Physician Compensation Methods

Webinar By:

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About the Presenter

Todd A. Zigrang, MBA, MHA, FACHE, ASA, is the President of HCC, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures involving acute care hospitals and health systems; physician practices; ambulatory surgery centers; diagnostic imaging centers; accountable care organizations, managed care organizations, and other third-party payors; dialysis centers; home health agencies; long-term care facilities; and, numerous other ancillary healthcare service businesses. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of the "*Adviser's Guide to Healthcare – 2nd Edition*" (AICPA, 2015), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA The Value Examiner*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute. You can see his full CV at: https://www.healthcapital.com/hcc/html2pdf31/TZigrang_CV.pdf

Overview

- Introduction to physician compensation
- Increasing Scrutiny of Physician and Executive Compensation
- Overview of Compensation Arrangements
- Types of Compensation Arrangements
- Fair Market Value (FMV)
- Commercial Reasonableness
- Role of the Valuation Team
- Concluding Remarks

INTRODUCTION

Introduction

- Physician services may be divided into 2 general categories:
  - *Clinical related*
  - *Nonclinical related*
- *Nonclinical-related* activities are further divided into 3 generalized subcategories:
  - *Administrative*
  - *Management*
  - *Executive*
- These categories may be defined by the specific *tasks, duties, responsibilities, and accountabilities* (TDRAs) involved in each

Introduction

- Clinical-Related Services
  - The provision of professional medical services related to the *diagnosis* and *treatment* of patients who present with various injuries, diseases, and ailments by *physicians*, *allied health professionals*, *midlevel providers*, *technicians*, & *paraprofessionals*
  - May also include *coverage and call*, *research activities*, *clinical academic appointments*, *medical outreach and public health*, and *service line medical directorships*

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 867.

Introduction

- Nonclinical-Related Services
  - Services where the TDRAs associated with the position aren't directly related to treatment of patients
  - Includes *chief executive officer, chief financial officer*, *chief information officer*, *chief legal counsel*, and other "*C-suite*" *executives*, as well as *strategic and operational management positions* (e.g., practice administrators, billing managers, payor contracting managers), and *nonclinical-related* support staff

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 874.

Introduction

- Classification of Physician Services

	A	B	C	D
	Physician Service	**Clinical-Related**	**Nonclinical-Related**	**Both**
1	Clinical	X		
2	Call Coverage	X		
3	Medical Directorship			X
4	Executive		X	

Introduction

- The challenge for *independent* valuation professionals, working alongside hospital administration and legal counsel, is *identifying* and *separating* the various TDRAs for *clinical services* from those to be provided for *administrative*, *management*, and/or *executive* functions, in order to ensure that compensation for each service complies with the legal requirements of:
  - The *Stark Law*
  - The *Anti-Kickback Statute*
  - For non-profit entities, *excess benefit/inurement of benefit* regulations promulgated by the *Internal Revenue Service*

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 866.

Introduction

- Generally, the process of valuing compensation agreements can be broken down into:
  - The economic principles underlying value
  - The necessary documentation for compensation agreement(s)
  - Types of compensation plans
  - Industry benchmarking of the compensation agreement(s)

Growth of Physician Employment by Hospitals

- Hospitals focused on recruiting primary care physicians during the 1990s
- However, attention has turned to specialty practitioners, resulting in a growing number of specialists being employed by hospitals
- Hospitals are also employing physicians for medical directorship, management, administrative, on-call and executive positions
- This paradigm shift in the reimbursement environment, from *volume* to *value*, has significantly affected the flow of revenue to healthcare providers, increasing the uncertainty related to the anticipated reimbursement for physician services, and driving the pursuit of closer relationships between hospitals and physicians

Compensation for Hospital-Employed Physicians

- Arrangements must:
  - Be for *bona fide* employment
  - Have compensation that is *Fair Market Value* (*FMV*) and is not related to referrals
  - Be *commercially reasonable* to avoid legal impermissibility under the **Stark** and **Anti-Kickback** statutes
- Arrangements where any threshold is not met can also be found legally impermissible under the **Federal False Claims Act (FCA)**
  - Provider cannot *knowingly* submit a claim for reimbursement to a government entity for services under compensation arrangements which are deemed to be Stark and Anti-Kickback violations
  - A suit filed under the FCA is known as a "*whistleblower suit*" or a "*qui tam action*"

Increasing Scrutiny of Physician and Executive Compensation

- ***Rebuttable Presumption***: If all three parts are met, executive compensation is presumed to be at *FMV:*
  - Compensation approved by an authorized body whose members have no conflicts of interest
  - Compensation has been based on a reliable set of data
  - Authorizing body documented the basis for pay-setting
- February 2009: IRS Report on not-for-profit executive compensation
  - Results: Compensation high, but 85% of hospitals followed ***Rebuttable Presumption*** process (pay-setting practices are defensible under Internal Revenue Code)

"Exempt Organizations Hospital Compliance Project Final Report," Internal Revenue Service, February 13, 2009, www.irs.gov.

Increasing Scrutiny of Physician and Executive Compensation

- February 2009: IRS Report on not-for-profit executive compensation
  - Report questions the validity of comparable data used
  - Variations in reporting and high executive pay rates have prompted questions regarding the use of comparables, as well as, the efficacy of the ***Rebuttable Presumption*** process at setting compensation at ***FMV***
  - Significant variations in how hospitals accounted for: bad debt; community benefit; and, uncompensated care
  - Report makes no policy recommendations, but it may be used as a basis for executive compensation reform (e.g., executive pay camps, similar to the ones recently created for the financial sector)

"Exempt Organizations Hospital Compliance Project Final Report," Internal Revenue Service, February 13, 2009.

Increasing Scrutiny of Physician and Executive Compensation

- May 2009: **Fraud Enforcement and Recovery Act (FERA)**
  - Broadens definition of "***knowingly***" used in the *False Claims Act* (FCA)
    1) *"Has actual knowledge of the information;*
    2) *Acts in deliberate ignorance of the truth or falsity of the information; or,*
    3) *Acts in reckless disregard of the truth or falsity of the information."*
  - Reduces government's burden of proof – no longer required to provide "*proof of specific intent to defraud*"
  - **FERA** will facilitate easier prosecution for violations of FCA

"Publication of OIG's Guidelines for Evaluating State False Claims Acts," 71 Fed. Reg. 48553 (Aug. 21, 2006).

Increasing Scrutiny of Physician and Executive Compensation

- **2009 –** DOJ and HHS create the **Health Care Fraud Prevention and Enforcement Action Team (HEAT)**
  - Launched over 1,000 investigations
  - Leading to 800 indictments
  - Resulting in 600 convictions
- **2009 –** $2.5 billion was recovered and returned to the Medicare Trust Fund
- **2010 –** Federal government estimated to have spent $1.7 billion fighting fraud and abuse
- **2011 –** Healthcare reform began allocating $100 million, annually, to finance the cost of fraud and abuse investigations

"Heat Task Force Official Website," stopmedicarefraud.gov, (accessed 9/23/10). "Sebelius, Holder: New Healthy Reform Law Will Help Prevent Medical Fraud," By Andrew Villegas, Kaiser Health News, May 13, 2010, http://www.kaiserhealthnews.org/Stories/2010/May/13/health-fraud-shorttake.aspx, (accessed 9/23/2010).

POLLING QUESTION 1

Overview of Compensation Arrangements

Guiding Economic Concepts Related to Valuing Services

Principle of Scarcity

- "*influences market participants to assign relative value to goods and services in order to choose between the limited amounts available*"

Principle of Utility

- Basis of all ***economic*** values derive from the usefulness, or ***utility***, derived from the use of properties or services
- Accordingly, "***An object can have no value unless it has utility***"
  - Economic value analysis should be based on benefits expected to be derived from the ***utility*** of the physician executive services

"Healthcare Valuation: Financial Appraisal of Enterprise, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 893.
"Economics" 8th ed. By Michael Parkin, Boston: Pearson Addison Wesley, 2008, p. 2.

Guiding Economic Concepts Related to Valuing Services

Principle of Substitution

- What normally sets the limit of what would be paid for a good is the cost of **an *equally desirable substitute*** or one of ***equal utility***
- Compensation arrangement should be based on the cost of an equally desirable substitute, or one of *equal utility*

Principle of Diminishing Marginal Utility

- "*…the additional benefit which a person derives from a given increase of his stock of a thing, diminishes with every increase in the stock that he already has*"

"Principles of Economics" By Alfred Marshall, Eighth Edition, New York, NY: Cosimo, Inc., 2009 (originally published in 1890), p. 79. "Healthcare Valuation: Financial Appraisal of Enterprise, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 894.

Guiding Economic Concepts Related to Valuing Services

Principle of Anticipation

"*The economic benefits of ownership of, or the contractual rights to control, the subject services to be performed under the contractual agreement are created from the expectation of those benefits or rights to be derived in the future; therefore, all economic value is forward looking.*"

"Appraisal and Valuation: An Interdisciplinary Approach" By Richard Rickert, American Society of Appraisers Washington, DC: International Valuation Sciences Institute, 1987, p. 47. "Healthcare Valuation: Financial Appraisal of Enterprise, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 894.

Guiding Economic Concepts Related to Valuing Services

- Opportunity Cost
  - Compensation for physician management, administrative, and executive positions has been based on the physician's historical clinical practice earnings
  - Increasing concern that payment based on lost "*opportunity cost*," may not meet regulatory scrutiny under Stark Law
  - Given that lost "*opportunity cost*" should not be the sole basis of determining the FMV of an agreement, the valuator must apply the Economic Principles of *Utility* and *Substitution*

"Beyond Anti-Mark-up: 'Stand in the Shoes' and Other Practical Implications," By Michael W. Paddock, Crowell & Moring LLP, (February 2008).
"Health Law: 2007 Highlights and Reminders for 2008." By Hanesboone, "Health Care Alert," (2008), p.3.

Guiding Economic Concepts Related to Valuing Services

Economic Value Analysis

- ***Economic Value Analysis*** should focus on the economic benefits expected to be derived from the *use* of the physician services in the future
- A detailed examination of the attributes of the physician executive performing the administrative services must be undertaken; each element of the attributes must be:
  - *Identified* as to their existence
  - Classified as to the specific factors and traits (i.e., **task, duty, responsibility, accountability**) which would exhibit the means by which they would reasonably be expected to provide *utility* to the hospital

Guiding Economic Concepts Related to Valuing Services

Economic Value Analysis

- Intrinsic to identifying and classifying each attribute is selecting the appropriate metric to be utilized in measuring the utility provided
  - **Tasks** and **Duties**: discretely identifiable metrics (e.g., physician hour requirements)
  - **Responsibility** and **Accountability**: more complex metrics
    - Not easily quantified, despite often being the attribute of ***utility that produces an equal or greater economic benefit*** to the organization
    - Value related to ***responsibility*** and ***accountability*** will provide greater economic benefit to the contracting organization *vis a vis* the **risk/reward continuum** and the physician's relative risk in undertaking the given ***responsibility*** and ***accountability*** attached to the terms of the contract

Guiding Economic Concepts Related to Valuing Services

Work RVU as a Fungible Commodity

- "A National Study of Resource-Based Relative Value Scales for Physician Services" By William C. Hsiao, PhD, et. al., (1988)
  - Broke down physician services into fungible units known as Relative Value Units (RVUs)
  - Total RVU comprised of three weighted inputs:
    - **Work** (52%) / **Practice Expense** (44%) / **Malpractice Cost** (4%)
  - Theory: by breaking down physician services into fungible commodities, equivalence per unit of care across physician services and specialties might ensure equitable, reasonable reimbursement rates while additionally providing a tool for cost containment
  - "*Work*" defined as time, mental effort and judgment, technical skill and physician effort, and psychological stress variables

"A National Study of Resource-Based Relative Value Scales for Physician Services," By William C. Hsiao, et. al., Cambridge, MA, 1988, p. 30.

Guiding Economic Concepts Related to Valuing Services

Healthcare as a Fungible Commodity

"Money is the classic example of the fungible product. It represents recognized value, but one dollar bill is just as good as the next…the doctor-patient visit as a fungible commodity? Why not?"

"Commodified Care," by William S. Andereck, Cambridge Quarterly of Healthcare Ethics, Vol. 16, No. 4, 2007, p. 401-402.

Guiding Economic Concepts Related to Valuing Services

Healthcare as a Fungible Commodity

"[I]f health care is 'fungible,' then by implication the parts of health care are also interchangeable. Practically speaking, this also includes providers and patients as they are simply reduced to their identity and purpose within the confines of a business relationship. Just as the seller is interested only in providing that which the buyer needs (or desires) in so far as there is sufficient financial reward, the buyer is only concerned with obtaining the desired object (or service). Who they are makes no real difference. Commodification dictates that a physician is like any other, as long as they are matched with respect to specialty. He or she ceases to be the indispensable community caregiver, and instead becomes the link between company and profit, or shareholder and dividend. Patients, by the same token, are no longer seen as individuals with unique personalities and health care needs but as a source of revenue; they become "covered lives" and a "business asset whose value is inversely proportional to the cost of health care resources their care is predicted (statistically or otherwise) to consume."

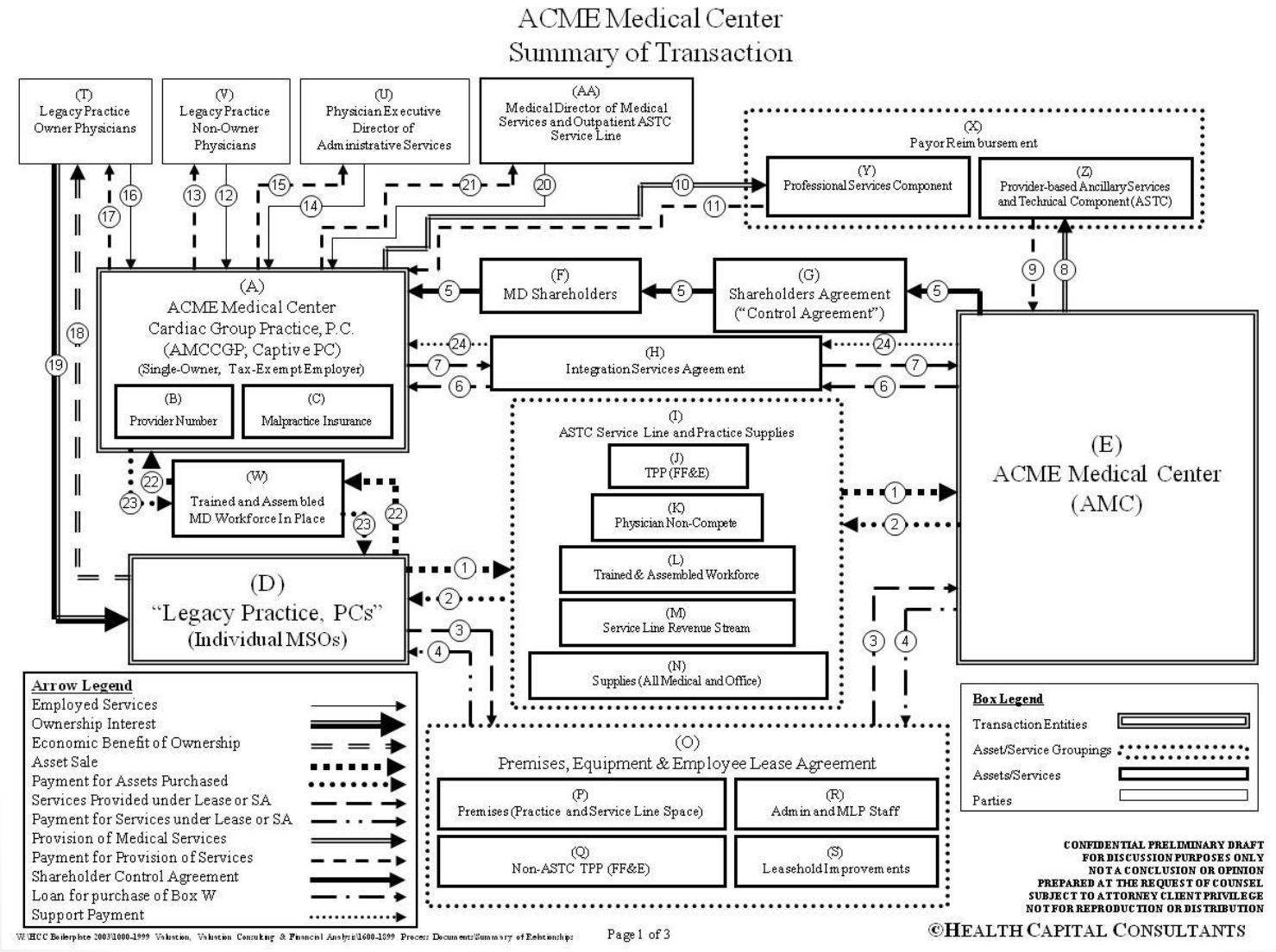
"Health Care as a Commodity: The Consequences of Letting Business Run Healthcare," By Timothy P. Doty, March 2008.

Enterprises? Assets? Services?

- ***FMV*** compensation for clinical services should be payment for only those specified services (i.e., wRVUs)
- Payment for profit from enterprise related activities (e.g. ASTC) should not be disguised as an increased $ per wRVU compensation

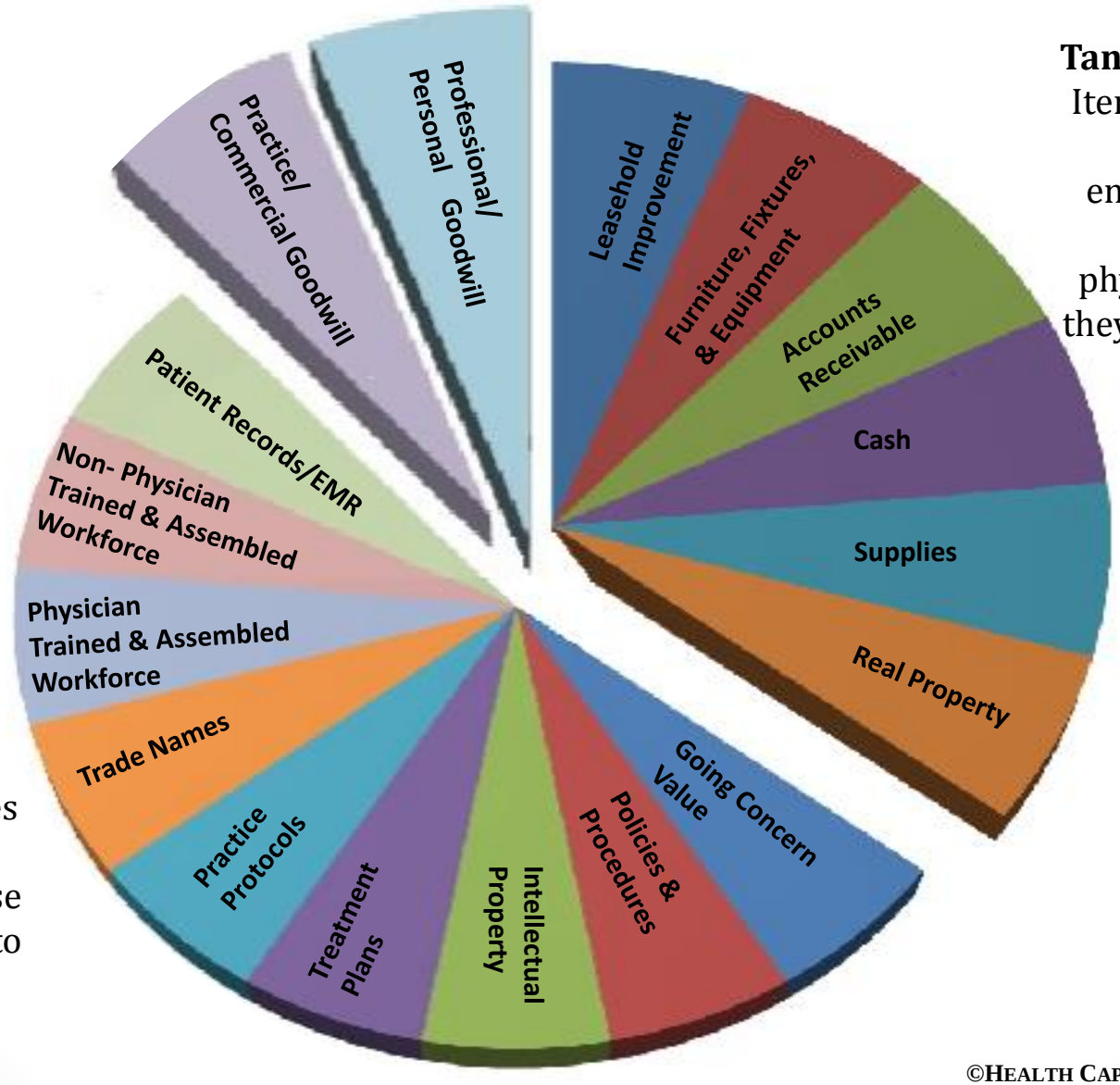
A wRVU is a wRVU!

Enterprises? Assets? Services? Summary of Transactions



Enterprises? Assets? Services?

Classification of Tangible and Intangible Assets



Tangible Assets
Items owned by the subject enterprise that possess a physicality (i.e., they can be seen or touched)

Intangible Assets
Non-physical items that grant certain specified property rights and privileges of ownership and that have or promise economic benefits to the owner(s) of the subject enterprise

POLLING QUESTION 2

Types of Compensation Arrangements

Types of Compensation Plans for Physician Services

	A	B	C	D	E
	Compensation Plan Element	**Clinical**	**Call Coverage**	**Medical Directorship**	**Executive**
1	*Fixed base salary* (i.e., compensation amount is set in advance and is not dependent on changes in productivity, time spent or other variable)	X	X	X	X
2	*Variable compensation* (e.g., compensation per hour spent)	X	X	X	X
3	*Clinical productivity* (e.g., compensation based on a *per wRVU* method, percentage of collections, or percentage of gross charges)	X	X		
4	*Incentive bonus* based on *clinical productivity*	X	X		
5	*Incentive payment* based on the performance of the area for which the individual is responsible, e.g., entity, department, service line			X	X
6	*Incentive payment* based on achieving *quality of patient and beneficial outcomes* gauged by agreed-upon measures and benchmarks	X	X	X	X
7	*Incentive payments* based on *specified legally permissible gainsharing arrangements* (e.g., *achieving certain cost savings and efficiencies*)	X	X	X	X
8	*Incentive payments* based on the contributions and economic input of the employed physician(s) to achieve *specified enhancement of the performance of the enterprise* (e.g., the development of a "*Center of Excellence*")	X	X	X	X

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 896.

Drivers of Clinical Productivity

- In developing a FMV analysis, the valuation analyst should consider the four provider-specific *drivers of clinical productivity*:
  - *Time*
  - *Efficiency*
  - *Volume*
  - *Quality performance*
- Consider these drivers either in comparison to internal sources or outside industry normative benchmark data

Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 908-910.

Drivers of Clinical Productivity

- ***Time:*** The amount of *time* dedicated to clinical activity will work to establish the bounds of that provider's volume of clinical productivity
  - In accordance with the *Principle of Substitution*, the provider has a finite limitation on both the number of hours and the volume of *clinical-related services* per hour they can provide
- ***Efficiency:*** Variances in the *level of provider efficiency* typically account for *differences in total volume* once adjustments for the incongruity introduced by *nonclinical time worked*, as well as for the variability introduced by *less hours worked by part-time providers*

"Measuring Physician Work and Effort" By Bruce A. Johnson and Deborah Keegan, in *Physician Compensation Plans: State-of-the-Art Strategies*, Medical Group Management Association, 2006, p. 114.

Drivers of Clinical Productivity

- ***Volume:*** The amount of clinical productivity possible
  - May be limited by the *time* spent on *nonclinical activities*, in a manner similar to that of *time* and *efficiency*
  - Therefore, the extent to which the potential *volume* of clinical production is limited should be taken into consideration when calculating *productivity.*
- ***Quality performance:*** *Quality metrics* are playing an increasingly important role in measuring a provider's performance for purposes of determining FMV compensation

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 910-911.

Physician Compensation Expense Allocation

- Compensation paid for physician clinical, on-call, and administrative services is distinct from ***reimbursement*** by a third-party payor for physician clinical services performed
- Compensation is an ***economic expense burden*** allocated against the revenue stream generated from the professional physician services performed by the employed physicians
- ***Economic expenses burden*** related to the physician's **malpractice insurance expense burden** must be properly allocated and accounted for in determining ***FMV*** and ***commercial reasonableness*** of proposed physician compensation transactional arrangements

Fringe Benefits

- Stark Law definitions – *Any remuneration*, whether in *cash* or *in kind*, is considered to be *compensation* for the purpose of determining FMV and *commercial reasonableness*
- Types of *benefit*s that are often part of a compensation arrangement include:
  - Health insurance for the physician and dependents
  - Contributions to retirement plans
  - Payment of automobile expenses
  - Compensation for continuing medical education
  - Reimbursement for business-related travel & entertainment
  - Payment of malpractice insurance coverage

"Definitions" 42 C.F.R. § 411.351 (October 1, 2014). "Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 912.

Physician Clinical Services

Gainsharing

- Arrangement "*under which a hospital gives physicians a share of the reduction in the hospital's costs (that is, the hospital's cost savings) attributable in part to the physicians' efforts*"
- Historically, gainsharing has been found to violate the **Civil Monetary Penalty Statute** (prohibits hospital for providing a payment to a physician as an inducement to reduce services) and **Anti-Kickback Statute**
- **2005**: OIG began to approve gainsharing arrangements due to benefits of decreased costs and increased quality
- **2009 Physician Fee Schedule** solicited comments regarding a possible new exception to **Stark Law** for shared savings programs (despite CMS's own concern for potential abuse)

"2009 Physician Fee Schedule Proposed Rule," 73 Fed. Reg. 23692-94 (Apr. 30, 2008).

Physician On-Call Services

Growing Need for Compensation for Provision of On-call Services Due to:

- Physician shortage and increased demand due to aging Baby Boomers
- Aging physician workforce
- Physicians demanding more "***regular***" work hours
- Physicians increasingly building practice through participation in ambulatory surgery centers and physician-owned specialty hospitals
- Physicians often receive inadequate payment for services provided while on-call as patients in the ED are often uninsured or under-insured

"OIG Advisory Opinion No. 07-10," Office of the Inspector General, Department of Health and Human Services, September 2007; "OIG Advisory Opinion No. 09-05," Office of the Inspector General, Department of Health and Human Services, May 2009.

Physician On-Call Services

OIG Approval of On-Call Compensation Arrangements

- **September 2007 (Opinion 07-10)**
  - First advisory opinion addressing on-call compensation arrangements
  - Physician's paid per-diem rate for on-call duties
  - On-call arrangement had sufficient safeguards to prevent Fraud – almost met the **Personnel Services and Management Safe Harbor**
    - Per Diem rates tailored to physician's burden and likelihood of response
    - Independent third party determined per diem rates were at ***FMV***
    - Payment not affected by volume or value of referrals
    - All physicians had equal on-call coverage, payment not higher for certain specialties

OIG Advisory Opinion No. 07-10," Office of the Inspector General, Department of Health and Human Services, September 2007, www.oig.gov.

Physician On-Call Services

OIG Approval of On-Call Compensation Arrangements

- **May 2009 (Opinion 09-05)**
  - Physicians paid on-call compensation for services to patients ineligible for Medicaid/other state health insurance programs - payment covered physician fees, emergency & inpatient services
  - Valuation methodology for compensation considered patient acuity, average length of stay, and physician time
  - On-call arrangement had sufficient safeguards to prevent Fraud – almost met the Personnel Services and Management Safe Harbor
  - Payments to physicians for services rendered, rather than availability (e.g., "*lost opportunity*")

OIG Advisory Opinion No. 09-05," Office of the Inspector General, Department of Health and Human Services, May 2009, www.oig.gov.

Physician On-Call Services

OIG Guidelines for Setting On-Call Compensation Arrangements at *FMV*

- Conduct independent, third party analysis, to determine if arrangement is at ***FMV***
- Ensure all physicians are eligible and payment is not based on the volume or value of referrals provided to the hospital
- Ensure equal division of on-call duties among all physicians
- Demonstrate that hospital has a "***legitimate, unmet need***" for on-call coverage and that compensation will ameliorate the situation
- Avoid payments for "***lost opportunity***" when services are not actually provided

"OIG Advisory Opinion No. 07-10" Office of the Inspector General, Department of Health and Human Services, September 2007, https://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-10A.pdf (Accessed 11/27/17). "OIG Advisory Opinion No. 09-05" Office of the Inspector General, Department of Health and Human Services, May 2009, https://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-05.pdf (Accessed 11/27/17).

Physician Administrative Services

Assessing *FMV* of Medical Directorships

- Employer should **document** the methodology used to set compensation
- Beneficial for employer to **track *and* document** the actual number of hours the medical director spends performing the services, as well as to make sure the documentation is consistent with the hours outlined in the medical director agreement
- ***"Justifying the need for medical director services goes hand-in-hand with showing that the services are actually furnished."***

"Fair Market Value Support Required: Physicians in Administrative Roles," By Jen Johnson, American Health Lawyers Association, Articles and Analyses, June 2008."Health Care Fraud and Abuse: Practical Perspectives," Edited By: Linda A. Baumann, The American Bar Association & The Bureau of National Affairs, Inc., Washington, D.C., (2002), pp. 281.

Compensation Benchmarking Sources

Generally accepted benchmarking data related to valuation of physician and executive compensation for clinical, administrative, and on-call services

	A	B	C	D	E
	Name	Publisher	Clinical	Medical Director	On-Call
1	Medical Group Compensation and Financial Survey	American Medical Group Association	×	×	
2	Cost Survey for Single-Specialty Practices	Medical Group Management Association	×		
3	Physician Compensation and Productivity Survey Report	Sullivan Cotter and Associates, Inc.	×	×	×
4	Physician Compensation Survey	National Foundation for Trauma Care	×		
5	Physician Executive Compensation Survey	American College of Physician Executives		×	
6	Physician Compensation and Production Survey	Medical Group Management Association	×		
7	Physician Salary Survey Report: Hospital-Based Group HMO Practice	John R. Zabka Associates	×	×	
8	Survey Report on Hospital and Healthcare Management Compensation	Watson Wyatt Data Services		×	
9	Cost Survey for Multispecialty Practices	Medical Group Management Association	×		
10	Healthcare Executive Compensation Survey	Integrated Healthcare Strategies		×	
11	Physician On-Call Pay Survey Report	Sullivan Cotter and Associates, Inc.			×
12	Management Compensation Survey	Medical Group Management Association		×	
13	Survey of Manager and Executive Compensation in Hospitals and Health Systems	Sullivan Cotter and Associates, Inc.		×	
14	Executive Compensation Assessor	Economic Research Institute		×	
15	Top Management and Executive	Abbott Langer Association, Economic Research Institute, and Salaries Review		×	
16	Executive Pay in the Biopharmaceutical Industry	Top 5 Data Services, Inc.		×	
17	Executive Pay in the Medical Device Industry	Top 5 Data Services, Inc.		×	
18	Hospital Salary & Benefits Report, 2007-2008	John R. Zabka Associates, Inc.		×	
19	US IHN Health Networks Compensation Survey Suite	Mercer, LLC		×	
20	Intellimarker	American Association of Ambulatory Surgery Centers	×	×	
21	Medical Directorship and On-Call Compensation Survey	Medical Group Management Association		×	×

Steps in the Benchmarking Analysis

	A	B	C	D	E
	Benchmarking Analysis Step	**Clinical**	**Call Coverage**	**Medical Directorship**	**Executive**
1	**Determine the specific characteristics of the arrangement, including:**				
2	*Applicable job training* and *education level* of the provider, relevant to the position	X	X	X	X
3	*Number of years of experience* and *reputation* of the provider	X	X	X	X
4	*Site of service* (e.g., hospital emergency departments, hospital service lines, trauma centers, birthing centers, ambulatory surgery centers, office-based physician practices)	X	X	X	X
5	*Geographic location* where the subject services are to be provided	X	X	X	X
6	*Specialty/subspecialty* of the provider	X	X	X	
7	*Nature of the revenue stream* that produces the income available for clinical-related services compensation	X		X	
8	The *size* of the organization (e.g., revenue, number of employees)			X	X
9	**Establish the *homogenous units of economic contribution* to be used as the *metric(s) of comparability*:**				
10	*Productivity components* (e.g., charges, collections, RVU)	X		X	
11	*Time components* (e.g., annual, monthly, hourly, full-time equivalent)	X	X	X	X

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 914-915, 918-919.

Steps in the Benchmarking Analysis

	A	B	C	D	E
	Benchmarking Analysis Step	**Clinical**	**Call Coverage**	**Medical Directorship**	**Executive**
12	**Develop the range of applicable, normative benchmark industry data, which should include measures within the range (e.g., 10th percentile, 25th percentile, 75th percentile, 90th percentile), as well as measures of central tendency (e.g., mean, median) and measures of dispersion (e.g., standard deviation). The range of normative benchmark industry data is typically compiled by taking a weighted average of the selected benchmark data from external sources that report the specified metric(s) of comparability. The percentage of consideration assigned to each data source, used to compile the range of normative benchmark industry data, should include contemplation of the following statistical and descriptive survey characteristics:**				
13	*Size of the data population sample* included in the external benchmark survey	X	X	X	X
14	Dispersion of the data – it should be noted that a useful metric for comparing the relative dispersion between data sets for the purposes of determining an applicable weight of consideration in calculating a range of applicable, normative benchmark industry data is the coefficient of variation	X	X	X	X
15	*Geographic proximity* in relation to area in which subject services will be provided	X	X	X	X
16	*Other elements of comparability* between the external benchmark survey source and the subject services (e.g., whether the external benchmark survey source includes elements of compensation not present in the subject *physician on-call services*, the date the external benchmark survey was compiled)	X	X	X	X

"Fair Market Value: Analysis and Tools to Comply With Stark and Anti-Kickback Rule" By Robert A. Wade, Esq., and Marcie Rose Levine, Esq., audio conference, HC Pro, Inc. (March 19, 2008), p. 35, 80; "Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 914-919.

Documentation per Type of Physician Service

	A	B	C	D	E
	Requisite Document to be Obtained	**Clinical**	**Call Coverage**	**Medical Directorship**	**Executive**
1	The proposed agreement(s) for the *physician services* (including a full description of all TDRAs related to the services to be performed)	X	X	X	X
2	Documentation as to the *board certification*, *qualifications*, and *tenure* of the providers (both of the subject professionals and of those providers performing services under similar arrangements)	X	X	X	X
3	The *medical staff bylaws* and *roster* of physician *medical directorships*	X	X	X	X
4	*Agreements for other similar positions* at the employer entity, including the *scope of services to be performed* under each of those agreements	X	X	X	X
5	The time requirements, e.g., the *number of hours* per week, anticipated under the agreement	X	X	X	X
6	The *curriculum vitae* for the provider performing the services	X	X	X	X
7	Documentation of *historical clinical productivity*, measured in *work Relative Value Units (RVUs), gross charges, net revenue, or count by Current Procedural Terminology (CPT) code* for an applicable time period to establish a relevant trend for forecasting purposes	X	X		
8	*Documentation as to the size of the employer*, *number of patients, acuity levels of patients*, and *specific needs* related to the organization		X	X	X

Documentation per Type of Physician Service

	A	B	C	D	E
	Requisite Document to be Obtained	**Clinical**	**Call Coverage**	**Medical Directorship**	**Executive**
9	The number of times the current (specialty specific) on-call physician was: (a) paged; and, (b) required to be present at the hospital for the last two years		X		
10	Time sheet records and the time spent and work performed by the physician on each subject service		X	X	X
11	Documentation of offers made to previous (or other existing) *professionals*	X	X	X	X
12	Documentation regarding the medical staff's *need for administrative direction* (based on clinical activities, hospital research efforts, community outreach programs, etc.)			X	X
13	The number of *committees/meetings* that require the professional's involvement and/or attendance, as well as the *average frequency* and *duration* of each committee and meeting			X	X
14	Documentation that the employer (at least) annually assesses the effectiveness of the *professional* in performing his or her TDRAs, as well as the *commercial reasonableness* of the contract			X	X
15	Descriptions of quality programs, including Centers of Excellence and "never event" committees, that the professional may participate in			X	X
16	Employer's administrative/management/executive agreement(s), with annual hour requirements and annual compensation paid to each professional/executive			X	X

Valuation Methodology for Physician Services

	A	B	C	D
	Valuation Methodology: Elements for Consideration	**Clinical**	**On-Call**	**Administrative**
1	Range (percentile) of compensation measured	×	×	×
2	Specialty or subspecialty need to be matched	×		
3	Metric of comparability must be selected	×[1]	×[2]	×
4	How the hourly rate (if applicable) and full-time equivalency (FTE) are calculated must be determined	×		
5	Whether on-call services are restricted or unrestricted[3]		×	
6	Determination of FMV for specific tasks, duties, responsibilities, and accountabilities required for services[4]	×	×	×
7	Determine whether productivity-based compensation is based on: (1) percentage of collections; (2) percentage of gross charges; or, (3) per RVU basis[5]	×		

Notes:

1. e.g., charges, collections, RVU
2. e.g., hourly, weekly, daily, annual metrics
3. *Restricted:* physician is required to stay on premises during call
   Unrestricted: physician is not required to stay on premises during call
4. May be beneficial to use the Principle of Substitution and Principle of Utility (e.g., Stark II, Phase III: Hourly rate may be used if it is set at *FMV*)
5. *Percentage of Collections:* may be high incentive to treat patients with higher paying payors
   Percentage of Gross Charges: beneficial as it is not based on patient payor mix, but may cause physician compensation to fluctuate
   Per RVU Basis: beneficial as compensation is based on productivity, but careful consideration should be paid to account for whether compensation is based on a total RVU basis or solely on a work RVU basis

"Stark II, Phase III," 72 Fed. Reg. 51015-16, September 5, 2007.

"Special Circumstances" Compensation Plan

- "*Special circumstances*" that could warrant paying in excess of the industry indicated benchmark data for a particular service may include:
  - Unique and, accordingly, scarce skill set of the provider
  - Additional TDRAs required of the provider, above those of typical providers in comparable positions, reported in the benchmark survey data
  - *Quality of the wRVU* generated by a provider *is higher* in relation to the wRVUs generated by the providers included in the benchmark survey data
  - Production a similar quality wRVU but at a lower cost per unit
  - Other special circumstances regarding the wRVUs produced by a particular provider

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 897-898.

POLLING QUESTION 3

Fair Market Value (FMV)

Definition of Fair Market Value (FMV) Stark Law

- *"The value in arm's-length transactions, consistent with the* ***General Market Value****"*
  - **General Market Value***: "The price that an asset would bring, as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement, as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. 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 Law: Definitions," 42 C.F.R. § 411.351 (2009).

Definition of Fair Market Value (FMV) Centers for Medicare & Medicaid Services (CMS)

- CMS (f/k/a Health Care Financing Administration) made the following statements regarding when a payment for services provided is at *FMV*:
  - *"[W]e believe the relevant comparison is aggregate compensation paid to physicians practicing in similar academic settings located in similar environments.* ***Relevant factors include geographic location, size of the academic institutions, scope of clinical and academic programs offered, and the nature of the local health care marketplace.****"*
  - *"...[We] intend to accept any method [for establishing FMV] 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****...The amount of documentation that will be sufficient to confirm [FMV]...will vary depending on the circumstances in any given case; that is, there is no rule of thumb that will suffice for all situations."*

"Stark II, Phase I," 66 Fed. Reg. 916, 944 (Jan. 4, 2001).

Definition of Fair Market Value (FMV) Centers for Medicare & Medicaid Services (CMS)

- In Stark II, Phase III, CMS provided the following guidance for valuing administrative positions:
  - *"A fair market value [**FMV**] hourly rate may be used to compensate physicians for both administrative and clinical work, provided that the rate paid for clinical work is [**FMV**] for the clinical work performed and the rate paid for administrative work is fair market value for the administrative work performed. We note that the fair market value of administrative services may differ from the fair market value of clinical services."*

"Stark II, Phase III," 72 Fed. Reg. 51016 (Sept. 5, 2007).

Definition of Fair Market Value (FMV) Case Law

- ***FMV*** is defined as "*the price a willing buyer would pay a willing seller… when neither is under compulsion to buy or sell*."
- Providing a discount is not evidence that an agreement is below ***FMV*** if there is no comparison between the original or discounted rates & ***FMV***
  - Medicare rate is not necessarily equivalent to ***FMV***
- An Illinois district court noted that ***FMV*** may differ from traditional economic valuation formulas, which take into account referrals
  - As the **Anti-Kickback Statute** prohibits any inducement for those referrals, they must be excluded from any ***FMV*** calculation
- Proving that an arrangement is at ***FMV*** is imperative in complying with requirements of the **Stark Law**
  - "*Payment exceeding fair market value is in effect deemed payment for referrals*."

Klaczak v. Consolidated Medical Transport, 458 F.Supp.2d 622 (N.D. Ill. 2006); U.S. ex rel. Obert-Hong v. Advocate Health Care, 211 F.Supp.2d 1045 (N.D. Ill. 2002). American Lithotripsy Society v. Thompson, 215 F.Supp.2d 23 (D. D.C. 2002).

Definition of Fair Market Value (FMV) Internal Revenue Service (IRS)

- 501 (c)(3) enterprises must avoid "***excess benefit***" transactions
- **Equates reasonable compensation to the value of services provided**
  - *"[A]mount that would ordinarily be paid for like services by the enterprises (whether taxable or tax-exempt) under like circumstances*"
- **Valuation standard (as cited by IRS Regulations)** is ***FMV***
  - "*[P]rice at which property or the right to use property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell, or transfer property or the right to use property, and both having reasonable knowledge of relevant facts*"

"Excess Benefit Transaction," 26 C.F.R. § 53.4958-4 (2002).

Stark Law Implications

- ***FMV*** is a critical requirement for compliance under the **Stark Law**
  - Stark Law prohibits a physician from making referrals for "***designated health services***" that may be paid for by Medicare or Medicaid to an entity with which the physician has a *financial relationship*, and prohibits the entity from billing
    - ***Designated health services*** are clinical laboratory services; physical therapy services; occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.
    - ***Financial relationships*** can be direct or indirect ownership or direct or indirect compensation
- Suspect arrangements may be at FMV if there is an applicable Stark Law Exception

"Limitation of Certain Physician Referrals" 42 U.S.C. § 1395nn (2010)

Stark Law Implications

Stark Law Exceptions

- Referrals are exempted from Stark Law under the exceptions for "*bona fide employment relationships*" and "*personal services agreements*"
- Used in: medical director, executive, on-call, & other physician services arrangements

Requirements for Exception	"Bona fide employment relationship"	"Personal service agreements"
The employment is for identifiable services (provided by physician to entity)	X	X
Amount of remuneration under the employment is consistent with FMV of the services	X	X[1]
Amount of remuneration under the employment is not determined in a manner that accounts for (directly or indirectly) the volume or value of any referrals by the referring physician	X	X
Remuneration is provided under an agreement that would be commercially reasonable even if no referrals were made to the employer	X	
Arrangement (which must be at least 12 months) specifies, in writing, serviced covered and is signed by both parties		X
Aggregate services "must not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement"		X
Services provided must not involve promotion of business arrangement that is a violation of state or federal law		X

Note:

1. Compensation must also be set in advance

"Health Care Fraud and Abuse: Practical Perspectives," Edited By Linda A. Baumann, The American Bar Association & The Bureau of National Affairs, Inc., Washington, D.C., (2002), pp. 280; "Exception to the referral prohibition related to compensation arrangements," 42 CFR 411.357 (Oct. 1 2004).

Stark Law Implications

Stark Law Exceptions

- Other exceptions that use ***FMV***:
  - FMV Compensation
  - Indirect Compensation
  - Isolated Transaction
  - Medical Office Lease
  - Equipment Lease
  - Academic Medical Centers

"Exceptions to the referral prohibition related to compensation arrangements," 42 CFR 411.357 (Oct. 1 2004).

Stark Law Implications

Independent Contractors vs. Group Practice Physicians

- Preceding discussion about ***FMV*** is related to compensation paid to physicians who are either employed or performing services on an independent contractor basis, *not* compensation paid or distributed to physician members of a ***"group practice"*** as defined within **Stark Law**

- Compensation paid within the ***"group practice"*** setting has fewer regulatory restrictions

"Group Practice," 42 CFR 411.352 (Jan. 4, 2001). "Stark II, Phase II," 69 Fed. Reg. 16067 (March 26, 2004).

Stark Law Implications

Compensation Paid Under Exceptions to the Stark Law

	A	B	C	D	E	F
1	**Terms of Exception**	**Group Practice Physicians [1877(h)(4);411.352]**	**Bona Fide Employment [1877(e)(2);411.357(c)]**	**Personal Service Arrangements [1877(e)(3); 411.357(d)]**	**Fair Market Value [411.347(1)]**	**Academic Medical Centers [411.355(e)]**
2	**Must compensation be Fair Market Value?**	No	Yes - 1877(e)(2)(B)(i)	Yes - 1877(e)(3)(A)(v)	Yes - 411.357 (1)(3)	Yes - 411.355 (e)(1)(ii)
3	**Must compensation be "set in advance"?**	No	No	Yes - 1877 (e)(3)(A)(v)	Yes - 411.357 (1)(3)	Yes - 411.355 (e)(1)(ii)
4	**Scope of "Volume of value" restriction**	DHS referrals - 1877(h)(4)(A)(iv)	DHS referrals 1877(e)(2)(B)(ii)	DHS referrals or other business - 1877 (e)(3)(A)(v)	DHS Referrals or other business - 411.357(1)(3)	DHS referrals or other business - 411.355(e)(1)(ii)
5	**Scope of productivity bonuses allowed**	Personally performed services and "*incident to*," plus indirect - 1877(h)(4)(B)(i)	Personally Performed services - 1877 (e)(2)	Personally performed services - 411.351 ("*referral*") and 411.354(d)(3)	Personally performed services - 411.351 ("*referral*") and 411.354(d)(3)	Personally performed services - 411.351 ("*referral*") and 411.351 (d)(3)
6	**Overall profit shares allowed**	Yes - 1877(h)(4)(B)(i)	No	No	No	No
7	**Written agreement required**	No	No	Yes, minimum 1 year term	Yes (Except for employment), no minimum term	Yes, written agreement(s) or other document(s)
8	**Physician Incentive Plan (PIP) exception for services to plan enrollees?**	No, but risk-sharing arrangement exception at 411.357(n) may apply	No, but risk-sharing arrangement exception at 411.357(n) may apply	Yes, and risk-sharing arrangement exception at 411.357 may also apply	No, but risk-sharing arrangement exception at 411.357(n) may apply	No, but risk-sharing arrangement exception at 411.357(n) may apply

"Stark II, Phase, II," 69 Fed. Reg. 16067-68 (Mar. 26, 2004).

Anti-Kickback Statute Implications

- ***FMV*** is a critical requirement for compliance under the **Anti-Kickback Statute**
- **Anti-Kickback** prohibits "*knowingly and willfully*" receiving payments (direct or indirect, cash or in kind) in return for
  - "*referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal healthcare program,*" or
  - "*purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, ordering any good, facility, or service, or item for which payment may be made in whole or in part under a Federal health care program*"

"Anti-Kickback Statute," 42 USC § 1320a-7b (2008).

Anti-Kickback Statute Implications

Exceptions to Anti-Kickback Statute

- **Safe Harbors** protect a given arrangement from **Anti-Kickback** scrutiny, but there is no *per se* **Anti-Kickback** violation for arrangements falling outside a safe harbor
- OIG Advisory Opinions assume ***FMV***

Anti-Kickback Statute Implications

Anti-Kickback Exceptions

Employment Exceptions

- In addition to the Anti-Kickback ***safe harbor***, there is an ***exception*** for any amount paid by an employer (who has a **bona fide employment** relationship with such employee) for employment in the provision of covered items or services
- The IRS definition of "***employee***" is utilized by both the **Anti-Kickback Statute** and **Stark Law** for purpose of determining "***employee***" status
- The IRS uses an 11-factor test for "***employee***" status broken into three general categories: (1) behavioral control; (2) financial control; and, (3) type of relationship between the parties
- These factors are taken together as evidence of a bona fide employment relationship; not all factors are necessary to satisfy the test and no single factor is dispositive

"Excess Benefit Transaction," 26 C.F.R. § 53.4958-4 (2002).

Anti-Kickback Statute Implications

IRS Determinates of "*Employee*" Status

Behavioral Control	
1	Instructions that the business gives to the worker
2	Training that the business gives to the worker
Financial Control	
1	The extent to which the worker has unreimbursed business expenses
2	The extent of the worker's investment
3	The extent to which the worker makes his or her services available to the relevant market
4	How the business pays the worker
5	The extent to which the worker can realize a profit or loss
Type of Relationship	
1	Written contracts describing the relationship the parties intended to create
2	Whether or not the business provides the worker with employee-type benefits, such as insurance, a pension plan, vacation pay, or sick pay
3	The permanency of the relationship
4	Extent to which services performed by the worker are a key aspect of regular business of the company

Anti-Kickback Statute Implications

Anti-Kickback Safe Harbors

- Two safe harbors apply to compensation for physician clinical, on-call, and executive services:

(1) **Employment Safe Harbor**

- Payments can be made from employer to employee under a bona fide employment relationship for the furnishing of any item or service for which payment may be made under Medicare or Medicaid
- No ***FMV*** requirement

Anti-Kickback Statute Implications

Anti-Kickback Safe Harbors

- Two safe harbors apply to compensation for physician clinical, on-call, and executive services:

(2) Personal Service and Management Contacts Safe Harbor

- Allows for compensation to be paid to physicians and executives that are acting as independent contractors, provided that these conditions are met:
  - Written agreement signed by both parties;
  - Term of at least one year;
  - Agreement must specify aggregate payment amounts and such payment amounts must be set in advance; and,
  - Compensation must be reasonable, at ***FMV***, and determined through arm's length negotiations

"Anti-Kickback Statute," 42 USC §1320a-7b (2008).

Anti-Kickback Statute Implications

Anti-Kickback Safe Harbors

- Other Safe Harbors using ***FMV***:
  - Space Lease
  - Equipment Lease
  - Personal Services and Management Contracts
  - Ambulance Replenishing
- Can the opportunity to earn a ***FMV*** return or payment violate the **Anti-Kickback Statute**?
  - Contract Joint Ventures
  - Reading Panels

POLLING QUESTION 4

COMMERCIAL REASONABLENESS

Definition of Commercial Reasonableness

- **Department of Health and Human Services (HHS)**
  - Arrangement appears to be "*a sensible prudent business agreement from the perspective of the particular parties involved, even in the absence of any potential referrals.*"
- **Stark II, Phase II**
  - "*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 . . . of similar scope and specialty, even if there were no potential DHS referrals.*"

"Stark II, Phase II," 69 Fed. Reg. 16093, 16107 (Mar. 26, 2004).

Determining Commercial Reasonableness

Questions to Consider

- Is it necessary to have a physician perform a certain service?
- Is it necessary to have a physician of that specialty perform a certain service?

Both *services* and *payments* must be considered ***commercially reasonable*** for the arrangement to survive scrutiny

Determining Commercial Reasonableness

IRS's Determination of *Commercial Reasonableness*

- Factors the IRS considers when determining the ***commercial reasonableness*** of a physician compensation arrangement:
  - Specialized training and experience of the physician
  - The nature of duties performed and the amount of responsibility
  - Time spent performing duties
  - Size of the organization
  - The physician's contribution to profits
  - National and local economic conditions

"Integrated Delivery Systems and Joint Venture Dissolutions Update," By Charles F. Kaiser, et al, 1995 EO CPE Text, Internal Revenue Service, (1995)."Physician Compensation Arrangements: Management & Legal Trends," By Daniel K. Zismer, 1999, p. 204.

Determining Commercial Reasonableness

IRS's Determination of *Commercial Reasonableness*

- Factors the IRS considers when determining the ***commercial reasonableness*** of a physician compensation arrangement:
  - Time of year when compensation is determined
  - Whether the compensation is in part or in whole payment for a business or assets
  - Salary ranges for equivalent physicians in comparable organizations
  - Independence of the board or committee that determines physician compensation arrangement

"Integrated Delivery Systems and Joint Venture Dissolutions Update," By Charles F. Kaiser, et al, 1995 EO CPE Text, Internal Revenue Service, (1995). "Physician Compensation Arrangements: Management & Legal Trends," By Daniel K. Zismer, 1999, p. 204.

Determining Commercial Reasonableness

IRS's Determination of *Excess Benefit Transaction Rule*

- Factors the IRS considers when determining if an incentive arrangement has violated the ***excess benefit transaction rule:***
  - Whether compensation arrangement was established by an independent board of directors
  - Whether incentive arrangement results in total physician compensation which is reasonable
  - Whether there was an arm's-length relationship between physician and hospital
  - Whether there is a ceiling on the compensation arrangement which indicates the maximum physician may earn to protect against projection errors or windfall benefits

"IRS FY 2000 Exempt Organization Continuing Professional Education," Internal Revenue Service, July 1999, p. 30 Note: The IRS website designates that this material was designed specifically for training purposes only and should not be relied upon as authority for setting or sustaining a technical position.

Determining Commercial Reasonableness

IRS's Determination of *Excess Benefit Transaction Rule:*

- Factors the IRS considers when determining if an incentive arrangement has violated the ***excess benefit transaction rule***:
  - Whether compensation arrangement may potentially reduce charitable services that organization may otherwise provide
  - Whether compensation arrangement takes into account quality of care and patient satisfaction data
  - Whether arrangement accomplishes the organization's charitable purposes if the amount physician earns under the arrangement depends on net revenues, which also dictate how much the organization charges for its services
  - Whether arrangement transforms the relationship between the organization and the physician into a joint venture

"IRS FY 2000 Exempt Organization Continuing Professional Education," Internal Revenue Service, July 1999, p. 30 Note: The IRS website indicates that this material was designed specifically for training purposes only and should not be relied upon as authority for setting or sustaining a technical position.

Determining Commercial Reasonableness

IRS's Determination of *Excess Benefit Transaction Rule*

- Factors the IRS considers when determining if an incentive arrangement has violated the ***excess benefit transaction rule***:
  - Whether arrangement distributes profits to persons who are in control of the organization
  - Whether arrangement serves a real discernible business purpose which is independent of any purpose to operate exempt organization for impermissible benefit of physicians
  - Whether arrangement includes controls to avoid abuse, unwarranted benefits and unnecessary utilization
  - Whether the arrangement rewards the physician for services he/she actually performs, or based on performance in an area where he/she performs no significant function

"IRS FY 2000 Exempt Organization Continuing Professional Education," Internal Revenue Service, July 1999, p. 30 Note: The IRS website designates that this material was designed specifically for training purposes only and should not be relied upon as authority for setting or sustaining a technical position.

Determining Commercial Reasonableness

Violations of *FMV* & *CR* Under Stark and Anti-Kickback

- Increasing scrutiny of compensation arrangements indicates that the courts will focus on determining whether physicians are ***actually performing*** the services specified in the arrangement
- If a physician is ***not*** performing services which are required within the scope of the compensation agreement, the arrangement will not meet the threshold of ***commercial reasonableness***

U.S. ex rel. Roberts v. Aging Care Home Health, Inc., 474 F.Supp. 2d 810, 818 (W.D. La. 2007).
U.S. v. Rogan, 459 F.Supp. 2d 692 (N.D. Ill. 2006).

POLLING QUESTION 5

ROLE OF THE VALUATION TEAM

Role of the Valuation Analyst

- Legal counsel typically doesn't provide a legal opinion as to the ***FMV*** or ***commercial reasonableness*** of a compensation arrangement
- Legal counsel will most likely obtain an independent valuation consultant to provide a certified valuation opinion as to the ***FMV*** and/or ***commercial reasonableness*** of a compensation arrangement
- Courts have found thorough valuations of lease & compensation arrangements as persuasive evidence of ***FMV*** as against a less thorough valuation of a government expert witness

U.S. ex rel. Goodstein v. McLaren Regional Medical Center, 202 F.Supp.2d 671 (E.D. Mich. 2002). U.S. ex rel. Villafane v. Solinger, 543 F.Supp.2d 678 (W.D. Ky. 2008).

Role of Legal Counsel

- Advise as to the legal permissibility of the underlying transaction
- Draft physician employment/independent contractor agreements
  - Include all physician duties in the agreement
- Serve as liaison between valuation consultant and hospital/health system
- Ensure valuation is consistent with the transaction documents
- Attempt to maintain attorney-client privilege

U.S. ex rel. Goodstein v. McLaren Regional Medical Center, 202 F.Supp.2d 671 (E.D. Mich. 2002).
U.S. ex rel. Villafane v. Solinger, 543 F.Supp.2d 678 (W.D. Ky. 2008).

CONCLUDING REMARKS

Conclusion

- Critical to obtain and maintain documentation that the compensation arrangement is **both** of at ***FMV*** and ***commercially reasonable*** in order to withstand scrutiny from OIG and the IRS
- A certified opinion as to whether the proposed compensation is both within the range of FMV and *commercially reasonable*, prepared by an *independent*, certified valuation professional, working with competent healthcare legal counsel as to the pertinent regulatory thresholds, and supported by adequate due diligence and documentation, will significantly enhance the efforts of healthcare providers to establish a defensible position that the proposed compensation arrangement is in compliance