

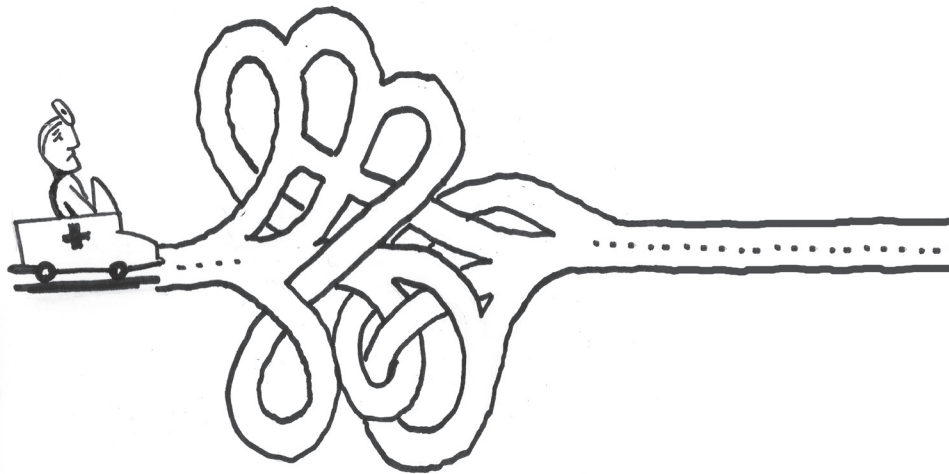


PYALeadership Briefing

Demystifying Fair Market Value Compensation

What Do You Need to Know?

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Demystifying Fair Market Value Compensation

What Do You Need to Know?

Have you read a recent hospital or physician practice management journal lately? If so, chances are you have heard about a multitude of different physician|hospital economic alignment options. Whether it is the concept of hospital employment of physicians (which is on the rise again), medical directorships, joint ventures, clinical co-management agreements, or paying physicians for being on call, one thing is for sure: hospitals need physicians, and physicians need hospitals. Or, perhaps better stated, hospitals need physicians, and physicians need hospitals, BUT ONLY when fair market value compensation is exchanged between the two parties.¹

While there are a number of reasons *why* physician|hospital relationships must be at fair market value (which is an in-depth legal discussion in and of itself but outside the scope of this paper), organizations often struggle to understand the definition of (and thus how to determine) fair market value compensation. Accordingly, the purpose of this article is to help demystify the concept of fair market value and assist you in determining fair market value compensation.

The Definition of Fair Market Value

Technical Definition

Fair market value is, "The price at which the property or service would change hands between a willing buyer and a willing seller, neither being under a compulsion to buy or sell and both having reasonable knowledge of the relevant facts."²

This definition is consistent with the Stark Law definitions of fair market value and general market value, which are defined as follows:

Fair Market Value: 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.³

¹ Fair market value compensation (as well as complying with other regulatory issues such as commercial reasonableness, the Anti-Kick-back statutes, etc.) must be in place and met for financial relationships between physicians (e.g., a referral source) and entities (e.g., a hospital) rendering designated health services. 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, and inpatient/ outpatient hospital services.

² Estate Tax Reg. 20.2031.1-1(b); Revenue Ruling 59-60, 1959-1, C.B. 237.

³ Federal Register / Vol. 69, No. 59 / Friday, March 26, 2004 / Rules and Regulations.

General Definition

The concept of fair market value is not unique to the health care environment. And, it is often best initially understood with the provision of an example in the real estate sector. Consider a scenario where you are looking to sell your home (e.g., a “willing seller.”) For purposes of illustration, imagine that you (and/or your real estate broker) believe your home is worth \$200,000. You create an informative flyer on your home listing the sales price, its square footage, the number of rooms, the home’s age, etc., (e.g., thereby providing “reasonable knowledge of the relevant facts”). After some time on the market, you have a prospective buyer (e.g., a “willing buyer”) who reviews the flyer, asks his real estate agent to identify any available market comparable data (e.g., the cost of recent homes on a per square footage basis near your neighborhood), and ultimately makes an offer on your home for \$175,000. You review the offer and then negotiate (e.g., “bona fide bargaining between well-informed parties”) to a mutually agreed upon sales price of \$190,000. This amount of money is then deemed to be “fair market value.”⁴

Determining Fair Market Value Compensation

While Stark II (Phase II) provided a “Safe Harbor” definition of fair market value, Stark II (Phase III) removed this Safe Harbor methodology and provided general guidance on how to determine fair market value compensation.⁵ Specifically, the Stark II (Phase III) regulations stated-

“ Nothing precludes parties from calculating 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.”

⁴ An important differentiation between the real estate fair market value example and a fair market value example in healthcare is that there would need to be another condition in place to ensure the prospective home buyer has no other financial relationship with the seller of the real estate property (e.g., “not otherwise in a position to generate business for the other party.”)

⁵ Federal Register / Vol. 69, No. 59 / Friday, March 26, 2004 / Rules and Regulations defined a fair market value compensation “Safe Harbor” as, “An hourly payment for a physician’s personal services (that is, services performed personally and not by employees, contractors, or others) shall be considered fair market value if the hourly payment is established using either of the following two methodologies: 1) the hourly rate is less than or equal to the average hourly rate for emergency room services in the relevant physician market, provided there are at least three hospitals providing emergency room services in the market. 2) The hourly rate is determined by averaging the 50th percentile national compensation level for physicians with the same physician specialty (or, if the specialty is not identified in the survey, for general practice) in at least four of the following surveys and dividing by 2,000 hours. These surveys are Sullivan Cotter & Associates, Inc. - Physician Compensation and Productivity Survey, Hay Group - Physicians Compensation Survey, Hospital and Healthcare Compensation Services - Physician Salary Survey Report, Medical Group Management Association - Physician Compensation and Productivity Survey, ECS Watson Wyatt - Hospital and Health Care Management Compensation Report, William M. Mercer - Integrated Health Networks Compensation Survey.”

⁶ Federal Register / Vol. 72, No. 171 / Wednesday, September 5, 2007 / Rules and Regulations.

With statements such as those provided by the Centers for Medicare & Medicaid Services (CMS), organizations have determined fair market value compensation in a number of different ways. Determining fair market value compensation under this guidance is not always black and white. Some of it is science; some is an art. Nevertheless, to assist you and your organization in determining fair market value compensation, consider the following **Five-Step Approach**:⁷

1. Identify the background, relevant facts, and key assumptions surrounding the fair market value arrangement.

Before starting the fair market value process, it is extremely important to identify exactly what is being valued and the reason for the fair market value compensation study. Some key questions to ask include:

- What is the specific service, position, etc., being valued?
- What type (e.g., specialty or sub-specialty) of physician is required?
- Where (or what region, state, or city) is the service, position, etc., located or being provided?
- How many hours or what is the staffing that will be required to fulfill the terms of the arrangement?

- Does the position, service, etc., fulfill a community need? For example, does it:
 - Help the institution meet a specific federal or state regulation (e.g., Level 1 Trauma status)?
 - Mitigate a specialty specific community physician need?
 - Assist the organization in accomplishing a charitable mission?
- What are the roles, responsibilities, complexity, and scope of duties surrounding the service, position, etc., being valued?
- Can the position, service, etc., be fulfilled by anyone other than the person or organization you are contemplating the arrangement with?
- Are there any special qualifications, training, or leadership attributes required of the individual or organization who will be providing the service(s)?
- Will the services rendered be billed for?⁸ If so, who (e.g., the hospital or physician) will bill for the services rendered?
- Are there relevant (e.g., payor reimbursement trends) changes in the market surrounding the service or position being valued?
- Are the services administrative or clinical in nature?⁹
- What assumptions are needed to perform the analysis?¹⁰
- What should be the date of the valuation?¹¹

⁷ While the approach outlined herein would be valid for all types of fair market value compensation projects (e.g., medical directorship, call coverage, physician employment, clinical co-management, etc.), not all variables, questions, etc. outlined in each step within this paper will be applicable for every type of fair market value transaction.

⁸ An example of a service for which a hospital may contract with a physician to render but for which there are no billable services may be a medical directorship.

⁹ It is important to identify whether the services which occur are clinical or administrative in nature. Guidance on determining fair market value compensation, as further described later in this article, may vary for clinical versus administrative services.

¹⁰ Often, certain information you believe necessary to perform a fair market value study is not available for one or more reason(s). Without this information, what will you need to assume and are the two parties that will be a part of the agreement comfortable with these assumptions?

¹¹ Those events that occur after the valuation date are not included in the determination of fair market value, so understanding and agreeing to this date is an important part of the valuation process.

2. Initiate an analysis by identifying multiple objective benchmark compensation surveys to help in analyzing the specific physician/hospital relationship.¹²

These surveys should contemplate the use of data as specific as possible to your individual circumstances without jeopardizing the sample size. For example, if you are looking to employ an academic physician and desire to determine fair market value 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, keep in mind that the data from one respondent in that survey can greatly influence the results of that survey. These survey anomalies are important to understand and account for appropriately in your fair market value analysis.

When using these salary surveys, 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 2012 generally represents 2011 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 utilized in a survey) of each survey is imperative to the successful compilation of benchmark data during this phase of your analysis.

A non-exhaustive list of surveys which may be used to assist you in your fair market value determination include but are not limited to:

- American Medical Group Association (“AMGA”) *Medical Group Compensation & Financial Survey*
- Association of American Medical Colleges (“AAMC”) *Report on Medical School Faculty Salaries*
- Hospital & Healthcare Compensation Service (“HHCS”) *Physician Salary Survey Report*
- Integrated Healthcare Strategies *Medical Director Survey*
- Medical Group Management Association (“MGMA”) *Physician Compensation and Production Survey*
- MGMA *Academic Practice Compensation and Production Survey for Faculty and Management*
- MGMA *Cost Survey*
- Sullivan Cotter and Associates (“Sullivan Cotter”) *Physician Compensation and Productivity Survey Report*
- Sullivan Cotter *Physician On-Call Pay Survey Report*
- Towers Watson *Health Care Clinical and Professional Compensation Survey Report*

Finally, note that survey data, by itself, should not be the sole determinant for a fair market opinion. Other factors, including but not limited to those discussed herein, should also be considered.

¹² Federal Register / Vol. 72, No. 171 / Wednesday, September 5, 2007 / Rules and Regulations states, “Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value.”

3. Identify all the factors and surrounding circumstances that should be considered when determining fair market value compensation for a specific transaction. A comprehensive (*although not all inclusive and/or applicable to every type of physician|hospital relationship*) list of factors for consideration includes, among others:

- **Supply and Demand of Physician Specialties** - Generally, specialties in which there is a significant need within a community may demand higher compensation than those specialties in the community with a smaller demand (e.g., with a higher supply), all other factors being the same. Current specialties in high demand on a national basis include hospitalists, cardiologists, orthopedic surgeons, and neurosurgeons, just to name a few.
- **Administrative Duties and Responsibilities** - A significant citation noted in Stark II, Phase III regulations states, “a fair market value hourly rate may be used to compensate physicians for both administrative and clinical work, provided that the rate paid for clinical work is fair market value for the clinical work performed and the rate paid for administrative work is fair market value for the administrative work performed.”¹³ This change in the Stark regulations has affected the approach for determining fair market value compensation associated with physician|hospital relationships involving administrative duties. For example, up until the effective date (December 5, 2007) for the Stark II, Phase III regulations, facilities may have utilized a “Safe Harbor” (as described previously) hourly rate to determine fair market value

compensation for medical directorship services. However, with numerous medical directorships representing clinical and administrative duties, many organizations have since been forced to re-evaluate the fair market value compensation associated with these arrangements.

- **Teaching Responsibilities** - Similar to administrative duties, in an Academic Medical Center (“AMC”) setting, many clinicians carry varying levels of teaching responsibilities (e.g., course development, instruction, grading papers, office hours, and rounding with residents). A physician’s teaching responsibilities, while enhancing the mission of the AMC, may limit the time he or she is otherwise available to see patients in a clinical setting. Therefore, the clinical productivity of a teaching clinician may be different than that of a private practice physician. Acknowledging these situations, and making “apples-to-apples” comparisons to like physicians, is essential when determining fair market value compensation for teaching physicians.

- Supply and Demand of Physician Specialties
- Administrative Duties and Responsibilities
- Teaching Responsibilities
- Operational and Financial Performance
- Historical Levels of Physician Compensation
- The “Burden” Factor
- Unionized Labor
- Previous Compensation Offers
- Provider Productivity
- Years of Experience
- Credentials and Specialized Training
- Community Norms
- Academic Duties
- Cost of Living
- Medicare/Medicaid Rates
- Physician Benefits
- Payor Reimbursement Trends
- Compensation Trends
- Consequences of Not Retaining an Individual



¹³Federal Register / Vol. 72, No. 171 / Wednesday, September 5, 2007 / Rules and Regulations

- **The Operational and Financial Performance of the Entity With Whom the Hospital Will Be Contracting**

- In the event that a physician or physician practice requests financial assistance (otherwise commonly known as a “subsidy”) from a hospital, it is important to consider at least two key items. First, consider what is fair market value compensation for those providers. Second, and equally important, consider the operational performance of the practice. For example, one should evaluate the physician practice’s historical and current collection levels, overhead, and benefits (e.g., 401k, profit sharing, health insurance, disability, etc.) It is not uncommon for a physician practice to yield relatively little compensation, only later to find out the physician practice has a “rich” physician benefit package or high overhead. In these cases, would the physician’s compensation and benefits be rendered fair market value in light of these facts? These are key questions that should be addressed and carefully evaluated.

Similarly, one of the reasons that a physician or physician practice may be requesting a subsidy is because they may be coding inappropriately, or are having difficulties in collecting on outstanding accounts. In this case, the practice’s financial assistance request should only be considered when collection performance and coding levels are appropriate, leaving issues (e.g., payor mix) outside the control of the physician practice as the reason for the need for financial assistance.

It is not uncommon for a physician practice to yield relatively little compensation, only later to find out the physician practice has a “rich” physician benefit package or high overhead. In these cases, would the physician’s compensation and benefits be rendered fair market value in light of these facts?

- **Historical levels of physician compensation-**

Another factor that can be reflective of fair market value compensation is the physician’s historical level of compensation. When operational and financial issues such as overhead and collection performance are appropriately accounted for, the current level of a physician’s income can

be indicative of fair market value, particularly when the physician is in a private practice in the same or similar market. When examining historical physician compensation, one should also evaluate whether the physician’s existing practice environment is similar to the environment he/she will be practicing under in the new physician|hospital relationship. Adjustments to the physician’s historical compensation, either higher or lower, may be appropriate, depending upon the physician’s new environment.

- **The “Burden” Factor** - Often, in physician|hospital arrangements such as call coverage arrangements, it is important to consider the “burden” placed upon the physician(s) to perform the service. For example, one should specifically evaluate the amount of time that will be spent answering phone calls, the number of nights on call per physician, the number of trips to the hospital (e.g., when the arrangement is “unrestricted,” or when the physician is not required to be physically present in the hospital) and/or time spent providing consults and inpatient care from patients arriving through the emergency department. Adding to this “burden factor” is the thought that follow-up care must often be provided to these individuals (generally regardless of the patient’s ability to pay,

Feedback from physicians who do not accept offers for financial reasons can be important documentation in assisting with the fair market value compensation determination process.

e.g., uninsured or underinsured patients) even after the physician's call shift is completed. Accordingly, this "burden factor" should be evaluated when applicable for the specific physician|hospital relationship being examined.¹⁴

- **Unionized Labor** - For some organizations, compensation may be determined by negotiations with a labor union. Such organizations utilize the leverage of its collective membership in negotiations related to both financial and non-financial employment terms. Depending upon several issues (e.g., supply and demand) discussed previously, unions may be able to command more compensation or otherwise negotiate more favorable contract terms than providers who are unable to collectively negotiate their respective contract terms.
- **Previous Compensation Offers Made by Your Organization** - As much as physician recruiters and others involved in the recruitment process (e.g. chief executive officers) may try to mitigate it, certain offers (e.g., of employment) are not accepted by all prospective candidates. Feedback from physicians who do not accept offers for financial reasons can be significant documentation in assisting with the fair market value compensation determination process. For example, if a similar financial package (e.g., salary, benefits, sign on bonus, etc.) is made to several physicians and all of these physicians do not accept it, this

is evidence that the current offer could be less than fair market value compensation for the specific market.

- **Provider Productivity** - If there is one measure that generally carries more weight than another, provider productivity may be just that variable. Of the various measures of productivity available, work relative value units ("wRVUs") are one of the more objective measures to monitor provider productivity.¹⁵ Work RVUs are established annually by CMS and stand to measure, on a uniform basis, the physician's work effort. These levels of productivity can be compared to benchmark data on an "apples-to-apples" basis and provide a strong indication of fair market value. As an example, if a physician's wRVU level is at the 75th percentile of one or more surveys, this gives an indication that his/her compensation should also approximate the 75th percentile (all other factors being the same).¹⁶
- **Years of Experience/Service** - Over a physician's career, he or she begins to develop specific experience based upon treating a number of different patients and medical conditions. This involves the

¹⁴ For additional information regarding valuing emergency room call pay, please reference the Office of Inspector General's ("OIG") Advisory Opinions 07-10, 09-05, and 12-15. While specific to a certain set of facts circumstances, each OIG opinion is considered a good resource for variables to consider when examining fair market value compensation for emergency room call pay arrangements.

¹⁵ Other measures of provider productivity include gross charges, collections, or encounters. Gross charges can vary widely from one practice to another, and accordingly is generally not a good indicator to measure physician productivity. For example, one practice's fee schedule may be set at 220 percent of Medicare's fee schedule while another is set at 150 percent of Medicare's fee schedule. If the exact same volume/work is performed by each physician, the physician whose fee schedule is set at 220 percent of Medicare will appear more productive. Collections, on the other hand, can be positively or negatively impacted by the practices payor mix, with those practices who have a higher proportion of Medicaid and Self Pay patients having lower collections (all other factors being the same). Encounters, generally defined as face-to-face visits with patients, can be a good indication of productivity but may be difficult to track and/or compare in an "apple- to-apples" fashion to survey data.

¹⁶ As a word of caution here, insure that the wRVUs (or other physician productivity indicators) and any comparison you make to benchmark data are "apples-to-apples". For example, it is not uncommon for wRVU benchmark survey data to exclude midlevel providers but during the information gathering process you may collect or receive wRVU data for a physician who has a midlevel billing under the physician's provider identification number. In this case, you would have an "apples to oranges" comparison and the physician could appear to be more productive than he/ she really is in comparison to the benchmark survey data.

Of the various measures of productivity available, work relative value units (“wRVUs”) are one of the more objective measures to monitor provider productivity.

development of individual and specific treatment plans based upon a patient’s specific set of symptoms and the physician’s evaluation of that patient. Over time, physicians build up a patient base and can evaluate the outcomes of these patients and offer this experience to existing and future patients to ensure effective and efficient patient care. For these reasons, higher compensation may be warranted for more experienced physicians than those physicians with less experience.

- **Credentials and Specialized Training and/or Education** - Training and/or education (e.g., for surgeons-robotic surgery or a fellowship) as well as specific credentials (e.g., board certification) have the ability to increase compensation for physicians. Typically, in these instances, certain positions and organizations recruit only those individuals with one or more of these specific skill sets, thus reducing the pool of available candidates for recruitment and increasing the willingness of the employer to compensate providers for these specific attributes.
- **Community Norms** - Each market has its own set of unique circumstances. And, some markets are more unique than others. For example, is the market place designated as a health professional shortage area? Does it qualify as a federally qualified health center? Is there a specialist like the one you are trying to recruit in the local market? These differentiating market attributes may be capable of allowing physicians to earn substantially more or less money than comparable specialty physicians

in different markets. When community compensation trends exist, these factors should be examined to determine how, if at all, they impact the determination of fair market value compensation.

- **Academic Duties** - In an academic medical center, a significant part of some faculty members’ responsibilities may be spent in teaching, performing clinical duties, and/or grant writing among other duties. Compensation can also vary based upon tenure and non-tenure status, faculty type, and faculty rank. The size of a research grant, the research subject, the time required in completing the study, and the number of individuals required to satisfy the grant could also potentially impact the level of fair market value compensation for the researcher.
- **Cost of Living** - When performing fair market value compensation studies, it may be appropriate to adjust your results by the cost of living. The Stark II, Phase III regulations state, “With respect to the inquiry regarding cost of living adjustments, we note that contracts for physician services may include an annual salary adjustment, provided that the resulting compensation is fair market value...”¹⁷
- **Medicare/Medicaid Rates for Clinical Services.** For the rendering of professional services (e.g., professional interpretations), it is not uncommon for organizations to contemplate compensation the equivalent of Medicare or Medicaid rates. These organizations typically believe that Medicare or Medicaid fee schedules appropriately reimburse providers for their costs, time, and malpractice

¹⁷ Federal Register / Vol. 72, No 171 / Wednesday, September 5, 2007 / Rules and Regulations.

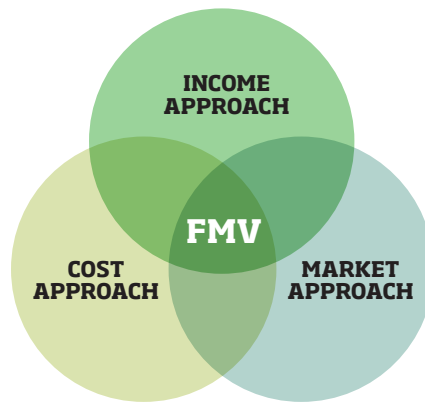
expenses. Additionally, if other payors are involved in a particular market and their specific fee schedules are known, it may fall within fair market value to adjust the Medicare or Medicaid rates to the reimbursement levels of these payors (e.g., for commercial payors, reimbursement at 120 percent of Medicare). When using this approach, make sure you are confident in your reimbursement assumptions (e.g. how do projected reimbursement assumptions compare to actual dollars received for the same service) and that you have a firm understanding of how the services being valued would be billed (e.g., facility versus non-facility basis, place of service differentials, etc.).

- **Physician Benefits** - In some instances, it may be appropriate to take into consideration not only direct physician compensation, but also physician benefits. This may occur, for example, when evaluating employment arrangements or medical directorships with independent contractors. Independent contractors often pay certain portions of their own taxes (e.g., self employment taxes) which can lead to a higher effective tax rate than employed physicians. Therefore, to make sure independent practitioners are not penalized for their "independent contractor" status, it may be appropriate to compensate the independent contractor more than an employed physician to appropriately consider the difference in benefits.

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- **Payor Reimbursement Trends** - Every year, it seems that Medicare is "threatening" to reduce its reimbursement. If this trend (or other trends for payors in your market) comes to fruition in a particular year, it will impact the level of insurance and patient collections that are used to pay for overhead and what is ultimately left for distribution as physician compensation. A practice with a payor mix highly dependent on one payor (e.g., Medicare) may be at a greater risk for sudden change in reimbursement. For this reason, an adjustment to fair market value compensation may be required if reimbursement significantly changes.
- **Compensation Trends Over the Last Few Years** - Compensation trends can be an indicator of fair market value compensation. And, if compensation for a specific specialty has been changing and both the revenue and expenses of a Practice are relatively stable, it may be appropriate to adjust compensation benchmarks (which are generally a year or more older) by a factor equivalent to the increase or decrease in recent compensation trends. Any adjustment that is contemplated based solely upon compensation trends should be reconciled with other factors that determine fair market value compensation.
- **Consequences of Not Retaining an Individual or Entity to Perform the Contracting Services** - Many organizations must have certain services (e.g., orthopedic trauma call coverage in a Level I Trauma facility) to maintain their licensure designations. Other professional or administrative services may also be required for accreditation or certification requirements. An example is the Joint Commission on Accreditation of Healthcare Organization's primary stroke center certification. In these

examples and certainly subject to the number of qualified providers available to render the specific services, it may be that the organization requiring these services must pay a premium to ensure that they maintain their licensure, accreditation, or certification status.



One frequently utilized substitute coverage approach involves the development of a pro-forma income statement for employed physicians to provide the services

being requested. For example, in the event that a hospital is unable to secure emergency department call coverage through an independent contractor (e.g., a private practice physician group), that hospital may consider employing physicians to provide this call coverage. When this occurs, the hospital would project the revenue it expects to collect while the physicians are rendering services and then deduct the expenses for the physicians compensation, benefits, malpractice, and overhead. The resulting variance (e.g., revenue minus expenses) would then be utilized to help establish fair market value compensation.

4. Identify one or more approaches to determine fair market value compensation. Historically, and as referenced above, direct guidance to determining fair market value has rarely (e.g., the former “Safe Harbor” being one exception) occurred. However, significant guidance (regarding various formal valuation approaches) from reputable sources does exist. These approaches include the income approach, cost approach, and market approach.

- **The 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.
- **The Cost Approach (e.g., the Evaluation of Substitute Coverage).** In performing a fair market value compensation study, it is often important to consider the use of substitute coverage (otherwise known as the “cost to replace”) for the services being negotiated. In other words, if you do not enter into an agreement with the group currently under consideration, then what are your other alternatives and what would they cost?

Another substitute coverage model which may be considered involves the use of *locum tenens*. Organizations such as *The Delta Company* summarize and publish locum tenens data on a frequent and specialty specific basis. However, if this approach is utilized, recognize that it may result in the highest amount of compensation that could be utilized for establishing fair market value compensation, and perhaps as a temporary and not long-term solution. The reason for this is the total cost of utilizing 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. Therefore, if you use this methodology in a fair market value compensation analysis but do

not use a locum tenens agency to fulfill the requirements of physician|hospital relationship, the actual fair market value compensation for an independent contractor may be less than the results identified through the locum tenens approach.

- **The Market Approach (e.g. the identification of market comparable data).** The market approach asks what are other individuals or organizations compensated for the provision of similar services in a like environment? Many of the physician compensation surveys outlined previously herein can be helpful. However, physician compensation benchmark data, in and by itself, does not establish fair market value

Physician compensation benchmark data, in and by itself, does not establish fair market value compensation.

compensation. Additionally, 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 its need to be for like services and its proprietary nature. However, in the end, remember that while you may have found three, seven, or even 15 market comparable data points, don't forget to consider and/or weigh the results of the market comparable data relative to all other factors that determine fair market value compensation.

5. Reconcile the various approaches and document your conclusion in writing.

At this point in the fair market value analysis, if you understand the situation, have identified relevant benchmark data and all other factors which may impact your fair market value determination, it is time to reconcile the factors and various approaches. Of all the processes involved in determining fair market value compensation, this is the most difficult. Here are a few helpful tips:

- Does one approach have more merit than another? For example, if you have three local market comparable data points, should the market comparable data be considered more or less than other benchmark survey data which may have over a thousand different data points? Ultimately, each fair market value compensation approach will have its own inherent strengths and weaknesses. Which approach is more reliable? Which approach has assumptions that you are most comfortable with resembling the real life scenario at hand? Finally, be careful of assigning "weights" to various factors. Current fair market value guidance suggests that there may be "no useful purpose" in doing so.¹⁸ Rather, consider the totality of facts, circumstances and analyses performed.

¹⁸ Estate Tax Reg. 20.2031.1-1(b); Revenue Ruling 59-60, 1959-1, C.B. 237 states, "Because valuations cannot be made on the basis of a prescribed formula, there is no means whereby the various applicable factors in a particular case can be assigned mathematical weights in deriving the fair market value. For this reason, no useful purpose is served by taking an average of several factors (for example, book value, capitalized earnings and capitalized dividends) and basing the valuation on the result. Such a process excludes active consideration of other pertinent factors, and the end result cannot be supported by a realistic application of the significant facts in the case by mere chance."

- Regardless of the approach utilized, what is the ultimate amount of money that is paid? And, when multiple agreements are rolled up or “stacked” into one contract (or multiple contracts exist with the same physician or group of physicians), what is the aggregate level of compensation paid and are both the individual components as well as the aggregate compensation at fair market value?
- Imagine yourself explaining your determination of fair market value compensation to a regulatory agency (e.g., CMS). Is your conclusion supported by sufficient evidence such that someone who is unaware of the situation would agree with your conclusion? A written report should clearly outline the background, facts, assumptions, analyses, and rationale for the conclusion.

In the end, it is important to remember that fair market value 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 fair market value is not an exact science, but rather an “artful science,” founded on common sense, informed judgment, and reasonableness.

Conclusion

Determining fair market value compensation can be a daunting task, one that is often misunderstood by the vested parties embarking upon such an initiative. However, by using the above referenced Five-Step Approach, you will be in a position to better understand and contemplate not only the variables which go into determining fair market value compensation, but the methods to determine such an amount in each “fact and circumstance specific” physician|hospital relationship. With time and experience, this process will become easier for you (and your organization).