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Defensibility of a fair market value analysis

by Bob Wade

Fair market value (FMV) is a pinnacle issue with respect to healthcare regulatory compliance and compensation agreements. This article will analyze the issues related to an FMV defensibility analysis of compensation agreements. It will explain that having what appears to be an FMV in your file is insufficient. The FMV review or opinions need to assess if the compensation arrangement was ever challenged by the government or a qui tam relator to defend the compensation agreement sufficiently.

FMV is a material component with compliance with the following exceptions in the Stark Law, 42 U.S.C. § 1395nn:

- Academic medical centers
- Rental of office space
- Rental of equipment
- Bona fide employment relationships
- Personal service arrangements
- Isolated transactions
- Payments by a physician
- FMV compensation
- Indirect compensation arrangements
- Limited remuneration to a physician

FMV is also a material component of compliance with the following safe harbors of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b (b):

- Space rental
- Equipment rental
- Personal services and management contracts

FMV opinions and benchmark data

Typical FMV opinions extensively analyze various benchmark data such as the total cash compensation (TCC) benchmarks and production benchmarks.[1] A typical FMV analysis applies the TCC to productivity, described as any of the following: work relative value units (wRVU), patient encounters, collections, charges, and hours worked. A typical FMV opinion attempts to align TCC with productivity based on benchmark data. This is a perfectly acceptable process assuming both the TCC and production.

From a defensibility perspective, the Stark Law final rule was published by the Centers for Medicare & Medicaid Services (CMS) on December 2, 2020, with an effective date of January 19, 2021.[2] The final rule contributed a material part of the regulations related to FMV and commercial reasonableness. The basic analysis under the final rules was that the application of benchmark data is not the sole source, from a defensibility perspective, to analyze the TCC being paid to a referring physician.

When analyzing the TCC, it is important to understand the following for a defensibility analysis:

- For employment agreements to comply with the bona fide employment arrangements, if any component of the compensation is based on production, are the wRVUs personally performed and being credited to the physician, or are they being performed by a non-physician practitioner?
- Are the wRVUs being credited to the physician medically necessary? This analysis should be based on the designated health service (DHS) entity employer, a medical necessity audit, or review.
- Are the wRVUs credited to the physician documented in the medical record? Again, this can be based on the employer's representation of medical record audit.
- If the physician is paid based on hours worked, is there a process to document the hours worked? For example, if the compensation arrangement is a medical directorship, are there time sheets or a representation from an officer of the DHS entity?
- If the physician is stating that there are competing offers, does documentation regarding the competing offers exist, or is the physician willing to provide an affidavit, by way of example?
- If national benchmark data does not support the TCC, is there reliable benchmark data from the local service area?

Evaluating the defensibility of an FMV opinion

When evaluating the defensibility of an FMV review or opinion, it is vital to consider the potential audiences that may be evaluating the physician's TCC or concluding that the compensation is above FMV. These audiences can include competitors, qui tam litigants, the U.S. Department of Health & Human Services Office of Inspector General, the U.S. Department of Justice, CMS, or a Medicaid Fraud Unit.

When evaluating the defensibility of a compensation arrangement with a physician referral source, the key issue is determining whether the documentation in the file is sufficient to support and defend the compensation arrangement. Although lawyers who understand cases and settlements involving FMV can do a defensibility review, it is possible that the defensibility analysis can be performed by a consultant or in-house employees (i.e., compliance officers and CFOs).

Based on the facts and circumstances, it is defensible that the TCC could be higher when compared with the physician's productivity based on benchmark data. Some of the possible indicators when a disconnect between the TCC and productivity exists are as follows:

- High wRVU production
- Failed attempts to recruit a physician in the applicable specialty
- A deficiency of physicians in the applicable specialty based on population
- Multiple board certifications
- Regional/national "thought leader" (sometimes referred to as "physician rock stars")
- Existence of a documented competing offer
- Author of multiple publications or articles
- Significant research
- Multiple speaking engagements
- Historical high compensation
- High number of hours worked (i.e., more than 2,100 hours)
- Disproportionate amount of call coverage (i.e., more than 1:3 or 1:4)
- Need for specialty with low population (population may not justify a 1.0 full-time equivalent, but the medical services in the specialty are needed for the patient population)
- Threats by physician to leave service area (a departure of a physician not only will temporarily deny the patients in the service area but may be more expense for the DHS entity to recruit a replacement physician)
- Only available alternative is locum tenens coverage
- New technology or new/expanded service line
- Physician serving in leadership positions not only for the DHS entity but also for professional associations
- Supervision of nonphysician practitioners

The final rule also emphasized that when compensating a referring physician, there should be buyer neutrality, which means that the physician should be compensated the same whether the physician is in private practice, employed by a hospital or health care system, or compensated through private equity. The final rules specifically stated the following:

> "... a hospital may not value a physician's services at a higher rate than a private equity investor or another physician practice simply because the hospital could bill for designated health services referred by the physician under the OPPS [Outpatient Protective Payment System], whereas a physician practice owned the private equity investor or other physicians would have to bill under the PFS [Physician Fee Schedule], which may have lower payment rates."[3]

When evaluating the defensibility of the TCC for a referring physician by CMS, the final rules made it clear that the service area dynamics need to be considered. The final rules stated the following:

> "As we have stated consistently in prior rulemakings, to establish the fair market value (and general market value) of a transaction that involves compensation paid for assets or services, we intend to accept any method that is commercially reasonable and provides us with evidence that the compensation is comparable to what is ordinarily paid for an item or service in the location at issue, by parties in arm's-length transactions that are not in a position to refer to one another (66 FR 944)."[4]

It should be noted that just because compensation was established at arm's length does not necessarily mean that the compensation is defensible from an FMV perspective.

Therefore, from a defensibility perspective, it is essential to not only analyze the benchmark data but also evaluate the local/service area and/or physician-specific issues impacting the TCC.

For example, if a service area, based on population, should have four cardiovascular surgeons, but it has only two cardiovascular surgeons and has found it challenging to recruit additional cardiovascular surgeons, then the recruiting entity may be able to justify the higher TCC compared to anticipated productivity. Such a situation may also impact the compensation paid to the two cardiovascular surgeons already in the service area.

Determining FMV is fact-specific. Careful analysis needs to be performed to determine whether there is physician-specific or service-area documentation to support the compensation. Unfortunately, there is no magical process where facts, circumstances, and benchmark data can be put into an "FMV determination device" to produce defensible FMV documentation.

Commercial reasonableness and FMV

Although FMV is a key consideration, it is also critical to determine if the arrangement is commercially reasonable. Commercial reasonableness is a separate analysis from FMV. Therefore, the compensation arrangement should be evaluated from a commercial reasonableness perspective in addition to an FMV perspective. A compensation arrangement may be FMV but not commercially reasonable.

One example of driving home this point is as follows: Suppose a hospital CEO was approached by physicians who owned a medical office building (MOB) that was only 50% occupied. In this situation, the physician owners of the MOB are losing money. The hospital or physicians may have obtained an FMV review. If the hospital has no intention to occupy or try to lease the unoccupied space, and if the hospital purchased the MOB at FMV, then the arrangement may not be commercially reasonable. In this case, the business risk would have shifted from the physicians to the hospital, and such shifting of the business risk may not be commercially reasonable even if an FMV appraisal exists.

FMV analyses need to be reviewed, and the commercial reasonableness factors need to be assessed to determine if it is reasonable to conclude that the arrangement has a high probability of being defended. That is why when providing FMV analyses, it is crucial to determine the defensibility of the arrangement from the perspectives of FMV, commercial reasonableness, and the risks associated with defending the arrangement if a case was brought concerning the compensation arrangement. This is imperative not only for the DHS entity (i.e., hospital) but also for the referring physicians involved.

Conclusion

It is imperative that the documentation to support the FMV of the TCC be evaluated to determine whether it is reasonably believed that the TCC can be defended. Simply having a document that appears to be an FMV review or

opinion is insufficient. It is important to analyze the documentation to determine whether it can be reasonably concluded that it is sufficient to defend the compensation arrangement if ever challenged.

Takeaways

- Fair market value (FMV) is a pinnacle issue regarding healthcare regulatory compliance for compensation agreements, particularly under the Stark Law and Anti-Kickback Statute.
- Typical FMV opinions extensively analyze various benchmark data such as total cash compensation (TCC) and production benchmarks.
- When analyzing TCC, it is essential to understand various factors about work relative value units, patient encounters, collections, charges, and hours worked.
- Determining FMV is fact specific, depending on whether physician-specific or service-area documentation can support the compensation.
- While the key issue is whether the compensation is FMV, it is also critical to determine if the arrangement is commercially reasonable.

1 Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16,054 (March 26, 2004), 16,128, https://www.govinfo.gov/content/pkg/FR-2004-03-26/pdf/04-6668.pdf. (*Note:* The following organizations are cited in the Phase II Regulations and provide compensation and productivity data: Sullivan, Cotter & Associates, Inc.; Hay Group; Hospital and Health Care Compensation Services; Medical Group Management Association; ECS Watson Wyatt; William M. Mercer. Although these entities were cited, other benchmark sources can be relied upon. This article references these sources because they were referenced in the Phase II Regulations. Although these sources are good sources from which to obtain benchmark data, I am not including these sources endorsing these sources providing compensation and productivity benchmark data.)
2 Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77,492 (Dec. 2, 2020), https://www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26140.pdf.
3 Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77,492, 77,555.
4 Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77,492, 77,556.