2011 ECG Trends Webinar Series

Auditing Hospital/Physician Arrangements: Better Safe Than Sorry

June 7, 2011

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Agenda

I. Avoid Being a Headline
II. Why Conduct a Compliance Review?
III. How to Conduct a Compliance Review
IV. Corrective Action Plan Considerations
V. Disclosure to Government?

Attachment A – Fair Market Value (FMV) Compensation Considerations

I. Avoid Being a Headline

I. Avoid Being a Headline
Bradford Regional Medical Center

BRMC Being Sued In Federal Court For Alleged Fraud, Paying Kickbacks to Doctors

by Marcie Schellhammer

January 15, 2010

BRADFORD, Pa. – Bradford Regional Medical Center is being sued in federal court for alleged fraud, and allegedly paying kickbacks to doctors Peter Vaccaro and Kamran Saleh for referring all their patients to Bradford Regional.

The lawsuit, filed in July 2004 by doctors Dilbagh Singh, V. Rao Nadella, Paul Kirsch and Martin Jacobs against Bradford Regional, V&S Medical Associates, Vaccaro and Saleh, is still pending in federal court in Erie before Judge Maurice Cohill. The doctors are suing under the Federal False Claims Act, as well as the Stark Law and Medicare anti-kickback statute.

The Stark Law prohibits a physician from referring patients to a medical facility with which he holds a financial relationship. The anti-kickback statute prevents a physician from being compensated for referrals. The false-claims portion alleges that the defendants perpetuated a scheme by which they presented claims for reimbursement to government agencies for services rendered to patients who were illegally referred to Bradford Regional.

The plaintiffs, Singh, Nadella, Kirsch and Jacobs, filed the suit as a “qui tam” action, meaning they are suing on behalf of the U.S. government against someone who has allegedly submitted a false claim to the government.

- Case going to jury trial for intent after determination of a Stark law violation.
- Hospital arrangements compensating physicians under an equipment sublease arrangement violated Stark law because payments were determined by accounting for volume and value of referrals.
- Violation despite:
  - Independent FMV by independent accountant.
  - Non-variable payments.

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I. Avoid Being a Headline
University of Medicine and Dentistry of New Jersey

The Star-Ledger

UMDNJ to Pay $8.3 Million to Settle Kickbacks

by Joe Ryan
September 30, 2009

NEWARK – The state's medical university agreed today to pay $8.3 million to the federal government, ending a probe into the school's alleged practice of paying kickbacks to doctors in exchange for patient referrals.

For more than a decade, the University of Medicine and Dentistry of New Jersey granted no-show faculty jobs to cardiologists who, in turn, directed patients from their private clinics to the school, authorities said.

Prosecutors say the move was part of an effort to increase cardiac procedures and maintain state accreditation at the medical school, one of the nation's largest. But federal law prohibits hospitals from paying doctors for referrals.

"…the university realized it was not performing enough cardiac procedures to maintain funding and accreditation..."

As part of the settlement, UMDNJ did not admit any wrongdoing. Spokesman Jeffrey R. Tolvin said the school has undergone sweeping reform since the investigation began.

"This settlement agreement marks the conclusion of a matter involving misconduct at UMDNJ that arose years ago in a much different culture," Tolvin said.

- $8.3 million settlement.
- 10-year period.
- No-show faculty jobs to cardiologists who, in turn, directed patients from their private clinics to the school.
- Annual reviews by federal health officials and to strengthen compliance efforts.
- Civil settlements with nine cardiologists, two others have pleaded guilty to criminal embezzlement charges, and two others have civil suits pending.

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I. Avoid Being a Headline
South Texas Health System

THE MONITOR

South Texas Health System Settles Fraud Lawsuit

by Sean Gaffney
October 30, 2009

McALLEN — Hidalgo County-based South Texas Health System agreed to pay $27.5 million to the federal government to settle allegations that the hospital system paid doctors illegal kickbacks to refer patients to its facilities, the U.S. Justice Department announced Friday.

The health system allegedly disguised the payouts as "sham contracts" that included leasing office space and awarding bogus medical directorships to doctors to induce them to send patients to their hospitals, according to the government.

With the settlement, South Texas Health System denies all allegations of wrongdoing and admits no liability.

"Improper financial arrangements like these can increase the cost of health care by shifting provider attention to the quantity of treatments, rather than keeping it focused on the quality of care"

"Improper financial relationships between health care providers and their referral sources can corrupt a physician's judgment about the patient's true health care needs," Tony West, the assistant attorney general for the Justice Department's civil division, said in a news release. "This settlement should deter similar conduct in the future and help make health care more affordable for patients."

The cost of medical care in McAllen garnered national interest earlier this year after an article in The New Yorker magazine alleged the area's high cost of Medicare care is the result of an "across-the-board overuse of medicine."

- $27.5 million settlement.
- False Claims Act suit brought by former employee who will receive $5.5 million.
- Violations of the False Claims Act, Anti-Kickback Statute (AKS), and Stark law between 1999 and 2006.
- " ... series of sham contracts, including medical directorships and lease agreements."
- 5-year Corporate Integrity Agreement (CIA).

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I. Avoid Being a Headline
Covenant Medical Center

Chicago Tribune

Iowa Hospital Pays $4.5 Million in Fraud Case

by Nigel Duara
August 25, 2009

IOWA CITY, Iowa – A Waterloo hospital paid $4.5 million to settle claims that it improperly used Medicare money to pay five doctors to refer patients to the hospital, making the physicians among the highest-paid doctors in the country.

The U.S. Justice Department alleged the five doctors employed by Covenant Medical Center were paid far above market value, disqualifying them from receiving Medicare dollars.

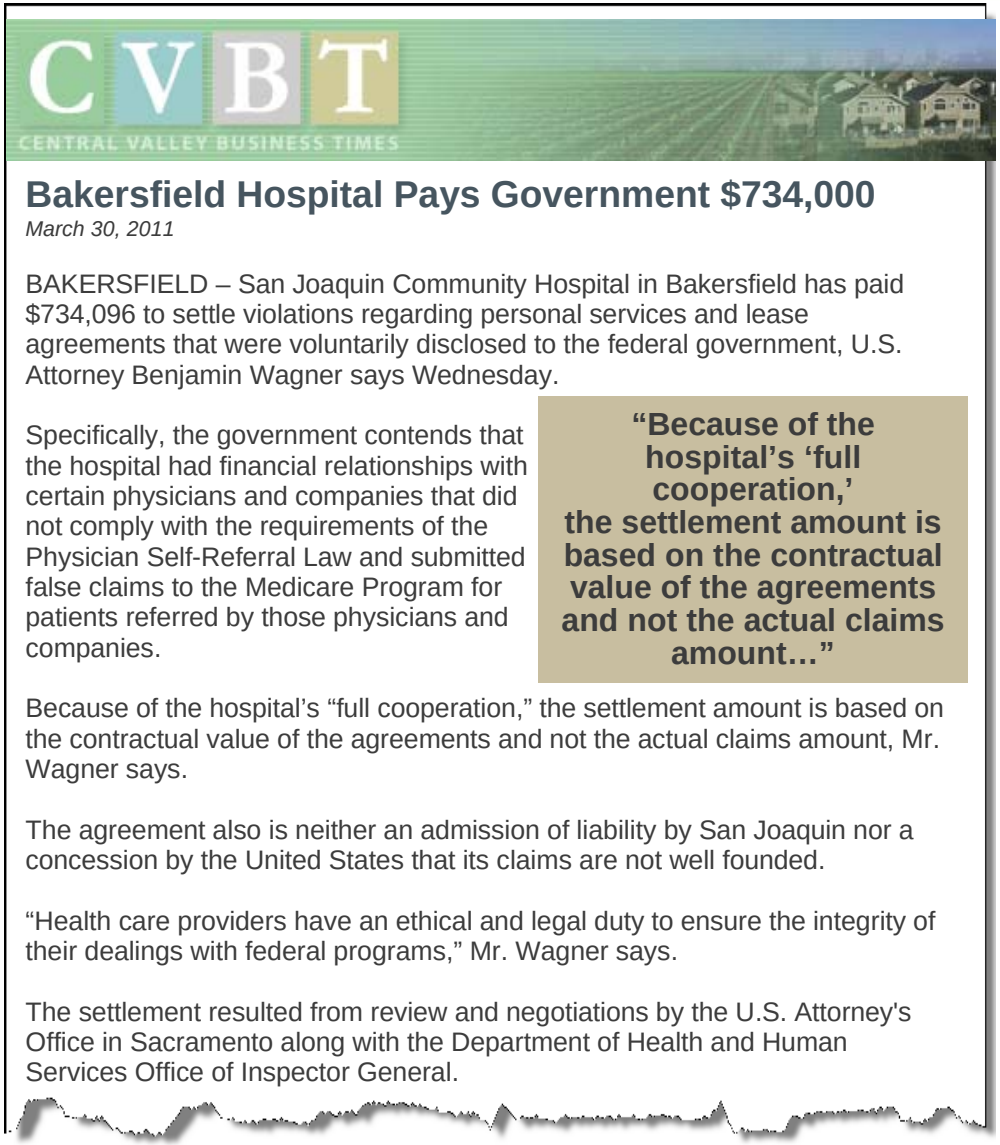
"They can do the referrals; that's not necessarily the problem," said U.S. Attorney Matt Dummermuth. "It's the combination of the referrals without being fair-market value and commercially reasonable. That's what has potential to compromise the medical judgment, when there's improper financial incentives potentially at play there."

"Covenant Medical Center made a business decision to settle to avoid the uncertainty of litigation..."

Covenant denied any wrongdoing in the settlement announced Tuesday. In a written statement, Covenant claimed prosecutors didn't find evidence of any illegal conduct, and the hospital called the physicians "highly productive."

- $4.5 million settlement.
- False Claims Act suit initiated when an independent practice complained that Covenant was providing excessive compensation to hire physicians away from Cedar Valley Medical Specialists, P.C.
- Claims compensation to several employed physicians exceeded FMV (neurosurgery, orthopedic surgery, and gastroenterology).
- CCA/CIA not required.

I. Avoid Being a Headline
San Joaquin Community Hospital



CVBT
CENTRAL VALLEY BUSINESS TIMES

Bakersfield Hospital Pays Government $734,000

March 30, 2011

BAKERSFIELD – San Joaquin Community Hospital in Bakersfield has paid $734,096 to settle violations regarding personal services and lease agreements that were voluntarily disclosed to the federal government, U.S. Attorney Benjamin Wagner says Wednesday.

Specifically, the government contends that the hospital had financial relationships with certain physicians and companies that did not comply with the requirements of the Physician Self-Referral Law and submitted false claims to the Medicare Program for patients referred by those physicians and companies.

"Because of the hospital's 'full cooperation,' the settlement amount is based on the contractual value of the agreements and not the actual claims amount…"

Because of the hospital's "full cooperation," the settlement amount is based on the contractual value of the agreements and not the actual claims amount, Mr. Wagner says.

The agreement also is neither an admission of liability by San Joaquin nor a concession by the United States that its claims are not well founded.

"Health care providers have an ethical and legal duty to ensure the integrity of their dealings with federal programs," Mr. Wagner says.

The settlement resulted from review and negotiations by the U.S. Attorney's Office in Sacramento along with the Department of Health and Human Services Office of Inspector General.

- $734,000 settlement.
- Voluntary disclosure.
- Violations of the False Claims Act and Stark law between 2006 and 2009.
- Noncompliant personal services agreements and office space leases.

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I. Avoid Being a Headline
The List Goes On – Historic Settlements

Settlements with the DOJ have cost health organizations millions of dollars, resulted in senior executives losing their jobs, and caused hospitals to lose strategic ground in their markets as their economic relationships with physicians are scrutinized.

- Condell Medical Center, Libertyville, Illinois – $36 million.
- Lester E. Cox Medical Centers, Springfield, Missouri – $60 million.
- HealthSouth Corporation, Birmingham, Alabama – $15 million.
- Memorial Health University Medical Center, Savannah, Georgia – $5 million.
- Alvarado Hospital, San Diego, California – $21 million.
- University Hospitals Health System, Cleveland, Ohio – $14 million.

The OIG estimates that it earns $17 for every $1 spent on healthcare investigations.

II. Why Conduct a Compliance Review?
Stark Law

Stark law is a civil statute prohibiting providers from billing Medicare for designated health services (DHS) associated with referrals from physicians who have a financial relationship with the provider – unless an exception applies.

- Stark law is a strict liability statute.
- Typical Stark violations: no written agreement; no signatures; expired agreement; compensation not FMV.
- Stark law contains a number of exceptions that allow a physician to refer to an entity for the provision of DHS.
- Exceptions: common elements include written agreement, FMV compensation, compensation set in advance, compensation does not vary with the volume or value of referrals.
- Consequences of a Stark violation include:
  - Denial of payment from CMS.
  - Repayment of all amounts billed to the Medicare program that violate the Stark law.
  - For a knowing violation, civil monetary penalties of up to $15,000 per service and up to $100,000 per arrangement considered to be a circumvention scheme.
  - Penalties under the False Claims Act.
  - Potential exclusion from the Medicare and Medicaid programs.

II. Why Conduct a Compliance Review?
Anti-Kickback Statute

The AKS is a criminal statute prohibiting anyone from offering remuneration of any kind with the intent to induce referrals for health services that are reimbursable by the federal government.

- Although both the AKS and Stark law were enacted to prevent healthcare providers from inappropriately profiting from referrals, the AKS, unlike Stark, requires a proof of intent to convict.
- The AKS applies to all federally funded healthcare programs.
- An offense under the AKS is a felony and is punishable by fines of up to $25,000 and imprisonment of up to 5 years.

II. Why Conduct a Compliance Review?
Tax Exemption Considerations

Tax-exempt organizations must guard against providing excess benefits to "disqualified persons."

- A charitable organization must be organized or operated for charitable purposes, and no part of the net earnings of a charitable organization may inure to the benefit of any private shareholder or individual.
- Intermediate sanctions afford the IRS a remedy to impose financial penalties for an excess-benefit transaction without revoking tax-exempt status of the tax-exempt organization.
- If the organization engages in an excess-benefit transaction with a person having substantial influence over the organization (a so-called disqualified person), an excise tax may be imposed on the person and any organization managers agreeing to the transaction.

II. Why Conduct a Compliance Review?
Raising the Stakes in Fraud and Abuse Enforcement

False Claims Act (FCA) Standard: False claims with knowledge, reckless disregard, or deliberate ignorance.

- Fraud Enforcement and Recovery Act of 2009 (FERA) broadens FCA liability:
  - New liability for the *retention* of overpayments, even if claim or receipt of overpayment was not knowingly false.
  - False claim now includes claims to *agents* of the government.
- Application of FERA to Stark violations.
- A Stark violation can be a False Claim.

II. Why Conduct a Compliance Review?
Key Provider Fraud Enforcement Provisions of the PPACA

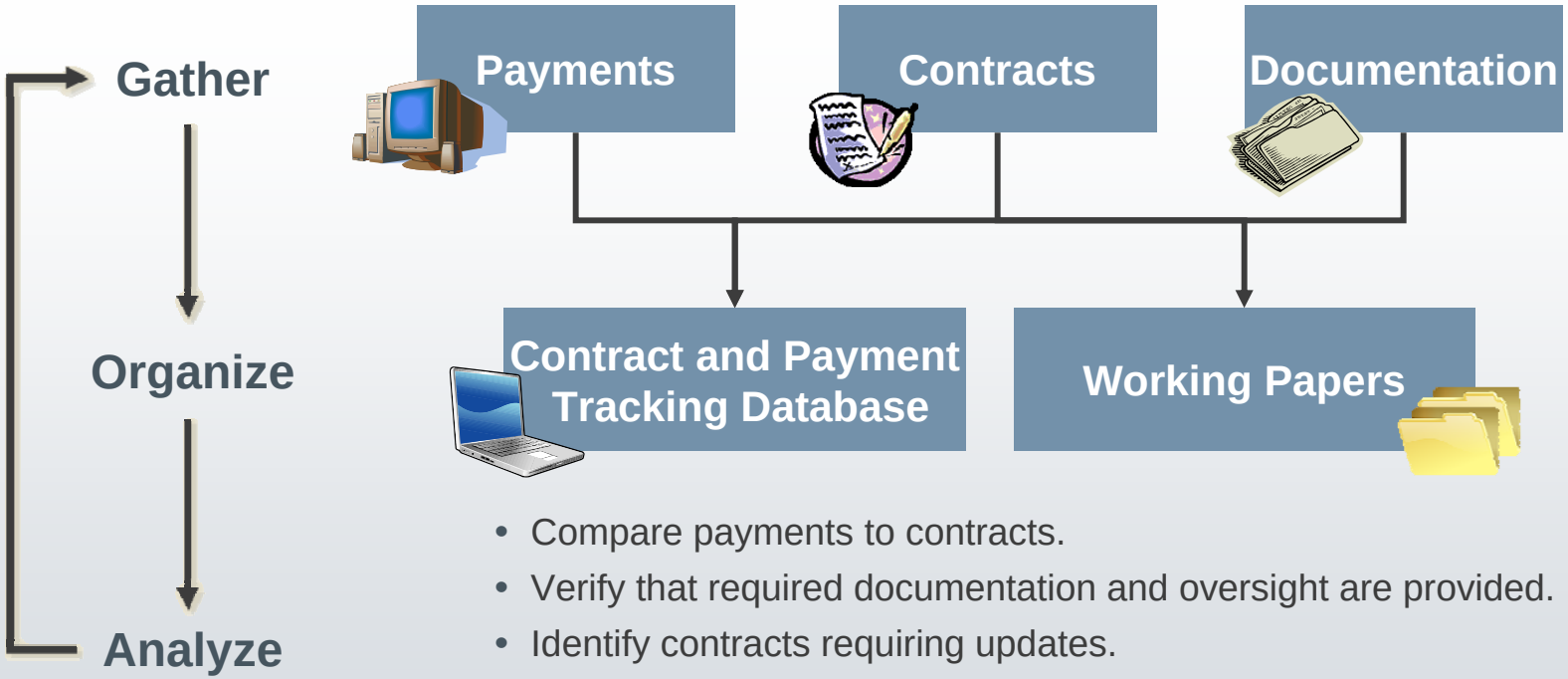
- Relaxes the intent requirements of the AKS – "repeals" the Hanlester case.
  - Old test – Violation occurs if:
    - » "One purpose" of payment is to induce an illegal referral.
    - » There is actual knowledge of the AKS's prohibitions.
    - » There is specific intent to violate the AKS.
  - New test – Violation occurs if "one purpose" of payment is to induce a referral: no need to show knowledge of AKS prohibitions only intent to induce a referral.
- Sets time period to return overpayments: 60 days; retention of overpayments after 60 days is defined as an "obligation" and therefore can be an FCA violation.
- Most providers and suppliers required to implement compliance programs as a condition to participation in Medicare or Medicaid.

II. Why Conduct a Compliance Review?
Fraud Enforcement Provisions of the PPACA (continued)

- Knowing falsity is grounds for program exclusion.
- Expands grounds for CMPs for excluded providers and falsities made in Medicare or Medicaid enrollment applications.
- Suspension of program payments pending investigation of "credible allegations of fraud."
- Increases funding – additional $350 million – to fight Medicare fraud and abuse.
- Establishes a national healthcare fraud and abuse data collection program for reporting adverse actions against providers, information to the NPDB.
- Establishes new grounds for terminating and excluding persons or entities from Medicaid who own or manage entities that fail to repay overpayments, that are excluded from Medicaid, or that are affiliated with excluded persons or entities.

III. How to Conduct a Compliance Review
Understanding the Methodology

The approach involves an iterative process whereby all payments made to physicians are identified, documented, categorized, and justified.



- Compare payments to contracts.
- Verify that required documentation and oversight are provided.
- Identify contracts requiring updates.
- Determine validity and necessity of contracts.
- Research payments without corresponding contracts or documentation.

III. How to Conduct a Compliance Review
Gathering Payment Data

The depth of a review of payments depends on the hospital's goal for the initiative.

Auditing Known Payments	Managing All Payments	Seeking Hidden Payments
• Pull all physician services payments from the check registry. • Pull additional payments for other known contracts (e.g., rental payments). • Eliminate unrelated payments.	• Pull all physician services payments from the check registry. • Pull additional payments for other known contracts (e.g., rental payments). • Eliminate unrelated payments. • Review all other payments that match certain queries (e.g., partial names of every physician and physician group in the area).	• Pull all physician services payments from the check registry. • Pull additional payments for other known contracts (e.g., rental payments). • Eliminate unrelated payments. • Review all other payments that match certain queries (e.g., partial names of every physician and physician group in the area). • Search for suspect payments and audit a sample.

III. How to Conduct a Compliance Review
Organizing Contracts and Documentation

Every contract resulting in one or more payments to a physician, physician group, or company owned by a practicing physician should be reviewed with documentation.

Contracts should be organized by type of arrangement:

- Physician recruitment.
- Call coverage.
- Medical directorship.
- Professional Services Agreement.
- Management Services Agreement.
- Lease agreements.
- Other (i.e., any other financial relationship between a hospital and a physician, family member of a physician, or physician organization).

Working papers should be created for each agreement to hold the contract, supporting documentation, and a history of all related payments.

III. How to Conduct a Compliance Review
Developing and Completing Checklists

Checklists should be prepared for every type of arrangement and completed consistently for every contract.

No.	Recruitment or Retention Agreement Checklist	True	False	Instructions/Comments
1	The agreement is signed by all parties.			List the parties to the agreement.
2	The agreement specifies the benefits to be provided by the hospital, the terms under which benefits are to be provided, and the obligations of the parties.			List the services to be performed.
3	The agreement contains a statement that the parties' arrangement was negotiated at arm's length.			List the intervals, length, and charge per interval.
4	The agreement indicates that the hospital's service area is a federally designated health professional shortage area or that a community need assessment demonstrates a documented need for the physician's specialty.			
5	The agreement indicates that the recruited physician has been practicing medicine for less than 1 year and is opening a practice in the hospital's service area.			
6	The agreement indicates that the recruited physician is relocating his/her practice by at least 25 miles or that the physician's new practice will derive at least 75% of its revenues from professional services to patients not seen or treated by the physician in the prior 3 years.			
7	The agreement indicates that the physician was not on the medical staff of the hospital prior to recruitment, including temporary staff privileges or other seemingly inactive privileges.			Indicate the term of the agreement, including the effective date.
8	The agreement indicates that a FMV analysis was performed by an independent third party.			
9	The recruitment benefits provided under the agreement do not exceed the range identified in the FMV assessment.			Briefly describe the termination provisions.

III. How to Conduct a Compliance Review
Developing and Populating Databases

A database is used to organize the key terms of each contract. A separate worksheet is employed for each type of physician arrangement.

Sample Contract Review Database

Physician	Group Name	Term Beginning	Term Ending	Compensation	Unit of Time	Monthly Maximum	Notes	Payment 1
Smith, John, M.D.	Internists, Ltd.	2/2/07	5/1/08	$100	Hour	$5,000	$5,000 per month cap; at risk: $15,000 annually.	N/A
Malone, Molly, M.D.	Caring Cardiology	4/1/07	10/31/09	$9,250	Month	$9,250		$9,250
Cole, Tim, M.D.	APM Anesthesia	10/1/07	9/30/08	$1,200	24-Hour Shift		After fifth delivery, reduces to $220.	$24,000
Rao, Anila, M.D.	Valley CT Surgery	1/1/08	12/31/08	$8,000	Month	$8,000	$150 per month for adm. up to $3,000 per month.	N/A

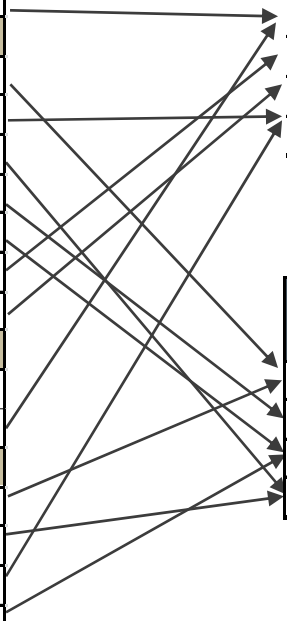
Fields within each database are expanded to include additional contract terms, such as service obligations, payment calculations, and repayment provisions. Elements of legal guidelines and requirements are also included in the databases and checklists as directed by legal counsel.

III. How to Conduct a Compliance Review
Matching Payments to Contracts

Every payment is matched to a contract and its required documentation. Payments without a corresponding contract or documentation are flagged for additional investigation.

General Ledger Accounts Payable and Check Registry Output

Payee	Payment	Date
Smith, John, M.D.	$10,500	1/15/07
Young, Chris, M.D.	$15,000	1/15/07
Borgorhoff, Emily, M.D	$2,000	1/15/07
Chang, Michelle, M.D.	$4,500	1/15/07
Chang, Michelle, M.D.	$9,000	1/15/07
Dalton, Matthew, M.D.	$15,000	1/15/07
Scheiber, Jill, M.D.	$13,000	1/25/07
Jones, Molly, M.D.	$14,000	1/25/07
Brown, Samantha, M.D.	$2,000	2/10/07
Wheeler, Sue, M.D.	$500	2/10/07
Knight, Raymond, M.D.	$5,000	2/15/07
Smith, John, M.D.	$9,000	2/15/07
Young, Chris, M.D.	$16,000	2/15/07
Borgorhoff, Emily, M.D	$2,200	2/15/07
Chang, Michelle, M.D.	$9,000	2/15/07
Chang, Michelle, M.D.	$3,800	2/15/07
Scheiber, Jill, M.D.	$13,000	2/25/07



Physician Recruitment Database

No.	Physician	Specialty	Recruitment Agreement
1	Smith, John, M.D.	Internal Medicine	Signed
2	Jones, Molly, M.D.	Maternal Fetal Medicine	Not Signed
3	Brown, Samantha, M.D.	Family Practice	Not Located
4	Chang, Michelle, M.D.	Neurology	Signed

Medical Director Database

No.	Physician	Specialty	Directorship Agreement
1	Borgorhoff, Emily, M.D.	Cardiology	Signed
2	Dalton, Matthew, M.D.	Orthopedics	Not Signed
3	Scheiber, Jill, M.D.	Psychiatry	Not Located
4	Chang, Michelle, M.D.	Neurology	Signed

Payments that do not cross-reference with contracts are researched manually.

III. How to Conduct a Compliance Review
Reporting Facts

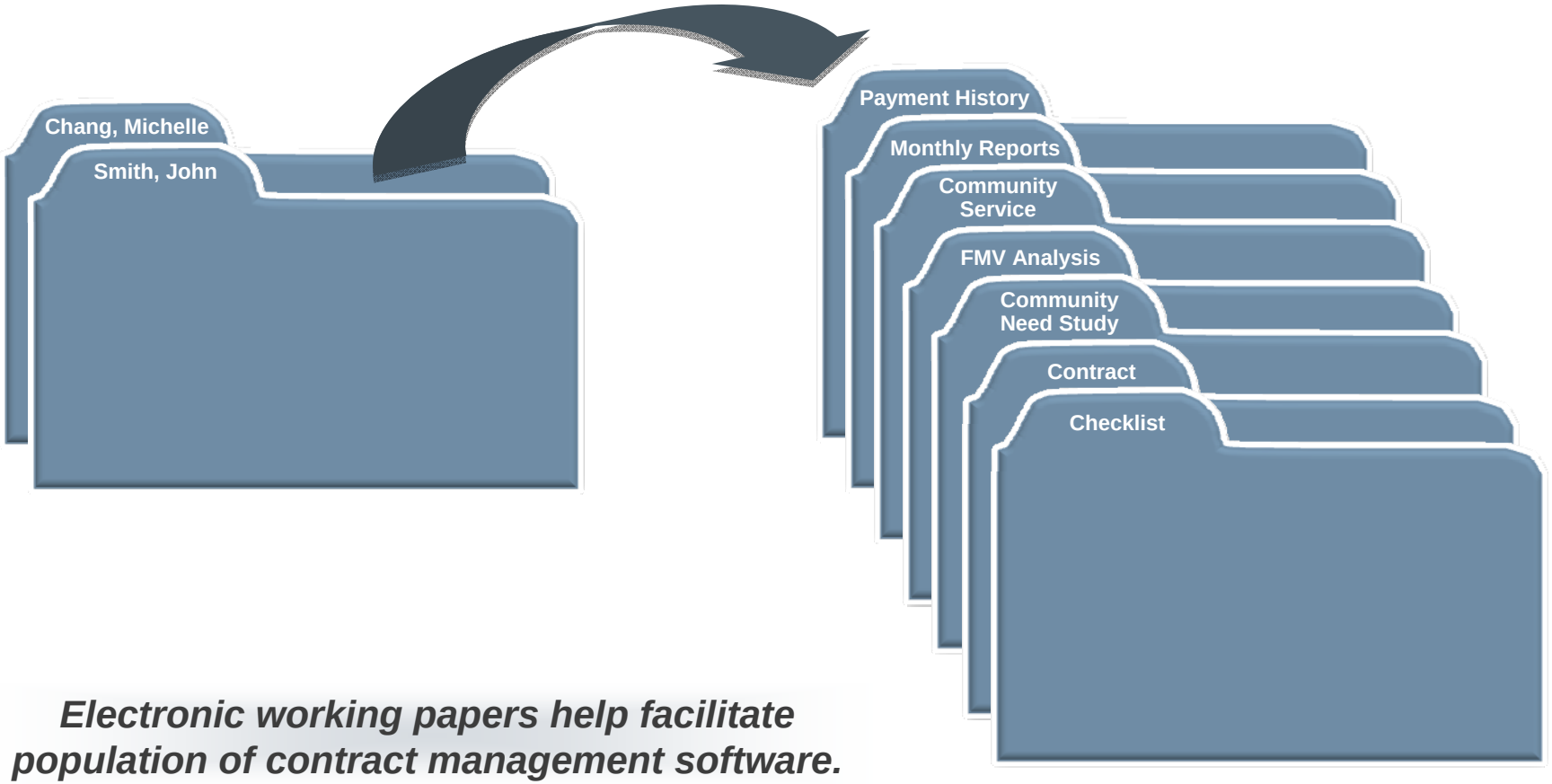
Facts about arrangements and payments should be complemented by relevant opinions reported separately.

Facts About Arrangements	Facts About Payments
• Contract is expired or not signed. • New agreement was entered into beyond the Stark 6-month holdover time period. • No evidence of legal counsel or board approval. • No community need assessment. • No FMV materials. • FMV materials are inappropriate for the contract. • Time sheet or invoicing documentation is missing.	• Payment made with no contract. • Payments do not match the contract terms. • Payment does not match time sheet or invoice. • Payment exceeds monthly maximum. • Compensation exceeds benchmark.

Opinions about arrangements should be reported separately.

III. How to Conduct a Compliance Review
Sharing Working Papers

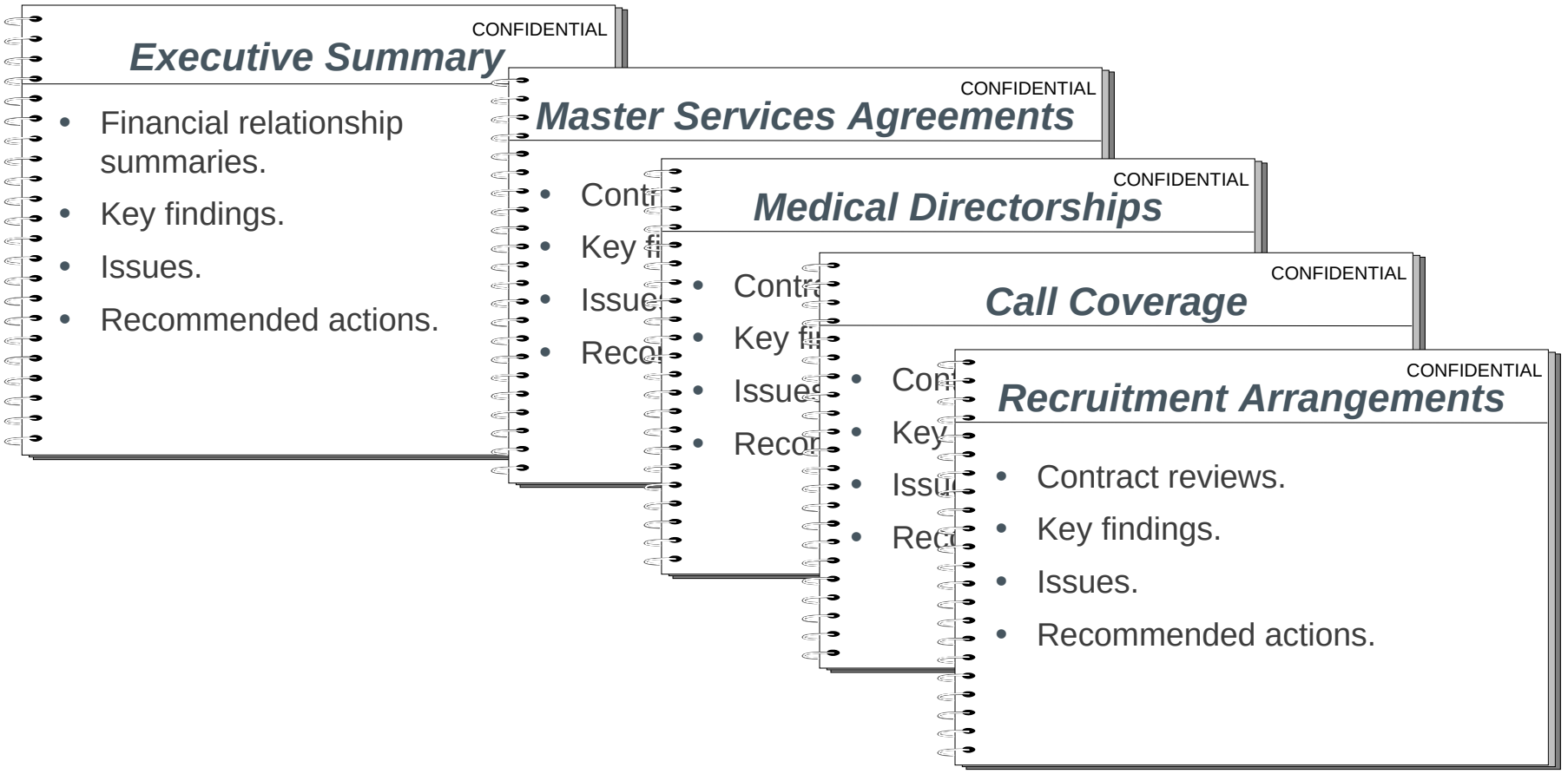
Documentation for each contract should be organized in a consistent manner, and missing documentation should be noted.



Electronic working papers help facilitate population of contract management software.

III. How to Conduct a Compliance Review
Compiling Reports

A report should be developed with an executive summary and sections for each type of financial relationship.



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IV. Corrective Action Plan Considerations
Period of Disallowance

Not only do arrangements found to be in violation of Stark need to be corrected, but Medicare may need to be paid back and penalties may be assessed.

- ***Stark Period of Disallowance*** – This is the period of time during which a physician cannot refer DHS to an entity and the entity cannot bill Medicare because a financial relationship between the referring physician and the entity failed to satisfy all of the requirements of a Stark exception.
- ***Potential Corrective Actions*** – These can include:
  - Correct costs or fees associated with deficiencies, such as overpaid fees, unpaid loans, or undercharged rent; prospective vs. retrospective application
  - Disclose the violation to CMS.
  - Pay CMS back for services billed while in violation.

IV. Corrective Action Plan Considerations
Potential Recommended Actions

The corrective action plan should fix existing problems and prevent future problems.

- Restructure or unwind financial arrangements.
- Revise compliance policies and procedures.
- Educate personnel on new compliance protocols.
- Distribute new compliance policies, procedures, and templates.
- Improve controls and accountability.
- Update and communicate document retention policies and procedures.

A single executive responsible for physician arrangements and centralized control is highly beneficial.

IV. Corrective Action Plan Considerations
Got Violation – What Now?!?

- No easy answers.
- Verify legal finding of violation; tread carefully regarding admission of violation.
- Capture attorney-client privilege – use of outside counsel.
- Inform appropriate hospital stakeholders (e.g., compliance department, management, and/or board).
- Limit participants to small, "need to know basis"; manage communications.
- Establish prospective compliance.

  Examples:
  - Execute written contract with physicians.
  - Sign unsigned agreements.
  - Obtain excess compensation from physicians.
  - Settle bona fide dispute with physicians.
  - Obtain FMV opinion.
- Does establishing prospective compliance "fix" compliance for prior time periods?

V. Disclosure to Government?
Factors to Consider

- Follow compliance plan.
- Strength/weakness of legal argument that no violation of Stark or AKS has occurred.
- Amount of monetary repayment.
- Likelihood government will discover violation.
- Possible negative publicity. Is violation high-profile?
- Sympathy/lack of sympathy anticipated from enforcement agency.
- How will physicians react? Is disclosure consistent with agreement with physicians?

V. Disclosure to Government?
Pros

- Cuts off whistleblower.
- Cuts off FCA liability.
- Limits/reduces fines and penalties (U.S. Sentencing Guideline, FCA, OIG).
- Avoids CIA or CCA.
- Heads off criminal indictment.
- Allows hospital to negotiate subpoenas.
- Allows hospital to “frame case” regarding law and publicity.
- Avoids broader investigation.

V. Disclosure to Government?
Cons

- Government will discover violation.
- Fine or penalty may be imposed – possibly worse than expected.
- Further investigation – possibly into areas not the subject of disclosed violation.
- Time and expense of cooperating with governmental investigation.
- Negative publicity – possible “headline” damage.
- May have to waive defenses/attorney-client privilege.
- Will physicians react negatively or will contract with physicians be breached?

V. Disclosure to Government?
Which Agency?

Disclosure to certain government agencies may resolve enforcement of some violations, but not others.

- ***FI*** – Routine billing errors but may not cut off whistleblower or FCA.
- ***CMS*** – Stark only; no criminal or FCA. Use Voluntary Self-Referral Disclosure Protocol where appropriate.
- ***OIG*** – Voluntary Disclosure Protocol – AKS, or Stark violations with colorable anti-kickback violation; no FCA. Sometimes used for conduct involving low grade intent, or for rogue employee. May not absolve from all claims, e.g., FCA, but VDP could be a "cover" to head off enforcement by other agencies.
- ***DOJ*** – Can resolve all claims but potentially will be a higher profile disclosure. Can be somewhat of a "crapshoot" depending on which DOJ attorney is involved, so preferable to have someone you know within DOJ that can act as an advocate. Will cut off whistleblowers and FCA.
- ***U.S. Attorney*** – Same as DOJ and hospital may be in a better position to identify local AUSA with prior relationship who will act as an advocate.

Questions & Answers

To submit a question for John or Dennis, type it into the Question and Answer pane at the right of your screen at any time.

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We hope you will join us for other upcoming programs in the ECG Trends Webinar Series. Visit *trends.ecgmc.com* for more details or to register for an upcoming session. Check back to the Web site regularly as new topics are posted.

Attachment A
FMV Compensation Considerations

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FMV Compensation Considerations
Overview

The analysis and the data sources utilized to calculate FMV compensation vary based on the circumstances of the specific arrangement.

- "Ultimately, fair market value is determined based on facts and circumstances. The appropriate method will depend on the nature of the transaction, its location, and other factors."[1]
- Factors influencing the appropriate approach to determining FMV include:
  - Services provided.
  - Physician specialty.
  - Availability of physicians.
  - Physician productivity.
  - Market and competitive factors.
- FMV is typically analyzed in two components:
  - Is the transaction commercially reasonable?
  - Is the remuneration exchanged FMV for the goods/services?

[1] *Federal Register*, Vol. 72, No. 171, CMS, 42 CFR Parts 411 and 424, September 5, 2007.

FMV Compensation Considerations
Options to Determine FMV

The appropriate methodology to use to calculate FMV compensation is affected by the business situation and financial arrangement.

Industry Percentile Rankings
FMV is estimated based on industry percentile rankings for compensation and productivity and assumes that physicians who produce at low levels relative to their specialty will also receive relatively low incomes and that high producers will earn high incomes.

Compensation per WRVU Productivity
A physician's compensation per WRVU is compared to market benchmarks to determine whether the physician's per unit compensation is comparable to that of his/her peers at similar productivity levels.

Earnings Potential
The amount of professional fee revenues that a similarly productive physician might expect to generate is estimated and the amount of overhead that one would expect from such a physician is deducted to arrive at an estimate of market-based compensation.

Comparable Payments
Especially useful for administrative services, this method applies the compensation that hospital's provide to other professionals for similar services.

FMV Compensation Considerations
Clinical Versus Administrative Compensation

A key distinguishing business characteristic of arrangements is whether they are for clinical or administrative services.

- CMS raised the question whether or not there should be a difference between administrative and clinical compensation in Phase III regulations but left the question unanswered.
  - Phase III: "…the fair market value of administrative services may differ from the fair market value of clinical services."
  - No guidance provided on how to determine FMV of administrative services.
- Valid options for compensation of administrative services include:
  - *Opportunity Cost* – What the physician could earn for the time spent completing the administrative duties.
  - *Typical Rate* – What the hospital typically pays to have the services conducted by other qualified professionals.

FMV Compensation Considerations
Types of Hospital/Physician Arrangements

Hospitals enter many different types of arrangements with physicians to address various strategic priorities.

Hospital/physician arrangements that require the determination of appropriate physician compensation include the following:

- Medical Directorships.
- Recruitment Arrangements.
- Call Coverage Arrangements.
- Professional Services Agreements.
- Equipment, Space, and Staffing Leases.
- Joint Ventures/Other Investment Vehicles.
- Management/Administrative Services Agreements.
- Information Technology Arrangements.

FMV Compensation Considerations
Standard FMV Assessments

Hospitals should consider an efficient and economical option that provides an FMV assessment that can be applied to many arrangements.

- A report providing an FMV range for approximately 100 specialties and subspecialties can be utilized for many arrangements.
- Annual compensation and hourly rates are calculated for each specialty based on national, regional, and state data from two surveys.
  - Medical Group Management Association (MGMA) Physician Compensation and Production Survey.
  - American Medical Group Association (AMGA) Medical Group Compensation & Financial Survey.
- Compensation is provided for the 25th, 50th, and 75th percentiles from the MGMA survey and for the 20th, 50th, and 80th percentiles from the AMGA survey.

FMV Compensation Considerations
Standard FMV Report Example

Many hospitals use the range of median values to estimate FMV for standard arrangements, with no further analysis required.

Internal Medicine

Annual Compensation

MGMA[1]	Providers	25th Percentile	Median	75th Percentile
National	4,822	$144,886	$177,059	$220,796
Western	1,614	156,833	184,832	217,859
California	817	175,467	201,434	231,250

AMGA[2]	Providers	20th Percentile	Median	80th Percentile
National	4,682	$155,728	$193,162	$237,634
Western	2,053	166,515	203,440	243,789

Fair Market Value Hourly Compensation

	Low		High
Median Compenation Range	$177,059	to	$203,440
Annual Clinical Hours Worked[3]	1,920	to	1,920
FMV Hourly Compensation	**$92.22**	**to**	**$105.96**

FMV Compensation Considerations
Medical Director Agreements

Results of the standard FMV assessment can be applied to many medical director agreements but others may call for a different approach.

- Medical directors tend to be leaders in their specialty and are therefore often more productive than the average physician.
- The most reliable way to determine a physician's true market value is often to understand the compensation that the physician could expect to earn elsewhere.
- Medical directors are typically paid an hourly rate.
- Bonus payments may be included for the achievement of certain targets but many hospitals prefer to use management service agreements to define quality and service targets.

FMV Compensation Considerations
Recruitment Arrangements

Recruitment arrangements typically include an income guarantee and reimbursement of business expenses.

- A range of compensation based on the median compensation provided in the MGMA and AMGA surveys is useful.
- Incremental and one-time costs are estimated to assess a reasonable monthly allowance for overhead costs for the recruited physician's practice.
  - Incremental costs typically encompass additional clinical and nonclinical office staff plus other operating expenses, including malpractice insurance.
  - One-time costs typically encompass relocation and start-up expenses.
  - Costs to start a new practice and to join an existing practice are estimated.

Many factors could cause the FMV compensation for a recruited physician to vary significantly from survey medians.

FMV Compensation Considerations
Call Coverage Arrangements

Stipends for call coverage duties have exploded as physicians increasingly utilize their market leverage to demand payment for the burden of call coverage.

- National benchmarks for call coverage stipends are in short supply and the complex nature of these arrangements, which can involve many different payment mechanisms, makes true apples-to-apples comparisons difficult.
- Outside assistance is often required to determine appropriate levels of call coverage payment.
  - Access to call coverage stipend databases.
  - Ability to quickly complete customized/localized surveys.
  - Expertise in helping hospitals to address call coverage issues.

FMV Compensation Considerations
Professional Service Agreements – Hospital Based

An FMV opinion for a professional service agreement often requires a thorough analysis of data from the hospital and the physicians.

Analysis varies by the specific situation but typical steps in an analysis of a professional service agreement for hospital-based physicians include:

- Identifying the number of clinical physician FTEs required to support the hospital given coverage and scheduling requirements.
- Documenting the historical compensation levels per physician FTE.
- Comparing physician compensation levels to appropriate regional and national benchmarks.
- Identifying potential issues, such as payor mix or utilization, that may influence compensation levels.
- Calculating an appropriate stipend level.
- Developing performance-based payment criteria.

FMV Compensation Considerations
Creative Solutions

Compensation arrangements often require creative solutions to achieve business objectives and provide a fair compensation package to the physician.

Situation	Resolution
Medical director who is licensed as a family practitioner is specially trained and conducts many procedures typically performed by a specialist.	Evaluate the mix of medical services the physician provides to the mix provided by other family practice physicians in his state from ECG proprietary surveys to determine whether family practice or specialty compensation is appropriate.
Hospital intends to pay physicians $150 per hour to assist with the design of its electronic medical record.	Convert the median annual compensation rate for all available specialties listed in the MGMA and AMGA reports into a range of hourly rates to confirm $150 is within the range.
Hospital intends to pay physicians $139 per hour for participation on committees that provide administrative services.	Apply the range of compensation that the hospital provides to non-physician professionals (i.e., business consultants and attorneys) to the compensation for physicians.
Hospital wishes to recruit a renowned clinician and researcher earning in excess of $1 million annually.	Identify a pool of academicians and clinical leaders with comparable income and determine whether the candidate is qualified to be considered for membership in this select group.

FMV Compensation Considerations
A Word About Benchmarks

Administrators need to be careful to utilize the best benchmarking information available when developing FMV financial arrangements.

- The number of surveys has grown in recent years; hospital executives need to be careful to apply the most relevant surveys possible.
- Commonly utilized national surveys include:
  - *Medical Group Management Association (MGMA)* – MGMA is generally viewed in the industry as the best national source of physician compensation, productivity, and expense data. Includes data from large and small (including many single specialty) practices.
  - *American Medical Group Association (AMGA)* – AMGA also produces a widely respected survey that encompasses data mostly from large group practices.
  - *Others* – There are many other surveys in the market, many of which are not conducted annually. Hospital administrators should be careful not to rely too heavily on ad hoc surveys that may not be available in future years; however, customized surveys may be necessary in some situations.
- When using surveys, regional data should be utilized to the extent possible. However, administrators should be wary of survey cohorts with a sample size of fewer than 50 physicians.
- When researching compensation for rare subspecialties such as pediatric neurosurgery, utilizing national data may be necessary due to small sample sizes.

FMV Compensation Considerations
When Do You Need a Third-Party Opinion?

Clearly, all hospital/financial relationships should be well documented in terms of FMV. However, not all relationships require a third-party opinion.

- All hospital contracts should be maintained in files that also provide FMV justification.
- However, FMV justification does not necessarily require outside assistance.
- Medical directorships and employed physician arrangements represent examples of when hospitals might not seek a third-party opinion, except under unique circumstances.

Developing an internal policy on when to seek FMV opinions will help hospitals decide when to most appropriately seek outside assistance.

FMV Compensation Consideration
Potential FMV Policy

Hospitals should consider developing policies regarding (1) the level of consistency required among their arrangements, and (2) when they will seek FMV opinions.

Type of Arrangement	Proposed Consistent Payment Methodology	Proposed Policy Regarding Third-Party Opinions
Medical Directorships	• Payment will be made using the average of the median of the most relevant market surveys. • "Relevant" is defined as using the regional benchmark with a sample size of 50 physicians or more.	Analysis can be completed internally to determine relevant market rates; however, a third-party opinion will be sought in the event that the compensation to be provided exceeds the 75th percentile.
Call Coverage	• Call coverage payment rates will be set based on principles developed by administrators and medical staff members. • Payment arrangements are reviewed annually.	The algorithm will be updated annually, and a third-party opinion of the key components of the plan will be required upon each update.
Hospital-Based Specialty	Stipends will be provided that enable physicians to earn between the median and the 75th percentile of their specialty.	• Groups desiring stipends will be required to submit their collections data (including those from private business ventures such as imaging centers) for the calculation of FMV. • All arrangements will receive a third-party opinion prior to the renegotiation of each contract renewal.
Physician Employment	Administrators will be required to adhere to a broad set of principles regarding compensation that require productivity-based compensation plans to be utilized (measured either in terms of work RVUs or professional collections).	Third-party opinions will be required on an annual basis for physicians who earn over the 90th percentile of the most relevant benchmark survey.