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Health Care Law Today Podcast

Episode 3: Let's Talk Compliance: Breaking Down
Fair Market Value and Commercial Reasonableness

Please note that the interview copy below is not verbatim. We do our best to provide you with a summary of what is covered during the show. Thank you for your consideration, and enjoy the show!

For this episode, Jana Kolarik, Foley Health Care Attorney, visits with Angie Caldwell, Principal at PYA, to discuss fair market value and commercial reasonableness and the impact that it has on physician compensation. The conversation dives into the practical considerations that affect the analysis of fair market value and commercial reasonableness under Federal Physician Self-referral law (also known as the "Stark Law") and the Federal Anti-kickback Statute.

Jana Kolarik

For today's podcast, we are going to talk about some practical considerations that affect compliance with the Stark Law, namely fair market value and commercial reasonableness—what it means and examples of how it can impact your organization. We are not going to address the background detail and hope that you call us if you need that. This is really intended to be a high level discussion of fair market value and commercial reasonableness. With me today is Angie Caldwell, a Principal at PYA. Angie, do you want to share a little bit about yourself and your background?

Angie Caldwell

Thank you Jana. I have been in healthcare for approximately 20 years. For the past 10 to 12 years, I have been focused primarily on physician compensation relative to fair market value and commercial reasonableness, specifically designing physician compensation plans as well as helping hospitals and health systems to look at various types of arrangements and to integrate physicians—whether through employment, medical directorships, or professional services agreements. I'm the managing principal of PYA's Tampa office.

Jana Kolarik

There's been a lot of movement with regard to the Stark Law and the interpretation of fair market value and commercial reasonableness. Can you tell us how things have changed over the last 10 years?

Angie Caldwell

The Stark Law is a little bit sticky as the environment continues to change, and as investigations and cases continue to move through the legal system, the focus on physician compensation continues to be heightened. With each new settlement, something new is learned about how the law may be interpreted, which involves then an increased pressure on compliance professionals and organizations that integrate and compensate physicians through various arrangements.

There is talk currently about Stark Law changes, potentially some reform on the horizon, but until that happens, this is the law that we have and what we are working with on a daily basis.

Jana Kolarik

Let's talk about some of the issues that you have faced, or been asked to address, with regard to new physician contracting, unknown productivity issues, or payer mix issues that have come into play. Can you talk a little bit about those issues and how that becomes complex?

Angie Caldwell

Absolutely. One of the things that PYA gets asked about regularly is how to handle advanced practice providers (APP) as it relates to physician compensation. Many physicians have the benefit of the assistance of an APP. To quickly level set, an APP can mean a nurse practitioner or, most likely, a physician assistant. With these new providers coming into practice, they can help the physician become much more productive. About 60-70% of all employed physician compensation models are based on productivity. As you are thinking about how the APP then impacts the physician's productivity, the question becomes, is the physician truly being compensated through that productivity-based model on only personally performed work RVUs (relative value unit)? How is the APP impacting physician compensation?

How to look at that [the impact of APPs on physician compensation] and how to analyze that, by way of example, include how the work RVUs are generated. Are the work RVUs based on split-shared or are they incident to services? Are they globally billed services? In all of those instances, special consideration needs to be made to ensure that the physician is only being credited for the productivity personally performed. Or, that there is a mechanism within the compensation structure to allow for that [tracking individual physician productivity]. And again, this is something new, and many folks are thinking about it.

Jana Kolarik

Give us an example of how this might come up when you're analyzing somebody's [a physician's] compensation. Are you seeing it with regard to incredibly high work RVUs? Are you seeing it with regard to compensation that's over the 90th percentile? Or is it a combination of both of those issues? What flags that issue for you, or is it really something that you're just analyzing for all physicians?

Angie Caldwell

It is most impactful when you have a highly productive physician. When those work RVUs start to creep up over and above the 75th percentile, and the provider has an APP, or more than one APP, to help them with his or her service, that's when we really begin to dig in. Not to say that it does not have an impact also for a median producer, but it becomes a concern from a compensation perspective when the provider is higher

producing, simply because then, the impact of that APP—whether through a globally billed service or a split-shared service—becomes more just in terms of volume. And to the extent then, that physician is being paid on every work RVU at 100%, it can become quite impactful.

It's very important [that] when analyzing physician compensation, when an APP is involved, to understand what the APP is doing and how the APP is supporting the physician, as well as get an understanding of the impact of that on the physician's productivity, especially when the physician is paid on a productivity basis.

Jana Kolarik

Is this something that you are addressing when you do compensation analyses for a physician? Is it something you look at initially to see whether the physician is using APPs, and then add that into your analysis of how that compensation, or the work RVUs of the APP, may be affecting the physician's compensation?

Angie Caldwell

Absolutely. So again, when that productivity level gets over and above that 75th percentile threshold and the physician is also using an APP, we began to analyze it more closely. It's an impact at the lower productivity levels, but more important at the higher productivity levels.

How we analyze that is to look at how the APP is being utilized and how the work RVUs are being generated. Whether through split-shared or being globally billed. Then look at the impact to the work RVUs from a compensation standpoint. We look at compensation as if the physician is getting paid 100% of the work RVU to ensure that it's fair market value, as well as applying a potential discount to the work RVU to make sure that the total stacked compensation is fair market value.

Jana Kolarik

Does that involve a deeper analysis of the work RVUs that are coming into play with that particular physician and who is the performing physician? Do you, for example, obtain billing reports that would give you that data?

Angie Caldwell

Absolutely. In an incident to setting, you can more easily see that if you're running your productivity reports on a rendered-by provider basis instead of a billing provider basis. Split-shared is a little bit harder to see because, most often, that occurs again in the inpatient setting where the APP will start the note or the encounter for the day in the medical records system, and the physician will take over when the physician signs off on that and does their part from a patient care perspective, they take over the encounter. Unless you can get and drill down into the notes for that particular split shared visit, it's very difficult to see.

The other part of this is a globally billed arrangement, a globally billed care set care where you have 30 to 60 days, or maybe even 90 days post-procedure where the patient is following up maybe in the physician office or otherwise. And the APP is taking care of that visit, but that visit was included in the global bill for that CPT code.

That is also very hard to see because the individual visits then within that global package, while they are noted in the medical record, the provider of record for billing purposes is the physician. To drill down and

really understand that information, you would need to get down into the notes within the EMR or perhaps do time studies. Interviews work well in order to be able to get an estimate of the level of that APP support.

Jana Kolarik

Give us an example of a problematic arrangement where you really had to dissect what was going on with a physician compensation. Was the physician above the 90th percentile; how many APPs were they using? Then how did you end up sorting it out to make sure that the physician was only being compensated fair market value and commercially reasonable because it needed to be for that physician's own service?

Angie Caldwell

A good example of this [scenario] is we recently looked at a gastroenterologist who was utilizing the services of an APP. The gastroenterologist was well over the 90th percentile from a productivity basis. Once we dug down into the detail of the work RVUs, and again, this physician was paid on a productivity basis, we were able to determine, by an accumulation of all of those means that I mentioned, whether it was notes in the medical records, interviews, time studies, etc., we were able to determine that the APP was assisting the physician about 15% [of the time]. Approximately 15% of the physician's work RVUs were in relation to services, or in collaboration with services with the APP, so the physician was credited for the entirety of that work RVU when in all actuality, the personally performed component of that work RVU was only about 85%. So in order to analyze that, we looked at it two different ways:

1. First, we looked at the total stacked compensation and then at the total accumulated non-discounted work RVUs, if you will, against that compensation. Then we looked at that compensation per work RVU and benchmarked that.
2. Then we also applied a discount to the work RVUs to say, “Okay, if we only looked at the personally performed portion of this, what would that look like?” The total staff compensation divided by the discounted work RVUs. What does that compensation per work RVU look like when compared to benchmark data?

Simply speaking, in the discounted analysis, if you have a provider that is benchmarking at greater than the 75th percentile compensation per work RVU, additional documentation and analysis would need to be done on that discounted basis to ensure that the compensation being paid is fair market value.

Jana Kolarik

That makes sense. What's interesting to me in figuring this out is that there is a component of physician's time and effort that is dedicated to supervising APPs. We've seen it in the past as a flat fee, and sometimes those have carried on, sometimes it is part of the work RVU that they're being credited in the way that we've discussed. How do you parse out that role of the physician in supervising the APP, which deserves compensation and the analysis that pulls out the work RVUs related to the work that that the APP has done?

Angie Caldwell

It gets tricky, doesn't it? Because there's absolutely a value there for the physician in supervising the APP. The APP is absolutely helping the physician to provide better care and as an extension of care of the physician, and to do so then, the APP has to be supervised. Different states have different rules for that supervision, so it's very important to understand the individual state rules as they relate to supervision. Some states require more than others, which may be an indication as to the value that may be applied then for that supervision.

In this case, one thing is to the extent, or if, the physician is also paid for a supervisory stipend in addition to 100% of the work RVUs generated by the physician through the billing scenario, there could be a cause for pause and further analysis because it could be questioned that the physician is being paid twice for the same supervisory service—once through the crediting of productivity through the work RVU, and then second through the supervisory stipend itself.

You have to be very careful in that situation when you are paying on a productivity basis, to also consider the need for and amount of any additional supervisory stipend. Supervisory stipends, again, there are certain circumstances where they are absolutely reasonable, especially where there are requirements for the physician to review a certain number of charts, for example, in addition to the day-to-day supervision. If there's an additional review of charts, evaluations, etc. that have to be performed, potentially additional supervisory compensation may be warranted.

Jana Kolarik

The model has switched from monthly compensation to the work RVU model - that's happened over the last several years. Are you finding that from that change from being monthly flat amount that physicians have been paid with that addition of that supervisory $5,000 or $10,000, that you're finding that [the supervisory stipend] is a vestige that just needs to be eliminated as you switch to the work RVU model more frequently than not?

Angie Caldwell

Yes, I do agree that because it becomes so tricky with the productivity model as to how much of that should be considered personally performed, and therefore credited to the physician, most often what we are seeing is that the supervisory stipend is going away.

Jana Kolarik

That makes sense to me as well. That's something just to note for our provider friends out there that it's something to look at in their compensation models that are work RVU-based. One of the other things that has come up, and has been a concern at least from a case law perspective—it's one of the things the government valuation consultant has brought up frequently—is physician practice losses. I wanted to touch base on that for our provider friends, because I think it's concerning from a hospital-based practice perspective because there are those practices that are not making money. When you're brought in, and in those particular circumstances, can you talk a little bit about the things that you look at related to those practices, and determining whether, in that case, the compensation to the physician is commercially reasonable?

Angie Caldwell

Yes, absolutely. It is something that is on their minds a lot as they're looking out across their employed, their owned physician practices, they're looking at that as an entire portfolio and considering the losses on those. What makes it difficult in a hospital-based, [hospital] practice-owned setting, is that the losses are inclusive of administrative overhead allocations pushed down to the individual physician practices. Sometimes that administrative overhead allocation that's pushed down is a larger amount than would be accumulated or put on the financial statement, or income statement, of a privately held practice.

That accumulates and adds to the loss that is shown for that physician practice. When analyzing those physician practice losses, it's very important to understand the administrative burden and the administrative

load that's being pushed down to those individual physician practices and then compare that to what may be an administrative load in the private practice world, because the two are very different.

Also, what's different in a hospital-based physician practice setting is that many times practices are established to benefit the community in a way that maybe a private practice physician wouldn't consider. For example, a pediatric clinic that is set up in a low income area, maybe a rural area, where 75-80% or more of that physician practice revenue is Medicaid driven. In that case, you're looking, while the practice, because the fair market value compensation for the physicians in that case may be not in excess of collections, but then once the hospital overhead is added on and the other administrative items added on, it would be nearly impossible to be at a net income for that practice. So then the need of that [detailed analysis] comes into play when considering the commercial reasonableness and analyzing that practice loss.

Jana Kolarik

That makes sense. It's that community need issue that a lot of hospitals focus on when they're recruiting physicians. What about—and it sounds like this is part of what you mentioned just now—the payor mix? So as you said, if you have a high Medicaid population, or if you have a high non-pay population, all those things can affect that as well?

Angie Caldwell

Absolutely.

Jana Kolarik

Angie, let's give an example, a case study or a scenario that can pull into the analysis some of the things that we've talked about at a higher level. A good example that you and I have talked about in the past is a physician practice being acquired by a hospital, where these compensation issues come up over multiple physicians. The hospital wants to pay those physicians higher than what they're currently being paid. Let's consider the physician compensation as lower than their production, and what market looks like. Also, as a third factor that would affect the analysis, the managed care contracts really haven't been negotiated in a while, and they're being compensated under those contracts at Medicare levels. Let's talk about the factors that you would look at? Tell me how you would look at compensating those physicians possibly at a higher level than what they make right now.

Angie Caldwell

Sure. There's a lot going on here [in this scenario]. Paying a physician more to be employed by a hospital coming from a private practice situation is not in and of itself problematic. But, you do have to weigh all of these things, and the facts that you've put out, Jana, are very important to consider because you are looking at what the physician in private practice was able to generate as compensation. [Compensation] which in and of itself was for that practice with that specific set of facts and circumstances was fair market value. So then the question becomes, as that physician moves from private practice to employed, why isn't that lower compensation for the same services in the same market still fair market value?

A couple of the other things that you said become very important because what has happened in the private practice, those scenarios, for example, the collections related to the managed care contracts. That's a fact that when that physician or that group of physicians moves over to the hospital employed setting that fact is going to change. Or you would hope that that fact will change, which then creates a new scenario, a new fact pattern to be analyzed for that physician compensation arrangement.

You really have to look at what were the drivers of why the physician wasn't able to generate fair market value compensation on their own in private practice, versus what will be the fair market value compensation as an employee or as an employed practice/provider of the hospital. You look at the expense structure differences, you look at the productivity and what productivity that physician is able to generate in connection with the, hopefully, newly improved collections on the hospital side. And consider that.

You do have to be careful. I opened these comments by saying giving a raise in and of itself is not problematic. To the extent that the raise is not reasonable and is not aligned with all of the other facts that are coming into your new fact pattern from the old fact pattern. If the raise then becomes unreasonable, and if then the raise that the physician is getting is then throwing off a practice loss under the hospital umbrella that is unreasonable, then you would want to lower the compensation for the physician. So all of those things have to be weighed and measured appropriately.

Jana Kolarik

That makes a lot of sense. Let's talk about one more scenario that I think could be helpful and something that provider clients call about as well. And that would be a new physician that's being recruited from outside of the community and being brought in, and offered market compensation, but there's no history there, so you don't know productivity levels. You really don't know much about what [productivity] that physician is going to turn out. Talk to us about things that you've done in establishing fair market value and commercial reasonableness with regard to new physicians.

Angie Caldwell

Sure. We get asked this question all the time. First and foremost, you have to document and demonstrate the need for the provider type. Is that documented in a physician needs assessment? Is there another needs analysis that has been done for the physician? First and foremost, very important.

One of the second things to look at is what other providers of that type are being compensated in that system. So to the extent you have other [physicians in] whatever specialty that you're bringing in, what are their compensation structures? Should they be similar? Should you start this position at a relatively similar base and with all of the same compensation components?

You do need to consider again, we've talked a lot about roles, responsibilities, duties, and productivity today. As part of that needs analysis, the organization needs to understand what do they anticipate the professional clinical duties of that physician to be? How long is the ramp up period? Guaranteeing compensation in a market for a one to two year period is not uncommon. So while the compensation would be at a higher level, then potentially that ramp up productivity may suggest that in and of itself does not make the compensation problematic, as long as the need and the ramp up period, and all of those other factors, have been addressed, considered, and documented.

One thing to consider, and we see a lot of this, is that when that ramp up period is over, and you've established what the market compensation is, whether through your own market and own experience with providers, or through benchmark survey data. When that ramp up period is over, should the organization consider putting in when as the contract flips then, maybe from that guaranteed base period, to a productivity model? Should there be a productivity floor that is established to support the base?

In other words, the ramp up period was two years; the base was set on an implied or an anticipated productivity level. So what if the ramp up period is longer than anticipated, and you get out into year three and the physician still isn't producing what was anticipated in that initial needs analysis, or initial needs

assessment? A work RVU floor is a very good tool to use to protect the organization then from potentially compensating the physician in excess of fair market value.

Jana Kolarik

One of the things that you and I have talked about as well that I think is part of some of what you analyze is physician engagement. Coming in new to a practice and setting the compensation for a brand new physician in a particular area versus physician burnout and being concerned about those issues. Can we touch on those issues a little bit?

Angie Caldwell

Absolutely. Hot topic in the industry right now Jana, [and] like you said, you and I have had some hallway conversations on this topic. There are several ways to combat burnout and engagement through a physician agreement. We are seeing a lot of providers move to sign-on bonus and retention bonus structures for physician compensations. Generally speaking, from a compliance perspective or fair market value perspective, there is no problem in adding in a bonus. Where you have to be concerned is when those values start to become large, where there is no clawback period, there's no repayment provision for those retention or sign-on bonuses, or in the case where you're just totally out of the market from that perspective.

Also, from a retention bonus perspective, you want to be sure that you have a policy in place for a retention bonus. In other words, a retention bonus just can't be made to a physician to make them whole because there's been another change in the compensation structure or a decrease in productivity. With retention bonuses, there needs to be a plan. There needs to be a policy, and physicians should be treated the same in accordance with that policy. Retentions and sign-ons just can't be stop gap measures, if you will.

Jana Kolarik

That's a legal issue from a Stark Law perspective because you can't come up with a retention bonus at the end to make somebody whole if it isn't baked into the agreement from the beginning.

Angie Caldwell

Exactly.

Jana Kolarik

And the clawback provision, we've seen a lot of that in physician compensation arrangements, and one of the things that I always push on with the provider clients is, can you get it back? Nobody wants to pay back money that they believe that they've earned. How, from a structuring perspective and from your perspective, how have you seen that play out, or have you seen that play out?

Angie Caldwell

So far so good.

Jana Kolarik

That's great.

Angie Caldwell

The larger the sign on bonus, I feel, the bigger concern that's going to be. If you have a sign on or retention bonus that's $100,000, and the clawback period is three years, then that's going to be a big check that somebody is going to have to cut if the agreement would come to an end. I think there's some reasonableness that needs to come into play when you're thinking about the amount of those as well as the term of the clawback. Clearly a longer clawback period calls for smaller paybacks if the agreement would terminate.

I think as long as the agreement is properly structured and it's thoroughly communicated within that documentation what happens over that clawback period, I do think that helps.

Jana Kolarik

That's great. And that's good to hear, from my perspective, because we do worry about it.

Burnout. How are you involved in burnout situations? I know we had mentioned that as one of the topics or hot topics, but how does that come into play? Is that through the same bonus situation? I'm trying to imagine how that comes up.

Angie Caldwell

It comes out mostly when we're analyzing the physician compensation related to the duties performed and the hours worked because physicians want to take their time off. And sometimes coming into an arrangement, they want to be able to negotiate to take more time off than maybe is normal or standard for the organization. There's nothing wrong with that; it is a consideration that needs to be made from the hospital perspective. Are you getting one provider, or are you getting one half of a provider, or are you getting 0.75 of a provider? And what do you need? Because if you are bringing in a provider that is needing or requiring more time off than is standard, then that FTE status should be taken into account, when analyzing the physician compensation.

We're seeing it on the back end too interestingly, as it relates to retirement. As physicians are nearing retirement, they still want to work. They still want to keep up their skills. But yet, what are the provisions to limit the call coverage taken? For example, is there an age out clause? Is there a provision in the agreement when you near retirement to work less hours, or to provide fewer administrative duties?

Jana Kolarik

That makes a lot of sense. It has to do with being more flexible in your approach and not quite so cookie cutter as people tend to like to do, because of the ease of it. Is there anything else that you can think of that we haven't covered today that are really hot topics in this fair market value and commercial reasonableness area?

Angie Caldwell

We hit on things that we are seeing a lot of in the industry right now. One other thing relates to physician executives and medical directorships. As we were talking about a moment ago with retention bonuses and sign on bonuses, medical directorships are also notoriously known for being a stop gap to make up for compensation potentially lost in another area within an a physician arrangement. So clearly, you have to have a need for that medical director. The duties have to be very well defined, and it shouldn't be used as a stop gap or a make-whole arrangement.

But with respect to physician executives—and I'm using a physician executive, and I'm terming that a little bit different than a medical director, a medical director is normally needed in the clinical course of the hospital—might be needed for a center of excellence or a specific service line or related to other accreditations or needs.

Whereas a physician executive is in addition to a chief medical officer, because of the industry and the move towards value-based compensation, many physicians are finding themselves in executive roles other than just the chief medical officer. And that creates a whole new area of analyzing for physician compensation, because then you have to delicately measure what the physician is doing. What are the duties, what are the roles this physician is playing? What type of physician should be filling this role? And to the extent that there's any clinical component of the role still remaining, how do you balance the administrative and the clinical, and ensure that it's still fair market value and commercially reasonable, and makes sense? Because a lot of the survey data that's out there, while great and wonderful directionally and a great starting point, might not address the new roles that we're seeing in physician leadership.

Jana Kolarik

We have seen that. And one of the complexities is obviously as you mentioned, making sure holistically from a provider standpoint that you don't have, for example, overlapping medical directorships, and that truly the services are needed.

One of the other things I'm curious about, because it comes up quite a bit still, is the difference between compensation for a clinical service (so the work RVU model), and what compensation looks like from an administrative services perspective, and how those can differ. Because what we see obviously, and what we get pushed on, is that those should look somewhat the same. And as you and I have discussed frequently, those two don't look the same. Can you talk a little bit about that?

Angie Caldwell

You hit the nail on the head. Sometimes, the clinical compensation tracks very closely to the administrative compensation, and sometimes it does not. It's really important in that situation to understand the role that the physician administrator is playing.

For example, if it's an administrative role where any type of physician could provide it, a primary care physician could serve in the role just as well as perhaps a neurosurgeon or an orthopedic surgeon. Then in that case, you are looking at a general medical directorship rate, which is then a combination of all of the administrative hourly rates.

In that case, the neurosurgeon or the orthopedic surgeon would not be paid at their specialty-specific hourly rates. It's only when that administrative role absolutely requires the expertise of that specialty-specific physician, then do you rely more heavily on that specialty-specific administrative data.

Jana Kolarik

That makes sense and I think will be very helpful for our provider clients to hear. The other piece of it from our perspective is also documentation of services being provided. Have you been in situations where you've come back to analyze, and had situations where documentation may not have been as fulsome as it needed to be? I know from our perspective, we see it unfortunately, and it can result in some self-disclosure situations. But from your perspective, how important is it as you're going in to understand the services to be rendered, and make sure, to the extent those roles have existed in the past, to see that documentation?

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Angie Caldwell

I think the documentation is very important. It's very important from a compliance perspective to know that in that hour, what was happening from an agreement perspective. What is the compensation being paid for? And if that's not documented in some form or fashion, then the assumption might be one that you don't want. So it is best to make sure that the documentation is available to support the duties performed by the physician in that administrative role. And those need to be clearly outlined in the contractual agreement. In other words, paying an hour of a medical directorship for reading the newspaper probably isn't what the arrangement bargained for, and probably shouldn't be paying for that. It's important to monitor those time sheets as well. It would be very easy for a physician in a normal course of a week or a month to say, "These are the standard things that I always do. And in any week, I always perform four hours, and I perform these four hours. So why not just copy my time sheet and change the date?" And that becomes a very curious, and it becomes just a little bit unnerving then problematic from a compliance perspective.

Jana Kolarik

Those times sheets are pesky. I agree with you. And there is often complaints about them. But absolutely. If you're being paid for admin services, if you're being paid for medical director services, document, document, document.

Angie Caldwell

Absolutely.

Jana Kolarik

Well this has been fantastic, Angie. I mean spending time with you and drilling down a little bit into these issues that are so impactful from a Stark Law perspective, but also from an anti-kickback perspective, these issues come up as well. This has been really helpful. Thank you so much for your time.

Angie Caldwell

Thank you for having me today.

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Foley would like to thank Angie Caldwell for her time on our show.

For more information about fair market value and commercial reasonableness, please contact [Jana Kolarik](#) at jkolarik@foley.com.