



Is Median Compensation in the Crosshairs?

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median | *noun* | me-di-an | \ˈmē-dē-ən\

- As defined by Merriam-Webster:
 - *The middle value in a series of values arranged from smallest to largest.*
 - What this means with respect to survey data: Half of the respondents reported amounts less than this value, and half of the respondents reported amounts higher than this value.
- As defined in physician compensation negotiation:
 - *The minimum value in a data set and floor for negotiations.*

Healthcare Transactions



- Generally, any transaction between potential referral sources must be:
 - Consistent with FMV; and
 - Commercially reasonable.
- A transaction can be “FMV,” but not commercially reasonable, and vice versa.
- Healthcare regulations impose specific guidance that directly impacts FMV analysis:
 - Avoid “tainted” market values
 - Avoid improper valuation methodologies



● FMV Defined (CMS)

- “...the value in arm's-length transactions, consistent with the general market value. ‘General market value’ means 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. Usually, the FMV is the compensation that has been included in bona fide service agreements...where the compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.
- Key question: *What is this service worth to a hypothetical market participant absent any consideration of patient referrals?*



- Commercial Reasonableness Defined (CMS)
 - The term “commercially reasonable” is defined as an arrangement that 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 business referrals between the parties.
 - Key question: *Would the parties enter into this arrangement if there were no potential referrals?*

Legal and Regulatory Framework

- False Claims Act
- Anti-Kickback Statute
- Federal Stark Law
- Other Relevant Laws
 - Tax Exemption Laws
 - Civil Monetary Penalties Law
 - State-level equivalents of the above

● Anti-Kickback Statute

- Criminal statute
- Prohibits knowingly and willfully offering and/or paying “compensation” to induce items or services payable under federal healthcare programs
- Exceptions and safe harbors to AKS include employment and personal services; many safe harbors require that compensation is consistent with FMV.

Legal and Regulatory Framework

● “Stark Law”

- If a physician has a financial relationship with an entity:
 - Then the physician may not make a referral to that entity for the furnishing of designated health services for which payment will be made under Medicare; and
 - The entity may not bill Medicare, an individual, or another payor for DHS performed pursuant to the prohibited referral.
- Unless...the arrangement fits within a Stark exception
 - Exceptions include personal services and bona fide employment, provided the arrangement is commercially reasonable and compensation is FMV.

Legal and Regulatory Framework

● Who determines FMV?

- CMS and the courts have not provided clear standards, and guidance has been inconsistent over the years.
- CMS guidance:
 - External valuations may indicate good intentions, but do not ensure FMV.
 - The use of multiple, objective, independently published surveys is prudent.
 - Documentation sufficient to support FMV will vary based upon the facts and circumstances of the arrangement.
 - FMV of physicians' administrative services may differ from FMV of their clinical services.

Legal and Regulatory Framework

- It can be difficult to apply the FMV requirements in practice.
 - Deal pressure is real.
 - Physicians' expectations are often set in advance, may be unrealistic, and negotiating leverage may be one-sided.
 - Competing offers from other hospitals may not have been subject to an independent valuation.
 - If they have, they likely can't be considered under the FMV definition.
 - It's difficult to find market data that does not include arrangements between parties in a position to refer business to one another. Is it even possible to meet this requirement?

Regulatory Evolution



- Stark Phase II (1993)
 - Defined “safe harbor” approaches to the determination of FMV hourly compensation.
 - Compensation for personally performed services is consistent with FMV **if the rate is less than or equal to the hourly rate calculated by dividing (i) the average of the median annual compensation values reported in national compensation surveys for the subject specialty by (ii) 2,000 annual hours.**
- Stark Phase III (2007)
 - Eliminated the safe harbor language, but noted that **“reference to multiple, objective, independently published surveys remains a prudent practice for evaluating fair market value.”**
- Tuomey (2012)
 - Among other issues, court focused on compensation that exceeded collections received from the professional practice
 - **Government’s expert witness suggested physician compensation at the 75th percentile as the threshold for Stark scrutiny.**
- Halifax Medical Center (2013)
 - Government’s expert witness report stated, with respect to industry surveys’ ratios of compensation to collections and compensation per wRVU, **“The supportable ratios are typically at the median and can in certain circumstances move up to the 75th percentile” if supported by the facts and circumstances of the situation.** “If a physician cannot earn at the median level, he or she can likely move to a community...where median or even above median levels can be earned if warranted by the particular facts and circumstances.”
- Citizens Medical Center (2015)
 - Case was settled, but the Court did indicate that **the allegation that Citizens was incurring material financial losses on the practices of various cardiologists allowed an inference that the physicians were receiving improper financial remuneration, even if total compensation to the physicians fell below median levels.**

Regulatory Evolution



● Citizens Details

● Relators' Allegations (among others...)

- Three employed interventional cardiologists' combined salaries increased from \$630,000 in 2006 to \$1,400,000 in 2007 (i.e., to an average of \$467,000 per physician per year in 2007). MGMA median compensation in 2007 was \$485,000 per year.
- The cardiologists' practices incurred losses of \$400,000 in 2008 and \$1,000,000 in 2009.

● Court Commentary

- Relators have made several allegations that, if true, provide a strong inference of the existence of a kickback...**Even if the cardiologists were making less than the national median salary for their profession, the allegations that they began making substantially more money once they were employed by Citizens is sufficient to allow an inference that they were receiving improper remuneration.** This inference is particularly strong given that it would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it were doing so for some ulterior motive—a motive Relators identify as a desire to induce referrals.

● Result

- Citizens settled for \$21.75 million. There was no determination of liability and no conclusive finding by the court that operating at an economic loss is a basis for Stark or AKS liability.

Regulatory Evolution



- Whether Citizens is a case of “bad (alleged) facts” or not, it does raise several concerns:
 - There is increased scrutiny of the facts, circumstances, and economics of compensation arrangements.
 - The threshold for intervention may be getting lower.
 - Sustained practice losses may call into question the commercial reasonableness of the arrangement.
 - Material compensation increases resulting from employment may be problematic.
 - Instinctively defaulting to median rates may not be a safe bet.
- The three plaintiffs received a collective \$5,981,250 *plus* payment of legal fees.

Regulatory Evolution



- Health Care Fraud and Abuse Recoveries, 2015
 - \$1.97 billion recovered
 - 423 *qui tam* actions
 - \$330 million paid to whistleblowers
- Whistleblower awards
 - 15-30% of recoveries under FCA
 - To date, whistleblowers have been awarded over \$5.2 billion
- Anyone can be a whistleblower
 - Other physicians
 - Employees
 - Attorneys
 - Consultants
- Decision is often made to settle the case rather than go to trial.

Valuation Approaches



● Quiz: Which one of the following establishes FMV?

The proposed compensation is...

- A. ...the outcome of an arm's length negotiation.
- B. ...equivalent to what the competing hospital is offering.
- C. ...less than what we are currently paying a locums agency.
- D. ...equivalent to median compensation reported by MGMA for my region.
- E. All of the above
- F. None of the above

Valuation Approaches



● The Market Approach

- “...a general way of determining a value indication of a business, business ownership interest, security, or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities, or intangible assets that have been sold.”
- When applied to physician compensation, this requires the use of market survey data (e.g., MGMA, AMGA, Sullivan Cotter).
- *Answers the question: “What are other people paying/earning for similar services?”*

Valuation Approaches



● The Market Approach

● Pros:

- A plethora of data is available in most cases.
- It's "easy."

● Cons:

- You get an "off the rack" answer that may not fit your arrangement.
- Survey data often reflects large practices that may not be comparable to the subject arrangement.
- The survey data is increasingly representative of hospital-employed groups.
- Nuances of market data can result in it being incorrectly applied in practice.
- Survey data is over a year old at the time of publishing. Data may represent a reimbursement environment that is no longer reality.
- Regional data may not be representative of the subject market.
- Market data is a self-fulfilling prophecy (i.e., if the median is the floor, then the median will increase each year).



● The Income Approach

- “...a general way of determining a value indication of a business, business ownership interest, security, or intangible asset using one or more methods that convert anticipated economic benefits into a present single amount.”
- When valuing a service arrangement, there is often no need to discount the cash flow to present value, but general principles still apply.
- *Answers the question: “What are the normalized distributable earnings this entity or arrangement will generate?”*

Valuation Approaches



● The Income Approach

● Pros:

- Can provide a “tailored” conclusion regarding the subject arrangement.
- Generally results in a conclusion of value that is supportable in the context of the economics of the subject arrangement (provided that proper valuation techniques are used).
- Can take into account known changes in the reimbursement environment.

● Cons:

- More time consuming (and more costly)
- May result in lower FMV indications than those resulting from a Market Approach.
- Uncertainty regarding how to treat the value of in-office ancillaries. Does this directly or indirectly assign specific value to referrals?
- May not produce a valid result in a needed specialty without sufficient demand.
- May result in a situation where two physicians in the same general market are compensated vastly different amounts for similar services.

The Market Approach: The Survey Data

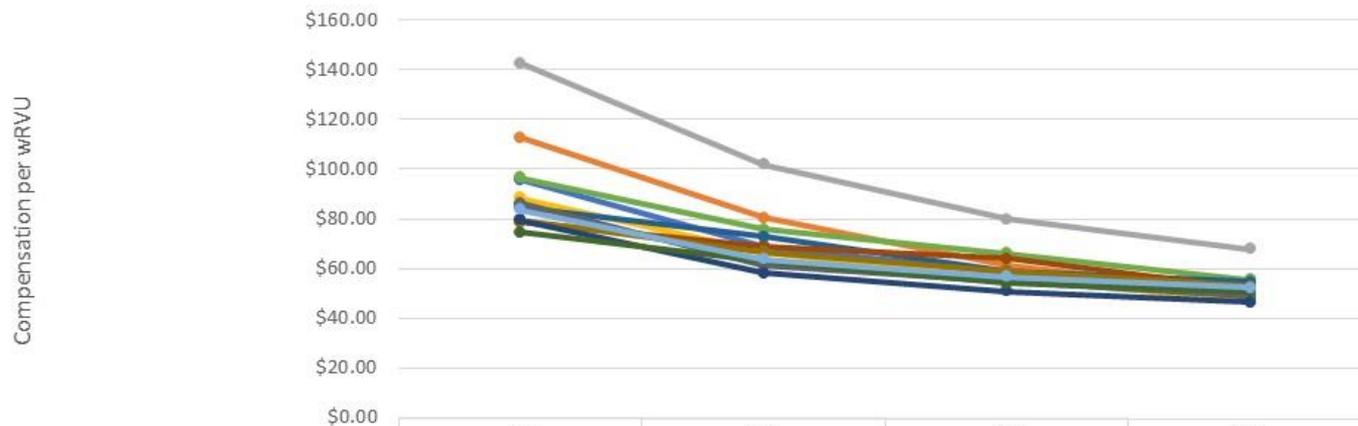


- What is collected? Among other metrics...
 - Total cash compensation from all sources
 - Collections from professional services
 - Aggregate work relative value units (“wRVUs”)
- The surveyors then use this data to calculate the following metrics:
 - Compensation as a percentage of collections
 - Compensation per wRVU
- Observations
 - The highest compensation per wRVU rates represent physicians at the low end of the annual production spectrum.
 - What does this mean? When selecting a compensation rate, aggregate production can be important.

The Market Approach: The Survey Data



Median Compensation per wRVU
Grouped by Quartile of Production

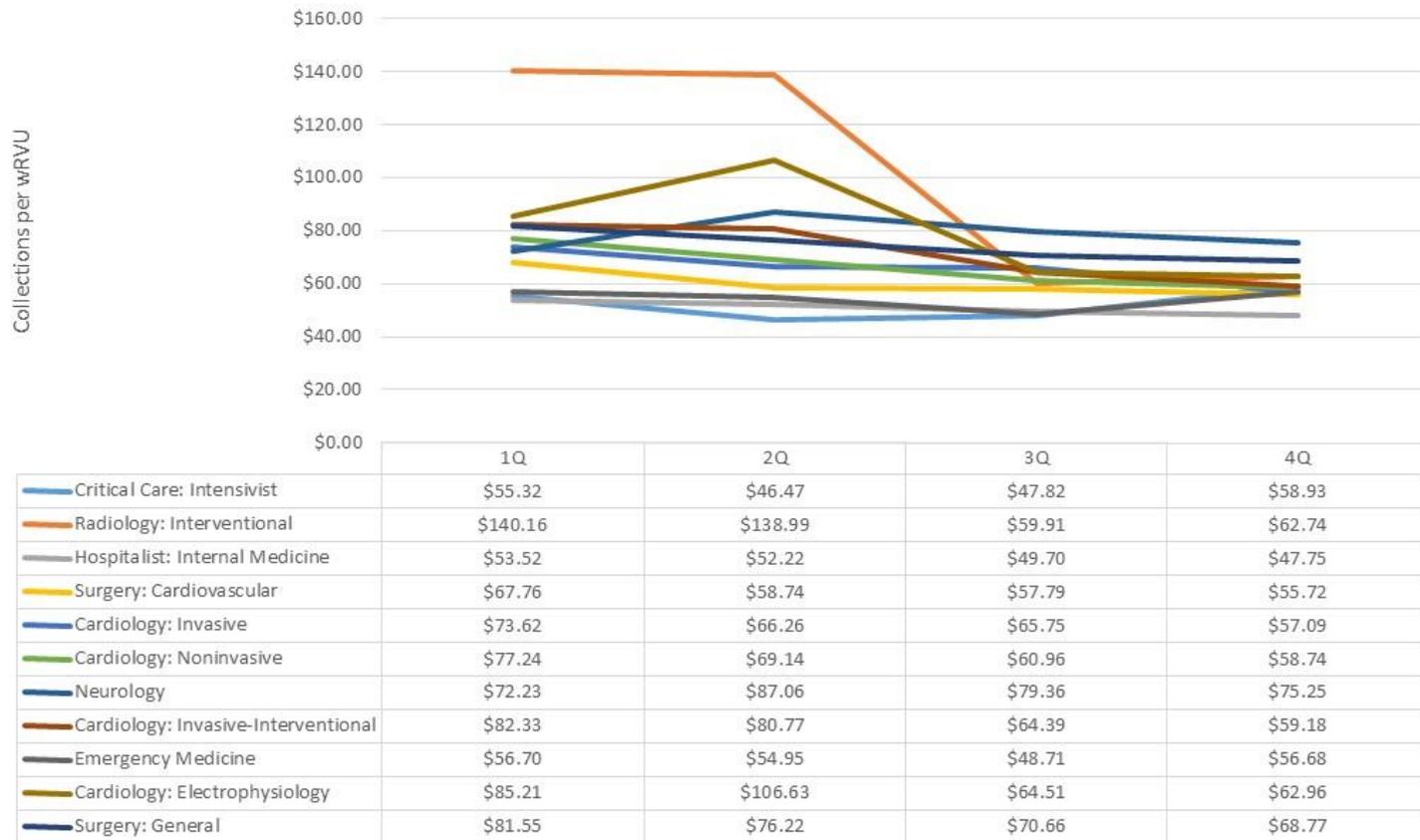


	1Q	2Q	3Q	4Q
Surgery: Trauma	\$112.65	\$80.58	\$61.31	\$50.92
Critical Care: Intensivist	\$142.70	\$101.99	\$79.78	\$67.79
Radiology: Interventional	\$88.24	\$66.78	\$56.11	\$46.98
Hospitalist: Internal Medicine	\$95.75	\$69.05	\$58.49	\$48.73
Surgery: Cardiovascular	\$96.57	\$75.79	\$66.13	\$55.48
Cardiology: Invasive	\$85.00	\$72.75	\$58.86	\$54.66
Cardiology: Noninvasive	\$78.71	\$68.73	\$63.97	\$51.86
Neurology	\$86.41	\$61.13	\$54.52	\$48.65
Cardiology: Invasive-Interventional	\$79.24	\$66.56	\$58.94	\$53.00
Emergency Medicine	\$79.71	\$58.27	\$50.91	\$46.47
Cardiology: Electrophysiology	\$74.70	\$63.20	\$54.13	\$50.69
Surgery: General	\$83.55	\$63.74	\$56.83	\$52.21

The Market Approach: The Survey Data



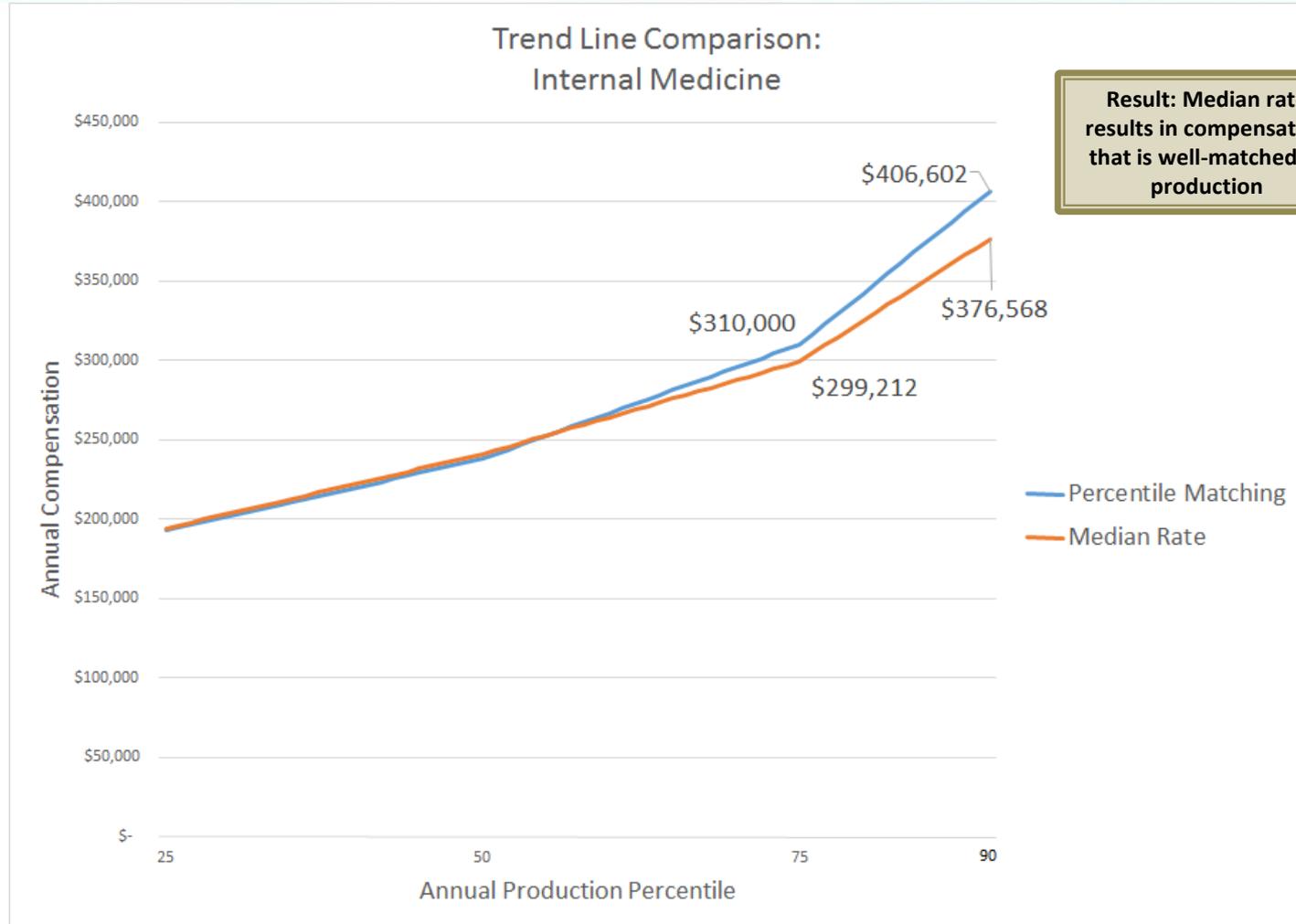
Median Collections per wRVU
Grouped by Quartile of Production



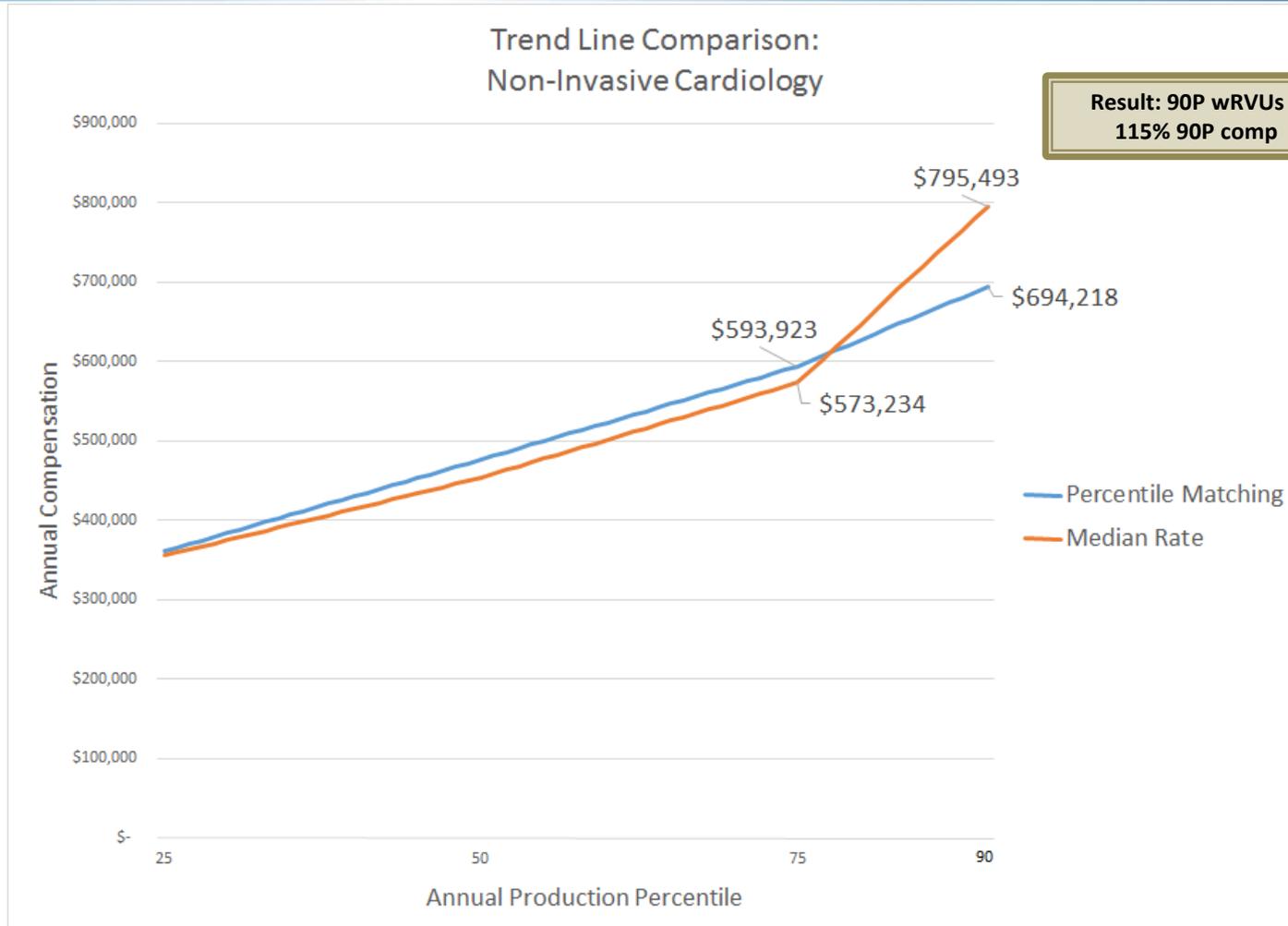
The Market Approach: Percentile Matching

- A common objective in compensation plan design and fair market value analysis is the concept of “percentile matching.”
- This does not mean matching the compensation rate per unit of productivity to their total production!
 - Example: Orthopedic surgery
 - 90th percentile wRVUs = 13,744
 - 90th percentile comp / wRVU = \$106.63
 - Calculated Compensation = \$1,466,000
 - 90th percentile compensation = \$1,003,000
- Even median compensation rates can result in distortions in percentile matching at higher levels of production.

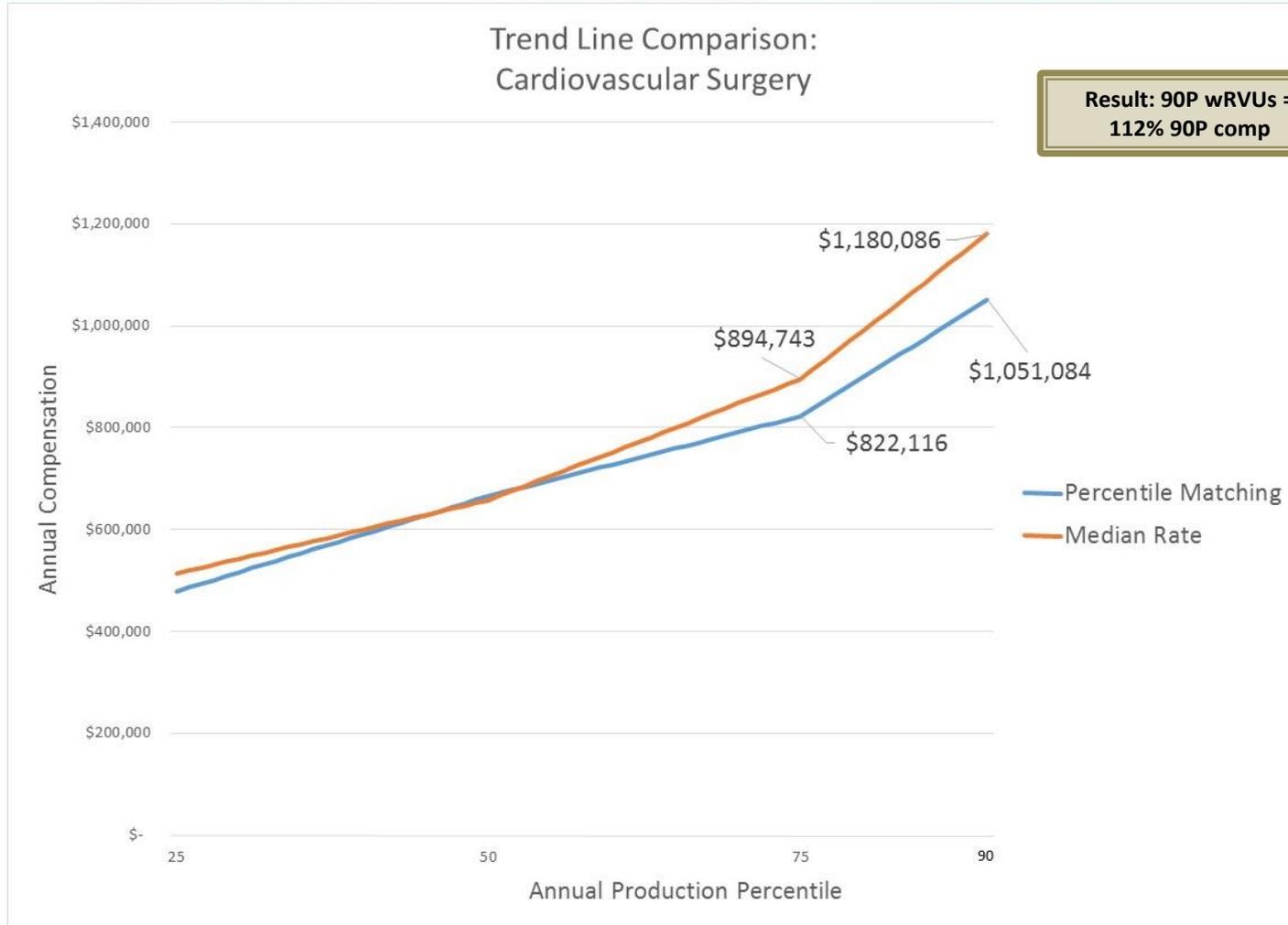
The Market Approach: Percentile Matching



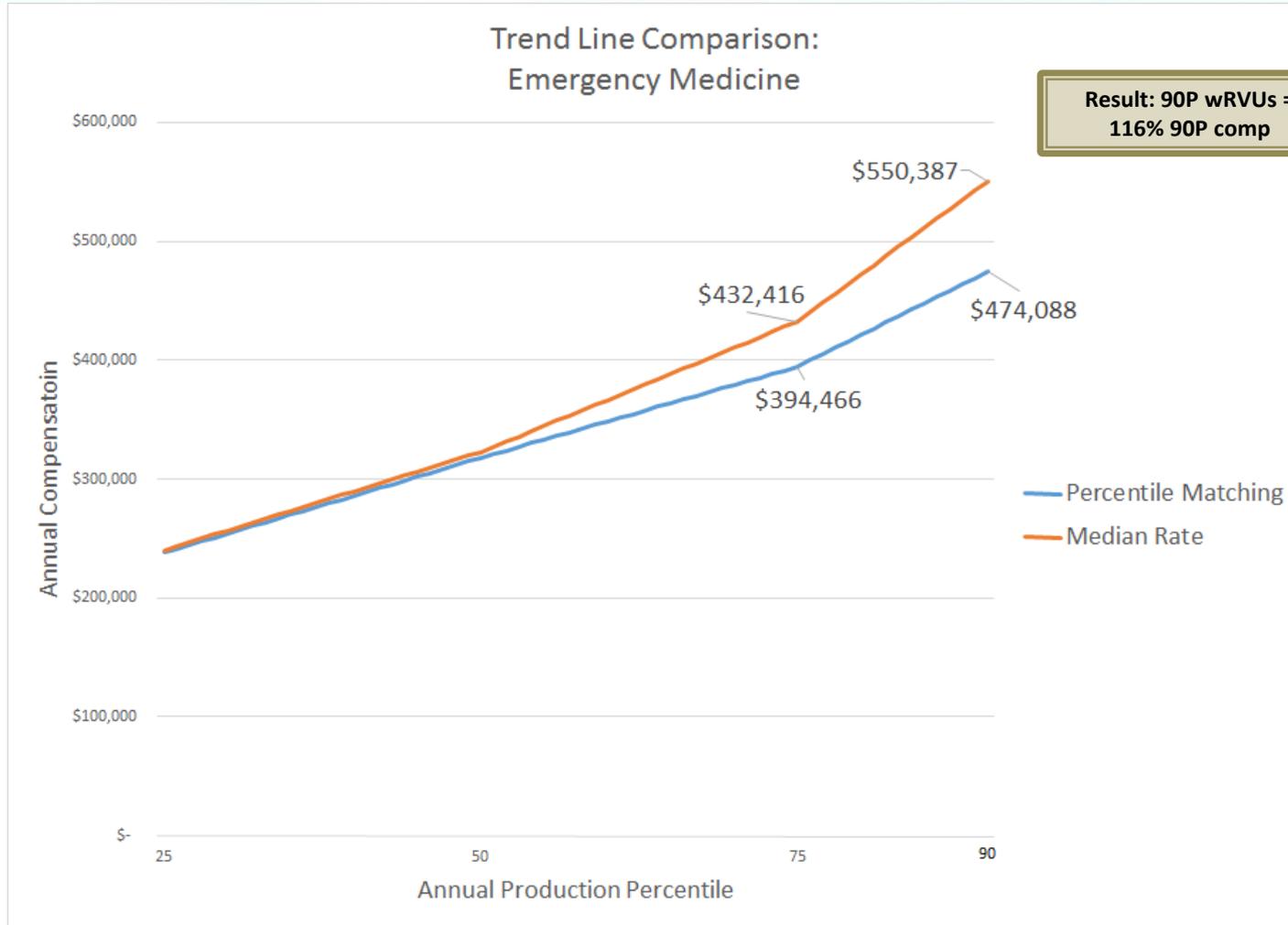
The Market Approach: Percentile Matching



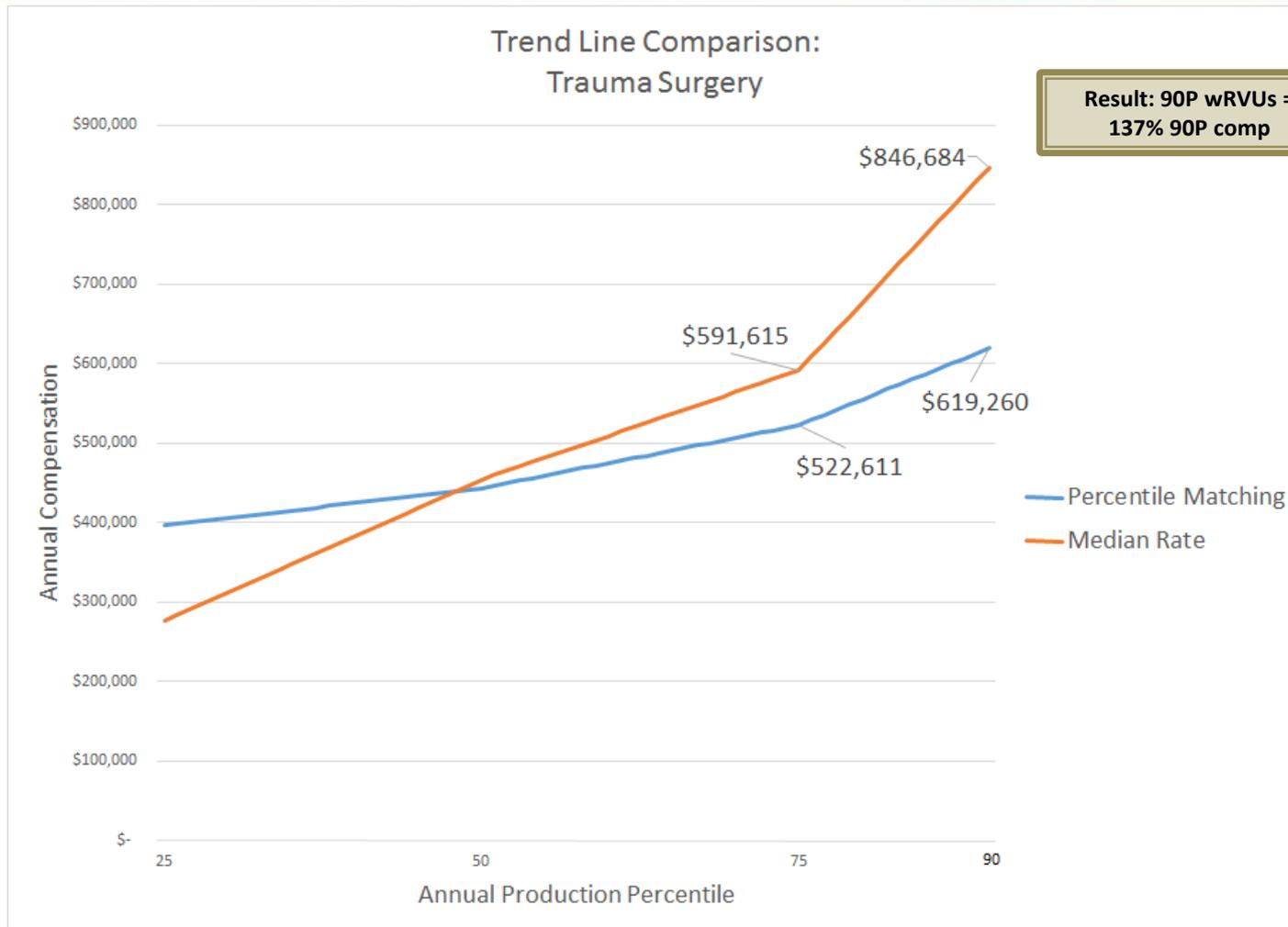
The Market Approach: Percentile Matching



The Market Approach: Percentile Matching



The Market Approach: Percentile Matching



The Market Approach: Percentile Matching



- When do median compensation rates tend to work well?
 - When the physician's aggregate clinical production approximates the median.
 - When the physician's aggregate compensation is not impacted by stacking concerns.
 - When multiple surveys report consistent data.
 - For specialties in which production-based compensation models are common.
 - **When the other facts and circumstances of the arrangement support the use of the median from a commercial reasonableness perspective.**

The Market Approach: Percentile Matching



- When do median compensation rates tend to *NOT* work well?
 - When the subject physician is extremely productive (or not very productive).
 - When compensation stacking is concern.
 - When the survey used provides an outlier value (e.g., use of regional data with a small “n”)
 - For specialties where it is uncommon to see compensation based primarily on clinical production (e.g., hospital-based specialties)
 - **When the facts and circumstances of the arrangement *do not* support the commercial reasonableness of the arrangement’s economics**

The Market Approach: Stacking Concerns



- Physicians are being compensated for more and more clinical and administrative activities than ever before.
- Plans may consist of a base salary *plus* production-based incentives *plus*...
 - Quality-based compensation
 - Co-management compensation
 - On-call compensation
 - Administrative services compensation
 - Outreach compensation
 - Midlevel provider supervision compensation
 - Research compensation
 - Night shift differential pay
 - Signing bonuses, commencement bonuses, retention bonuses, student loan repayments, residency stipends....

The Market Approach: Stacking Concerns



- Why is stacking a concern?
- The surveys report compensation rates that include compensation from *all sources*. There is no such thing as “clinical compensation per wRVU” reported by the surveys.
- Using a median compensation rate as the foundation for a compensation plan, and then stacking other compensation components on top of this rate, can result in an aggregate compensation per wRVU rate that exceeds the 75th percentile reported values.
- Example: OB/GYN
 - 6,686 wRVUs and Compensation / wRVU = \$50.25 (median data)
 - On Call Pay: \$42,000 (median per diem x 5 days per month)
 - Medical Director: \$36,000 (median rate x 20 hours per month)
 - Quality Bonus: \$20,000
 - Midlevel Supervision: \$20,000
 - Total Compensation: \$453,972 (79th percentile)
 - Total Compensation per wRVU: \$67.90 (79th percentile)
- Is this a problem?

The Market Approach: Stacking Concerns



● Tips to Mitigate Stacking Risks

- To the greatest extent possible, ensure time devoted to various services is mutually exclusive, and specify this in the agreement.
- Compensate medical directorships and other administrative duties on an hourly basis rather than annual stipends. Ensure time doesn't overlap with expected clinical hours.
- Ensure that midlevel provider supervision compensation reflects reasonable expectations of productivity drag.
- Require a certain number of “uncompensated” call shifts.
 - The reported market data includes compensation for a certain number of call shifts already.
- Realistically assess whether the required compensated duties can be accomplished by a single individual.
- Compare total compensation per unit of production under the agreement to survey data. Be prepared to justify high amounts.

The Market Approach: Regional Data

- Common to observe operators using regional data in compensation plan design.
- Justification: More representative of the subject market
- Potential pitfalls:
 - Sample sizes may be small, leading to the use of outlier data and/or fluctuations year over year.
 - Regional data may not actually contain many respondents from your state.
 - MGMA Non invasive cardiology: 843 national respondents, 107 regional respondents, 0 respondents from Montana.
 - If your state is well-represented, the data may not be representative of your local market

The Income Approach



- Comparable to a private practice scenario
- Compensation to the physicians is based upon distributable earnings before physician compensation (i.e., revenue less expenses).
- Can be used to derive compensation per wRVU, compensation as a percent of collections, etc.
- Will generally result in a conclusion of value that is supportable in the context of the practice's financial situation.
- Some attorneys prefer to avoid the income approach as it could be construed to directly or indirectly consider the value of DHS referrals (i.e., in office ancillaries).
- Even if an Income Approach is not directly used, it is advisable for operators to develop pro forma financial statements for the *professional practice*.

Commercial Reasonableness



- Commercial reasonableness addresses the “WHY” question.
- Questions to ask:
 - Why do I need to employ this physician?
 - Do the physician’s qualifications match my needs?
 - Could the services be provided by someone with less training?
 - If practice losses exist, are they justifiable in the absence of referrals?
 - Would a hypothetical operator incur these losses based on my market?
 - Are losses “fictitious” due to ancillary carve-outs?

Commercial Reasonableness



- Can sustained practice losses be commercially reasonable? Yes.
 - There are numerous reasons it may be reasonable to operate a medical practice at a loss (other than securing referrals)
 - Community need
 - Population health and other value-based contracting initiatives
 - Cost accounting optics
- Document the business case for incurring losses.

Conclusion and Takeaways



- Whether median compensation rates are appropriate will depend on your situation.
- There are plenty of arrangements in which median compensation works well...however, operators should be cautious about blindly defaulting to certain survey benchmarks.
- A thorough understanding of the survey data is necessary to apply it properly in compensation plan design.
- Be aware of the effects of compensation stacking on total compensation rates.
- The median is not the floor. There may be situations where it makes sense to establish compensation amounts below the median depending on your situation.

Questions?



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