Fair Market Value Physician Compensation
HOW MUCH IS TOO MUCH?

The following article, "Fair Market Value Physician Compensation--**HOW MUCH IS TOO MUCH?**" by Tynan Olechny, PYA Consulting Principal and W. Lyle Oelrich, Jr., PYA Consulting Principal, appears in *Valuation Strategies*, September/October, Copyright 2015 Thomson Reuters/RIA.

To protect both hospitals and physicians in the current regulatory environment, it is important to understand the nuances of particular alignment arrangements, and apply appropriate methods for considering whether the compensation paid to physicians is within fair market value.

In an era of rapid consolidation and increasing integration, hospitals, health systems, and other healthcare entities that affiliate with physicians and other, non-physician providers are posing the increasingly ubiquitous question of **"how much compensation is too much?"**

In recent years, physician compensation has become a hot topic for healthcare executives and their advisors as a result of dynamic industry transformation and the need for various stakeholders to weather the change together. Specifically, the trend of hospital-owned physician practices is increasing, as evidenced by data from the Medical Group Management Association's Physician Compensation & Production Survey. In 2004, only 24% of physician practice respondents reported ownership by a hospital or integrated delivery system. However, by 2014, approximately 82% of the respondents reported hospital, health system, or integrated delivery system ownership. Further, alternative integration models have allowed for looser alignment structures, which presents greater appeal to physicians hesitant to transition from an independent private practice to hospital or health system employment.

With hospital/physician alignment arguably at its peak, as well as renewed focus by the government on healthcare fraud and abuse, it is more imperative now than ever before that compensation to physicians resulting from new (and existing) organizational models be compliant with the current regulatory environment. Accordingly, this article will introduce current alignment trends, discuss key regulatory considerations, and highlight prevalent compensation models, prior to presenting processes for valuing compensation and physician services arrangements. A sample of government enforcement activity and potential pitfalls to avoid in determining "how much is too much" for physician services will also be addressed.

Alignment Trends

Though such alignments first surged in the 1990s, hospitals and health systems continue to strategically align with physicians and physician groups at a fast pace across many different specialties. Hospitals seek to enhance their collaboration with physicians in order to increase market share and further develop service line expertise. In addition, the growing focus in the U.S. on population health, chronic care and disease management, improved quality of care, and lowering of healthcare costs has challenged many organizations to consider alignment options.

Affordable Care Act. The passage of the Affordable Care Act (ACA) on 3/23/2010 overhauled the nation's healthcare delivery system, and included provisions for new reimbursement models, electronic health record implementation, and quality reporting requirements, with eventual financial penalties for non-compliance.[1] The ACA has served as a further driver for alignment since participation in many of these new initiatives requires access to capabilities and resources that independent physician practices may not have, or are potentially reluctant to acquire. For these reasons, alignment strategies for hospitals and physicians will continue to be essential for both parties to remain financially and operationally viable during the transition from fee-for-service to value-based reimbursement.

Alignment Models

Physician alignment strategies can range from full-scale hospital employment to arrangements that involve less, but still significant integration, such as clinical co-management and professional services agreements. Traditional hospital employment continues to be a compelling option, with physicians reporting lifestyle implications such as more stable work hours and decreased administrative responsibilities (e.g., monitoring of malpractice issues, expenses, electronic medical record conversion, and physician reimbursement changes) as key factors in making the decision to move from an independently owned practice to full hospital employment. Further, generational changes suggest that younger physicians may be more apt to consider hospital employment.[2]

Models just shy of employment that still require certain levels of clinical or financial integration, such as participation in a hospital's clinically integrated network (CIN), in a clinical co-management arrangement, or in an accountable care organization (ACO) have also increased in popularity. Participation in a CIN may allow physician practices to secure certain benefits through an affiliation with a hospital (with appropriate discussion and approval by antitrust counsel). Another non-employment affiliation option includes a co-management arrangement which allows physicians to more tangibly affect the operations of a specific hospital service line, such as cardiology, orthopedics, or oncology, while assisting a hospital or health system advance and strengthen its focus on quality and value.

ACOs. While the concept is still evolving, ACOs are typically comprised of healthcare providers that voluntarily come together to assume responsibility for the care of an attributed patient population. Working together, ACO providers ideally identify and adopt strategies to improve quality and reduce per capita costs. Such cost reductions are then available to be shared amongst the participants. For example, under the Medicare Shared Savings Program (MSSP) which was initiated as part of the ACA, ACO participants across multiple care settings (e.g., physician offices, hospitals, and long term care facilities, etc.) may receive a "shared savings" payment if the ACO meets quality performance standards and has generated "shareable savings" under the payment methodology defined in the ACA.[3]

Professional Service Arrangements. In addition to CINs, clinical co-management arrangements, and ACOs, "full service" professional services arrangements (PSA) are also increasing as viable affiliation options, whereby hospitals contract with a healthcare provider for defined clinical services, yet the physician practice maintains its corporate entity. PSA options range from a payment to physicians for professional services only (e.g., the hospital or health system directly employs the non-physician staff and handles all practice operating expenses) to a global payment to the physicians who are then responsible for direct payment of all practice operating expenses and physician compensation.

Other alternative hospital affiliation options may require even less integration, including alignment through medical directorships and call coverage agreements. In addition, the upsurge of hospitals and physicians working together via telemedicine demonstrates another integration opportunity using virtual or electronic means.[4] Telemedicine allows providers to care for patients that generally for geographic reasons (e.g., in a rural area) would not otherwise receive care. In the end, all of these independent contractor arrangements allow physicians to strengthen their position in the market through the cultivation of hospital relationships while continuing to maintain the independence of their practice. Regardless of the forms that alignment or consolidation between physicians or hospitals may take, including employment or independent contractor arrangements, these trends are helping to drive a significant number of complex healthcare transactions requiring compensation valuation expertise.

Why is Fair Market Value Important?

As evidenced above, unprecedented changes in the healthcare industry have increasingly required that physicians and hospitals work together in order to be successful. However, physicians and hospitals must understand and comply with the applicable regulations when developing and implementing such relationships. Transactions between physicians and hospitals or other medical facilities must comply with various laws and regulations including, but not limited to, the federal Anti-Kickback Statute (AKS), the Physician Self-Referral Act (Stark Law), the False Claims Act (FCA), the IRS' intermediate sanctions regulations and prohibitions against private inurement, and federal and state antitrust laws intended to prevent arrangements that hinder market competition.

Statutory Prohibitions. The AKS makes it a felony to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by any federal healthcare program. Moreover, the Stark Law prohibits a physician who has a financial relationship with an entity that provides certain "designated health services"[5] (DHS) from referring patients to the entity for the furnishing of DHS, unless the financial relationship satisfies a statutory or regulatory exception. Further, the False Claims Act, which imposes liability on any person who submits a claim to the federal government that the person knows (or should know) is false, is often implicated in AKS and Stark violations involving submission of Medicare claims that arise out of prohibited compensation arrangements. Additionally, tax-exempt organizations, which include many hospitals, must be operated exclusively for charitable purposes and abide by regulations requiring that no part of their earnings inure to the private benefit of shareholders or individuals.

The AKS, Stark Law, and IRS' tax-exempt restrictions all have their own regulatory nuances and exceptions; however, they also include some common concepts. For example, to meet a number of the AKS safe harbors and Stark exceptions, compensation between physicians and hospitals must be consistent with fair market value (FMV).

Defining Fair Market Value. The Stark Law defines FMV as the "value in arm's-length transactions, consistent with the general market value." "General market value" means:

> 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.[6]

The IRS has defined FMV as the price at which a property or service would change hands between a willing buyer and a willing seller "neither being under any compulsion to buy or sell and both having reasonable knowledge of relevant facts."[7]

Potential Penalties. Stark Law penalties (which do not require demonstration of intent) can include refund or denial of payment, civil monetary penalties of up to $15,000 per claim and up to $100,000 per "scheme" designed to circumvent the law, and exclusion from the Medicare and Medicaid programs. Violation of the AKS, which requires demonstration of intent, may result in both civil monetary penalties of up to $50,000 and possible criminal penalties, in addition to exclusion from the Medicare and Medicaid programs. When the False Claims Act is also implicated additional damages of up to $11,000 per claim filed, as well as three times the amount of each fraudulent claim, may be imposed.[8] Accordingly, ensuring that the financial terms of compensation arrangements between hospitals and physicians are FMV is a significant responsibility, and requires a solid understanding of the healthcare industry and its regulatory environment. Analyzing transactions for compliance with FMV regulations, either through an internal organizational process or opinions issued by independent third party valuators (often working in concert with legal counsel), may help protect both hospitals and physicians in the event of a government review.

Compensation Plan "Primer"

As discussed above, the types of hospital/physician alignment arrangements vary widely. Thus, hospital compensation to physicians can come in many forms. For example, though pure productivity-based models have historically been popular in employment arrangements, the ACA and the move to value-based healthcare have led to the more frequent inclusion of quality-based measures in physician compensation arrangements. Compensation paid by a hospital to a physician for clinical services can include a combination of several components, such as a fixed base salary, productivity-based measures (e.g., tracking of personally performed and modifier adjusted work relative value units or "wRVUs"), a percentage of collected payments above a certain threshold reserved for overhead expenses, or at-risk compensation that requires the achievement of predefined quality metrics.

Quality Metrics. Quality metrics are generally designed by hospitals in order to incentivize physicians to meet or exceed certain industry standards. While quality incentives aimed at improving clinical outcomes may be the most well-known, hospitals may also develop quality metrics that incentivize improvement in other aspects of care, including better cost-efficiency or increased access. As reported in the 2014 Sullivan Cotter Physician Compensation and Productivity Report, the incorporation of quality components has been widely implemented in primary care specialties, with 45% of organizations reporting using quality incentives for experienced physicians. However, in these organizations, only approximately 7% of total compensation was dependent on quality. Medical, surgical, and hospital-based specialties are not far behind, with 34%, 37%, and 38%, respectively, of organizations reporting the use of some form of quality incentive in compensation plans. Similarly, this accounted for about 8% to 9% of total compensation in these groups.

VM Program. The robustness of such quality measure programs appears to be growing in part due to the government's recent rollout of the Medicare Physician Value Modifier Program (VM Program), which includes adjustments to Medicare Physician Fee Schedule (MPFS) payments based on performance on certain specific quality and efficiency measures. By 2017, all physician practices participating in Medicare will be subject to the VM Program based on 2015 performance, and groups with ten or more eligible practitioners will be subject to upward or downward adjustments to MPFS payments of up to 4%.[9] Through this program, CMS plans to significantly increase the information available on Physician Compare, a publicly searchable database that lists physicians and other healthcare professionals enrolled in Medicare, to include quality and efficiency scores in the future.[10] Thus, the VM Program has both financial as well as broad reputational implications that underscore the need for a focus on quality of care.[11] In addition, the Center for Medicare and Medicaid Innovation (CMMI) is currently developing new payment and delivery models with a focus on specialty-specific care. One such case, the proposed Oncology Care Model, includes episode-based payments for chemotherapy administration to cancer patients.[12]

Compensation for Non-Clinical Services. In addition to the compensation a physician may receive under an agreement for clinical services (employment or otherwise), physicians may also receive compensation for medical director services, academic teaching duties, or call coverage services. In such cases, each individual component included in the compensation arrangement should be reviewed in order to determine if it represents FMV for the specific services provided.

Bonuses and Financial Assistance. Likewise, physicians may also receive additional forms of compensation, such as a signing bonus, relocation assistance, or educational forgiveness. In fact, Merritt Hawkins' 2014 Review of Physician and Advanced Practitioner Recruiting Incentives reports that 70% of organizations offered a signing bonus to physicians during the recruitment process, 90% of organizations provided relocation assistance, and 26% of organizations provided educational forgiveness.

The Valuation Process

While the government has not issued definitive guidance regarding appropriate valuation methodologies for determining the FMV of physician services, the Stark II (Phase III) regulations state:

> Nothing precludes parties from calculating the fair market value using any commercially reasonable methodology that is appropriate under the circumstances… the appropriate method will depend on the nature of the transaction, its location, and other factors. Because the statute covers a broad range of transactions, we cannot comment definitively on particular valuation methodologies.[13]

With statements such as this one being provided by the Centers for Medicare and Medicaid Services (CMS), organizations have determined FMV compensation in a number of ways. Guidance from recent enforcement actions provide valuators with added perspective as to how compensation transactions may be scrutinized. For these reasons, determining FMV compensation under this guidance is not always black and white and will be specific to the facts and circumstances of a particular transaction. Nevertheless, the following five-step approach represents a valuable framework for consideration, in determining whether the proposed compensation in an arrangement is FMV.

Step 1—Understand the Surrounding Background

Before starting the FMV process, it is extremely important to identify exactly what is being valued and the reason for the compensation study. Since each arrangement is unique and has a different background story to tell, there is no "one size fits all" approach to determining the FMV of physician compensation. Thus, it is imperative to understand the nuances of the arrangement in question. Understanding the background, including but not limited to service requirements, necessary skill sets and experience, and identified need, can come from a variety of sources, including initial discussions with the parties to the arrangement. This also may involve a comprehensive review of the proposed legal agreement, or in the absence of such an agreement, a request for a description of the anticipated services to be provided. As such, one should look to understand the requirements of the arrangement, including the term, duties and responsibilities, and specific facts and circumstances from both sides (i.e., from that of the provider and recipient of services).

Step 2—Identify Multiple Objective Surveys

The use of multiple compensation surveys, including but not limited to those published by the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA), and Sullivan Cotter, can also be beneficial when evaluating physician compensation. Further in Phase III commentary of the Stark II Law, the government stated that "reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value."[14]

Common pitfalls related to the use of survey data are discussed further below, and it is important to tailor the use of survey data to the specific services being valued. In particular, valuators should consider survey data that is as comparable as possible to the individual circumstances of the arrangement without jeopardizing the sample size. For example, if an organization is looking to employ an academic physician and desires to determine FMV compensation for this individual, it may be more appropriate to use academic physician compensation data instead of private practice compensation data. Furthermore, if only a few responses are available in a specific survey, it is important to keep in mind that the data from one respondent in that survey may greatly influence the results of that survey. Understanding the individual survey definitions is imperative as well, given various surveys may define common terms such as compensation, benefits, and operating costs differently. This can create a variance when subject data in one survey is compared to another survey, let alone comparison across multiple individual surveys. For these reasons, it is important to understand and account for these survey anomalies appropriately in the FMV analysis.

Finally, survey data by itself should not be the sole determinant for an FMV opinion. Reliance on survey data alone, without any adjustments to account for the unique considerations inherent in the arrangement in question, may result in overlooking key factors that affect the conclusion of value. For example, in an emergency room call coverage arrangement, using benchmark data alone without consideration of the call burden (e.g., likelihood of having to respond or provide clinical services while on call) or that specialty's emergency department payer mix may result in an amount outside of FMV. Therefore, benchmark data should be used as a starting, not ending point, for any FMV analysis.

Step 3—Pinpoint Relevant Facts and Other Factors for Consideration

Another important step in performing a FMV analysis is the identification of relevant facts and circumstances for consideration in determining FMV. A comprehensive (although not all-inclusive, or applicable to every type of physician/hospital relationship) list of those items includes, among others:

- Supply and demand of physician specialties (often quantified via a physician needs assessment or medical staff development plan).
- Defined need for a contemplated service.
- Administrative duties.
- Teaching or other academic responsibilities.
- Excess (vs. required by medical staff bylaws) call coverage.

- Historical levels of physician compensation.
- Previous or current compensation offers.
- Provider productivity.
- Years of experience.
- Credentials and specialized training.
- Physician benefits.
- Payer mix and reimbursement trends, including Medicare/Medicaid rates.
- Annual compensation trends.

Step 4—Identify Approach for Determining FMV

Historically, and as referenced previously, direct guidance to determining FMV for service transactions has not occurred (e.g., the former Stark II (Phase II)) "safe harbors" being one exception, which were later removed in Stark II (Phase III)). However, significant guidance from reputable sources has led most valuators to consider the three approaches used in business valuation, including the cost approach, market approach, and the income approach.

Cost Approach. The cost approach involves considering the use of substitute coverage (otherwise known as the "cost to replace" or "cost to replicate") for the services being negotiated. In other words, if the hospital does not enter into an agreement with the physician or group currently under consideration, then what are the other alternatives and how much do they cost? One frequently used substitute coverage approach involves determination of medical director compensation. For example, one may consider hiring a physician to provide these services and use the cost approach to determine compensation.

Another substitute coverage model which may be considered involves the use of locum tenens (hiring a medical practitioner to temporarily take the place of another). However, if this approach is used, a valuator should recognize that it may result in the highest monetary amount that may be considered for establishing FMV compensation, representing perhaps only a temporary and not long-term solution. The reason for this is the total cost of using locum tenens not only includes the cost to compensate various providers for their compensation, benefits, and malpractice, but additional costs such as airfare, hotels, meals, and agency fees may also exist. Therefore, if this methodology is used in an analysis, but a locum tenens agency is not used to fulfill the requirements of the physician/hospital relationship, adjustments to the data may be required as the actual FMV compensation for an independent contractor may be less than the results identified through evaluating locum tenens data.

Market Approach. The market approach (the identification of market comparable data) asks what other individuals or organizations are compensated for the provision of similar services in a like environment. Many physician compensation surveys are available and can be helpful in performing this approach, such as the MGMA, AMGA, and Sullivan Cotter surveys referenced previously. Market comparable data which is at arms-length (e.g., the level of compensation that is agreed to by two parties who do not have a financial relationship with one another) may be difficult to find given (1) its need to be for like services and (2) its proprietary nature. If such market comparable data is available, its use should be carefully balanced against all other factors that determine FMV compensation. In addition, some common concerns related to the use of market data (such as ensuring comparisons are appropriate) are outlined further below.

Income Approach. The income approach is a forward-looking premise of value based on the assumption that the value of a service or ownership interest is equal to the sum of present values of the expected future benefits of providing a service, or owning that interest. Typically, the income approach is not used as frequently as the cost and market approaches in valuing compensation arrangements. Among other reasons, a drawback to using this approach is that it may appear to attribute the value of potential referrals among the parties. However, there are instances when the income approach may be appropriate, such as when valuing physician noncompete agreements or shared cost-savings arrangements.

With respect to non-compete agreements, it may be appropriate to pursue the income approach under a "with and without" analysis. Specifically, under a "without" the non-compete scenario, the valuator may determine cash flows

in the absence of a non-compete provision (e.g., estimate the impact of cash flows if the employee were to leave and join a competing business). Then, a valuator may compare those results to a different series of cash flows under a non-compete provision (i.e., the "with" the non-compete analysis). The difference in value resulting from each analysis can then help determine the value of the non-compete agreement. A similar with and without methodology may be used in determining the value of shared cost-savings arrangements and the compensation that may be attributable to physicians under such an arrangement. In this case, the income approach may be appropriate given the lack of applicable market comparables for similar services as well as the difficulty in using the cost approach to adequately quantify the potential compensation to the physicians, since physician participation is generally required to achieve cost savings.

Step 5—Reconciliation and Documentation of Conclusion

At this point in the FMV analysis, the valuator has analyzed the situation, identified relevant benchmark data and other factors which may affect FMV determination, and determined and deployed the appropriate valuation approaches, and is now ready to reconcile the factors and various approaches. Of all the processes involved in determining FMV compensation, this can be the most difficult. In the end, it is important to remember that FMV conclusions are the result of professional judgment and experience. And, in some instances, wide variances in opinion may exist. This is a result of the fact that FMV is not an exact science, but rather an "artful science," founded on common sense, informed judgment, and reasonableness.

Recent Fair Market Value Enforcement Cases

When completed, use of this five-step approach may help safeguard against potential exposure should the government or another party inquire about the FMV of a compensation arrangement. This is particularly important in light of recent FMV enforcement cases.

In recent years, the federal government has increased its efforts to identify and bring action against hospitals that compensate physicians at levels outside of FMV, or for involvement in transactions that may not be considered "commercially reasonable."[15] Both parties share responsibility for violations of the AKS, the Stark Law, and the False Claims Act, with physicians also increasingly being held liable for violations of these healthcare regulations. Recent enforcement actions brought by the government against institutions such as All Children's Hospital, Halifax Health Medical Center, and Tuomey Medical Center can help to identify certain elements of compensation arrangements which may carry additional risk, if highlighted by the government as outside of the bounds of FMV or commercial reasonableness.

All Children's Hospital. In April of 2014, All Children's Hospital settled a Stark-related qui tam (whistleblower) action in which the relator alleged that compensation for certain employed physicians exceeded the 75th percentile for physicians with little prior experience, and thus was above FMV. In addition, in some instances, the hospital offered additional compensation or benefit packages to certain physicians in excess of their typical employment agreement. The hospital also purchased a hematology/oncology practice at the high end of the valuation range as determined by an external appraiser.[16]

Halifax Health Medical Center. In another qui tam action in which the Office of the Inspector General (OIG) intervened, the relator alleged that Halifax Health Medical Center (HHMC) violated the False Claims Act by submitting Medicare and Medicaid claims for services provided pursuant to compensation arrangements with medical oncologists and neurosurgeons that violated the Stark Law. The issue was whether the compensation arrangements satisfied the Stark Law's bona fide employee exception. The government argued that the arrangements did not satisfy the employment exception because they provided for productivity bonus payments to the physicians from a bonus pool that included DHS revenue, and the bonus was based on revenues from referrals made by the physicians. The court found that compensation paid to the neurosurgeons was outside the bounds of FMV and commercial reasonableness. The government cited various factors, including the compensation formula (which allowed physicians to receive 100% of collections, with no consideration for overhead expenses), the hospital's financial losses related to the physician practices, the hospital's favorable treatment of the neurosurgeons in the form of additional benefits that were not provided to other hospital physicians (such as car allowances), and

inconsistencies regarding the neurosurgeons' time and productivity (e.g.., the time requirements for the level of services provided were greater than one fulltime equivalent, and the physicians' wRVUs were materially different from year to year).[17]

Tuomey Medical Center. The Tuomey Medical Center case (which also originated as a qui tam action) centered on a group of 19 physicians planning to develop an independent ambulatory surgery center in the vicinity of the hospital. The OIG alleged that the hospital conducted a study of the financial impact (i.e., the loss of downstream revenues) that might occur if these physicians stopped performing certain procedures within the hospital. The physicians subsequently entered into part-time agreements with the hospital (which the relator alleged took into account the value of anticipated referrals) and abandoned plans for development of the surgery center. The court determined that compensation under the part-time agreements exceeded FMV. Primary factors in the court's determination included:

- The part-time nature of the contracted services which were for outpatient procedures only (part-time, partial service contracts are unusual).
- The length of the contract term (a ten-year term is atypical).
- The provision of certain benefits despite part-time status (full-time benefits for part-time employees was inconsistent with normal hospital policies).
- Issues surrounding a strict non-compete clause (physicians were required to perform all outpatient procedures at the hospital).

The federal district court ruled that the arrangements violated the Stark Law and resulted in the submission of 21,000 tainted Medicare false claims under the False Claims Act.[18] It entered a $237 million judgment against the hospital in September 2013.[19]

As indicated by these enforcement actions, it is clear that the government is focused on scrutinizing physician compensation arrangements. In fact, the Department of Justice announced a record recovery of $4.3 billion dollars related to healthcare fraud prevention and enforcement efforts in fiscal year 2013, up from $4.2 billion in 2012. Further, over the last five years (and while not solely related to physician compensation arrangements), a total of $19.2 billion dollars have been recovered, demonstrating the administration's commitment to the prevention of healthcare fraud and abuse.[20] Therefore, a diligent and well-documented approach to determining FMV compensation will continue to be a critical focus for those valuing such arrangements.

Common Pitfalls in Determining Fair Market Value

In light of increased governmental activity in this arena, equally as important as implementing the five-step process above is understanding and avoiding possible pitfalls when determining FMV. In addition to the issues identified in the cases presented above, and while not an exhaustive list, consideration of the following additional concepts should help mitigate potential compensation valuation missteps.

Compensation "Stacking." The process by which compensation for the provision of various services (whether in one or multiple agreements) is determined by cumulatively adding the value of each service is often referred to as "compensation stacking." As previously discussed, a physician may receive several different sources of payment for multiple types of services when rendered. For example, an orthopedic surgeon may provide call coverage services and serve as a hospital's medical director, in addition to providing certain clinical services. Stacking the compensation in a situation such as this is a worthy exercise due to the potential for duplication of payment for the same services or time periods. It is possible to ensure the FMV of such arrangements via thorough analysis and consideration of the arrangement's specific facts and circumstances. Stacked compensation arrangements are typically more complex from a valuation perspective since the total compensation, as well as each individual compensation component, must be FMV. Key factors to consider when assessing such an arrangement may include:

- Hours for the provision of the services (i.e., are the hours reasonable and sustainable, individually and in the aggregate).
- Total compensation and each compensation component as compared to market data.

- The need for each type of service.

At the end of the day, even when total compensation is reasonable, the inclusion of individual components which are paid above FMV may still be considered "too much."

Inappropriate Use of Benchmark Data. While the use of benchmark data can be an essential step in the FMV process, dependence on only one of many different surveys can potentially result in significantly different conclusions regarding compensation for physician services. As previously indicated, data can come from a variety of sources, and each source may have its own strengths and weaknesses. Thus, regulatory guidance encourages the use of numerous salary survey sources when determining FMV compensation.

In addition to the considerations outlined in the valuation process discussion above, further distinctions related to benchmark data use are important. In particular, when using the salary surveys, valuators recognize that they are typically updated at least once per year, generally lag one to two years in arrears (e.g., a survey published in 2014 generally represents 2013 data) and do not always report compensation from one survey to another in an "apples-to-apples" comparison. For example, one survey may report "total" compensation while another salary survey may report "base" compensation only. Understanding the uniqueness (e.g., the definitions of key terms used in a survey) of each survey is imperative to the successful compilation of benchmark data during an FMV analysis.

In addition, organizations should consider other possible challenges when using survey data, including a variance in data points across multiple surveys (which may call for the use of a weighted average versus a straight average when aggregating the data), geographic variances, and inconsistencies in compensation results from year to year.

Reliance on a benchmark conversion factor, such as compensation per wRVU, can also result in compensation in excess of productivity and potentially outside of FMV. For example, basing compensation per wRVU at the corresponding productivity percentile can result in compensation well above the 90th percentile, since there is not necessarily a relationship between percentiles of different metrics. Exhibit 1 illustrates this paradigm. When compensation per wRVU is set at the 75th percentile based on a physician's corresponding wRVU productivity at the 75th percentile of reported survey benchmarks, the resulting compensation calculation is above the 75th percentile of reported compensation data. However, when the median compensation per wRVU is used at each level of wRVU productivity, the calculated compensation approximates the reported compensation at each percentile.

Finally, increases in hospital-employed respondents may also affect certain benchmark metrics, such as overhead costs. Specifically, operating expenses related to a physician practice may be higher with hospital employment due to the allocation of certain indirect hospital expenses (e.g., administration costs) which do not exist in private practice. For these reasons, it is important to remember that benchmarks often do not tell the whole story, but instead offer insight and a starting point.

Conclusion

The threshold for "too much" in compensation for physician services will inevitably vary due to the specific facts and circumstances of each arrangement. There are considerable challenges in the process for determining "how much is too much" due to current regulatory guidance, and non-compliance can carry heavy regulatory penalties. Still, with no end in sight for hospital/physician alignment trends, the demand for an objective process in determining the fair market value of physician services, such as the five-step approach and avoidance of common pitfalls identified herein, may help to mitigate a portion of these inherent risks.

EXHIBIT 1
Survey Data Illustration

National Survey Data, Family Practice (without OB)

Description[1]	Data Points	Median	75th Percentile	90th Percentile
Reported wRVU Survey Data	4,324	4,763	5,887	7,342
Reported Compensation per wRVU Survey Data	4,302	$ 45.34	$ 55.25	$ 71.03
Calculated Compensation Using Corresponding Percentile Compensation per wRVU[2]		$ 215,954	$ 325,257	$ 521,502
Calculated Compensation Using Median Compensation per wRVU[3]		$ 215,954	$ 266,917	$ 332,886
Reported Clinical Compensation Survey Data	5,983	$ 211,452	$ 268,915	$ 345,540

[1] Per the MGMA Physician Compensation and Productivity Survey: 2014 Report Based on 2013 Data.
[2] Calculated by using each benchmark wRVU percentile and the corresponding compensation per wRVU percentile (i.e., the 75th percentile of wRVUs multiplied by the 75th percentile of compensation per wRVU).
[3] Calculated by using each benchmark wRVU percentile and the median compensation per wRVU percentile (i.e., the 75th percentile of wRVUs multiplied by the median percentile of compensation per wRVU).

[1] http://www.whitehouse.gov/healthreform/healthcare-overview.
[2] Buschmann and Bozik, "Hospital-physician alignment: Passing trend or a new paradigm?," AAOS Now (American Academy of Orthopaedic Surgeons, October 2009) http://www.aaos.org/news/aaosnow/oct09/reimbursement3.asp.
[3] Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Methodology for Determining Shared Savings and Losses Under the Medicare Shared Savings Program," ICN 907405, April 2014.
[4] The American Telemedicine Association defines telemedicine as the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. (http://www.americantelemed.org/about-telemedicine/what-is-telemedicine).
[5] Designated health services are typically defined as clinical laboratory, physical therapy, occupational therapy, speech pathology, nuclear medicine, radiology, radiation therapy, durable medical equipment and supplies, parenteral and enteral nutrients, prosthetics/orthotics, home health, outpatient prescription drugs, infusion therapy, and inpatient/outpatient hospital services.
[6] 42 C.F.R. section 411.351 (2011).
[7] Reg. 20.2031-1(b); Rev. Rul. 59-60, 1959-1 CB 237.
[8] http://oig.hhs.gov/compliance/physician-education/01laws.asp.
[9] Note that groups with two to nine eligible practitioners, along with solo practitioners, that meet the requirements for reporting under the Physician Quality Reporting System (PQRS) will be eligible for upward adjustments only.
[10] Located at www.medicare.gov/physiciancompare/search.html.
[11] http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.
[12] http://innovation.cms.gov/initiatives/Oncology-Care/.
[13] 72 Fed. Reg. 51016 (2007).
[14] Id.
[15] General definitions from the Department of Health and Human Services and Stark II (Phase II) suggest that commercial reasonableness implies a sensible, prudent business arrangement, which would make commercial sense even in the absence of referrals. While outside of the scope of this article, commercial reasonableness represents another critical component in ensuring compliance with regulatory standards.
[16] http://www.bricker.com/publications-andresources/publications-and-resources-details.aspx?Publicationid=2798.
[17] http://www.huschblackwell.com/businessinsights/inside-the-halifax-case-an-interview-with-the-governments-expert-witness-04-24-2014.
[18] U.S. ex. rel. Drakeford v. Tuomey Healthcare System Inc., 976 F. Supp. 2d 776 (DC S.Car., 2013).
[19] Tuomey's board and management has appealed the decision to the 4th Circuit Court of Appeals.
[20] http://www.hhs.gov/news/press/2014pres/02/20140226a.html.

TYNAN P. OLECHNY, MBA/MPH, CVA, is a principal with Pershing Yoakley & Associates (PYA) where she performs fair market value opinions and valuations of medical practices for a variety of physician and hospital transactions. Ms. Olechny is based in PYA's Atlanta, Georgia, office and may be reached at (404) 266-9876 or tolechny@pyapc.com.

W. LYLE OELRICH, JR., MHA, FACHE, CMPE, is a principal in the healthcare consulting practice of PYA where he specializes in fair market value compensation and commercial reasonableness services for a wide range of healthcare organizations across the United States. Mr. Oelrich is based in PYA's Knoxville, Tennessee, office and may be reached at (865) 673-0844 or loelrich@pyapc.com.

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