficient to support the level of pay?
- Consider all aspects of the contribution

WRVU Production Plans
- Base compensation divided by WRVU threshold results in compensation per WRVU above median $/WRVU
- Can market reimbursement support level of pay?
- WRVU pay rates mirror WRVU production levels
- Evaluate total compensation compared to production

Revenue minus Expense Plans
- Compensation to Collections Ratio Exceeds Market Median
- Ensure collections credit is appropriate – excludes DHS
- Evaluate whether expense allocation is sufficient

Wrap-Up
- Understand the mechanics of physician compensation
- Appreciate the technical substance of FMV and commercial reasonableness
- Know the regulatory requirements
- Ask the tough questions
- Set up policies and procedures to review, approve and audit physician arrangements
- Elevate Compliance
Questions and Contact Info

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