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Health Care Law Today Podcast

Episode 17: Let's Talk Compliance (Again!) – An Update on Fair Market Value & Commercial Reasonableness

In this episode, Foley Partner Jana Kolarik and PYA, P.C. Principal Angie Caldwell come together again to discuss recent updates on fair market value and commercial reasonableness since COVID-19, and the impact that it has on physician compensation. You can find their first episode together by clicking here.

Jana Kolarik is a partner and health care lawyer with Foley & Lardner LLP. Her practice focuses on health law issues, including health regulatory due diligence; requirements and risks related to acquisitions and sales of for-profit and not-for-profit health care entities; fraud and abuse issues such as anti-kickback and self-referral law compliance; enrollment, coverage and payment issues and licensure issues. Jana has worked with the spectrum of health care entities from academic medical centers (AMCs) to device and pharmaceutical manufacturers.

Angie Caldwell advises physician practices and healthcare systems in the areas of fair market value compensation; commercial reasonableness; physician compensation design, development, and strategy; physician/hospital economic alignment models; and value-based compensation. Additionally, she assists physician practices with strategic, financial, and operational issues.

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!

Jana Kolarik

This is Jana Kolarik. I'm a partner in Foley's Jacksonville, Florida, and Washington D.C. offices. I am a health care compliance and regulatory attorney and have been for over 20 years. Relevant to today's podcast, I address federal Physician Self-Referral, or Stark Law, as well as federal Anti-Kickback Statute issues for a range of providers, suppliers, manufacturers, and distributors. Angie, can you give us a little bit of your background?

Angie Caldwell

Absolutely. I am the Managing Principal of PYA's Tampa office. I spend probably 95% of my time in physician compensation valuation, physician-hospital integration, and related matters.

Jana Kolarik

Wonderful. So today's podcast, just so the audience knows, is really a follow-up to the 2019 podcast that Angie and I did, also for Let's Talk Compliance. And that one was really a nice primer, and I recommend folks go back and look at the transcript, which is online or listen to the podcast itself. It gives about 45 minutes of good background to these fair market value and commercial reasonableness discussions that we're going to sort of tee off of today. Let's dive in, Angie. So excited to be doing this with you again. Yay!

Angie Caldwell

Yay! Me, too.

Jana Kolarik

For today's subject matter, frankly relevant to the audience, this is a fair market value and commercial reasonableness discussion. We're now in 2021. Our prior discussion was in 2019. Want to talk a little bit about how the changes to the Stark Law and to the Anti-Kickback Statute regulations may have affected some of the things that you're dealing with in your valuation world?

Angie Caldwell

Absolutely. The new Stark and Anti-Kickback regulations were highly anticipated. I mean, we were so ready for those regulations and really hoped that they would bring about a significant change in the way that valuation was approached from a compensation perspective. We didn't really get that with the changes to the regulations. We got a lot of cleanup…at least from my perspective, we got a lot of cleanup. The definitions were tweaked—all of the cleanup is very important, don't get me wrong, but at the end of the day, from a valuation perspective, perhaps a few things were tweaked—but big sweeping changes really didn't come about in the new regulations, except perhaps related to the value-based exceptions.

Jana Kolarik

Right.

Angie Caldwell

That was probably the biggest change**,** but overall, there was a lot of cleanup. The definitions got changed, and from a valuation perspective, we're looking at those

definitions and updating our reports. But again, that's not a big change. One of the things that tweaked our approach a little bit and perhaps our service offering a little bit was related to the big two concepts, and that prior regulation of [fair market value] FMV and [commercial reasonableness] CR is now the big three concepts of FMV, CR, and volume or value.

Jana Kolarik

Because they split it up.

Angie Caldwell

Exactly, exactly. So now, from a valuation perspective, most of the time we're asked to provide an opinion on fair market value—some of the time we're asked to provide an assessment of commercial reasonableness—but now, we could also be asked to provide an assessment or an opinion related to volume or value. So that was broken out. CMS was helpful with that because they developed a two-part test so that folks could take a look at it and determine if their compensation methodology was, or was not in, compliance. I'm sure there are some gray areas out there where some folks would like to have an outside third party take a look at it with them. So that was a little bit of a change. Then what I alluded to probably the biggest change that came out of these regulations was the value-based exception change.

Jana Kolarik

So are you seeing a lot of activity with a lot of questions? Or a lot more questions than you had seen in the past related to value-based arrangements?

Angie Caldwell

Not yet. We have not seen a windfall of entities trying to use this particular exception. I don't know if entities have been distracted just from the ongoing pandemic, the virus—they've got other things on their minds. It could be that they are absorbing it. I think that it will be an exception that is going to start getting some traction, especially perhaps with certain specialties, like radiation oncology. With the new radiation oncology model implementation starting in January 2022, that might expedite some value-based exceptions activity in this last half of 2021. We have not seen extensive use or analysis surrounding that exception yet. How about you?

Jana Kolarik

Well, no, not a lot. I mean, there's been discussion. I do wonder a little bit if some of those discussions are happening more behind the scenes and more with payers, frankly, to try to set out certain arrangements or start the ball rolling because frequently those discussions can take months if not years to really come to fruition. So that may be where we're seeing it. We've seen more discussion, and I think more thoughtful discussion around some of the value-based aspects of comp just generally. So I think

there's been more thoughtfulness provided related to not just traditional [work relative value units] wRVU or hourly comp, but rather some of those panel formation issues and some of those quality issues than frankly I've seen in the past. How about you?

Angie Caldwell

I would totally agree, and if nothing else, even if the value-based exception is not utilized, the regulation does a good job describing value-based incentives and metrics and measures. That framework is important and could be foundational for an organization because, as I'm sure you experienced as well, a few years ago, when the industry started talking about value-based incentives and value-based metrics, organizations ran to put those in their agreements just as quickly as they could because they wanted to show that they're paying attention to the industry, paying attention to what's going on around you, and really getting your physicians accustomed to being at risk for such things, such as quality metrics.

So organizations rushed to put that in, and at times, maybe ahead of what their data systems could measure and support. If nothing else, the regulation provides a nice framework for people to take a look at as far as improvement year over year. The regulation talks about how there should be a change, there should be opportunity for modification, improvement, et cetera, and I think that's very important too. Good change out of the regulation.

Jana Kolarik

One of the things you and I have been talking about quite a bit lately is the impact of the 2021 Medicare Physician Fee Schedule on compensation. So let's talk a little bit about what you've seen related to maybe employed physician modeling, as well as PSA's, or independent contractor physician modeling, related to that.

Angie Caldwell

You bet. So if 2020 wasn't difficult enough with the pandemic, with the shutdowns, with the new Stark regs and Anti-Kickback regulations and guidance, we also had a significant change in the 2021 Medicare Physician Fee Schedule. I'm sure all of our listeners are groaning and shaking their heads at this. In a nutshell for those that might not be familiar, what happened was in the course of that update, certain work RVUs, especially for E&M services, (evaluation and management services) were significantly increased. As the fee schedule is budget neutral, there was an offsetting conversion factor payment decrease to make it budget-neutral for Medicare.

So this, of course, creates havoc on an employed physician who is compensated on a work RVU model or a professional services agreement that uses work RVUs for its payment structure. If you think about that and all that goes into that work RVU substantially increasing, and the contractual conversion factor within the physician's

agreements, staying contractual, staying the same, but reimbursement changing only for Medicare. Because, again, this is a Medicare change. Only to the extent that your other payer agreements are tied to Medicare would those (reimbursements) change. They are paying along as they always have. So, the increase in collections due to the increase in work RVUs for the specialist with increased work RVUs is not enough to offset the potential impact to the physician's compensation.

So without some kind of mitigation on part of the employer, through the contract, it could create some significant compensation increases for the impacted specialties, as well as increased physician practice losses for those specialties.

Jana Kolarik

So let's talk about who this has impacted specifically. Who benefited from the changes in the modeling? And when I say benefited, who had an increase in the wRVUs that they're recognizing as of 2021?

Angie Caldwell

Mostly your primary care type physicians. So family medicine, internal medicine, endocrinology, rheumatology, all big winners in this change from CMS. I don't like to call anybody a loser, but if you had to have a column of winners and losers on the other side of the deck, on the other side of the equation, the losers were the proceduralists. So the folks that do not do as many E&M codes that are mostly proceduralists, those were the folks that took a hit, and again, all of this within CMS's world has to be budget-neutral. So if you add to one place, you have to take away from another.

Jana Kolarik

Right. And so, when you and I have spoken about this in the past, a lot of compensation models for physicians are based on wRVUs. I mean, it's not uncommon in industry for that to be standard. So because of these changes and because of what the increase in wRVUs, especially for those family medicine-type specialties. What are you seeing your clients having to do? Are they having to freeze the conversion factor? Are they having to switch models? How are folks reacting to this change?

Angie Caldwell

Predominantly what we have seen out there is that folks have frozen their work RVU calculation to the 2020 schedule. They have deferred implementing 2021, which is a great idea because it allows the organization time to assess the impact and prepare contractually for changes that may have to occur going forward into 2022 and beyond. Others are assessing the impact, and to the extent that it is affordable for them, then they are assessing it more purely from a fair market value and commercial reasonableness perspective. They are taking a look at it and saying, "Okay, what does this mean? Is it still FMV and CR?" To that extent they may have to make changes to

the individual physician contract. They are either lowering the conversion factor in the contract or lowering the threshold work RVUs before an incentive is earned. But again, as you know, Jana, that's a contract change. That's not just a, "Oh, hey, by the way, we're going to do this."

Jana Kolarik

And it makes sense. I mean, and I've seen folks changing their comp plans. I think it was some of these entities had the same compensation plan for years. And so this is an opportunity for them to revisit it, to get buy-in from the physicians to really explain and be transparent with the process, which, in my mind, is the best way to go. What have you seen from a reaction perspective, because obviously, with some larger systems or just even hospitals, this can be incredibly impactful from a contracting perspective? And the family practice physicians that you talked about are incredibly important to the system. So have they been dealing with comp plans? Have they been coming to you just to try to figure out lay of the land and then addressing the contractual issues themselves? I find you effective in helping, or being another voice to lend to the expertise in this area, to get the transparent message across as to why things are changing. So what have you seen?

Angie Caldwell

From an operations perspective, from a physician practice operations perspective, we have seen impacts because of this change for one physician upwards of $80,000. Then based upon other analyses and case studies that we've done, on average, in this category of physicians, your primary care type specialties on average, could have approximately a $20,000 increase to physician compensation. If you take $20,000 over a multitude of physicians, a number of employed physicians, this is incredibly impactful for a physician practice, which may already be at a net loss position. So it isn't just from a practice perspective. It's a compensation issue, balancing the compensation to the physician and paying the physician fairly and within fair market value, but it's also a commercial reasonableness issue, right? Because then all of a sudden—whereas the new Stark regs actually talked about this a little bit—while you can be commercially reasonable and be in a loss position, at some point, it isn't just, "How big of a loss can you take for long-term viability of the hospital, for the health system, for the practice? How much of a loss can you handle?" The regs helped us by clarifying that you can have a loss with an arrangement and still be commercially reasonable. You still have to assess the amount of the loss. At some point, it will become not commercially reasonable. But back to your original question, which was, “What are organizations doing related to their compensation plans?”

They're really looking at this and saying, "Okay, work RVUs, they've changed every year. This wasn't a new thing that CMS did in 2021 with the Medicare physician fee schedule." It's just that it was a significant impact and change. Looking out into 2022 with the new proposed Medicare Physician Fee Schedule that just came out, it's going

to happen again. So folks are starting to look at the work RVU maybe with not as much love as they have in the past. The work RVU was easy. It was standard. They could explain it. They could track it. There's decent benchmark data out there related to it from a compensation perspective. All of a sudden, folks aren't as in love with the work RVU, perhaps as they once were. Organizations are starting to take a look at their compensation plans and their methodologies and thinking, "Do all of our physicians, or do these certain specialties or groups of physicians, do they still really need to be on a work RVU model? Or is there another model that would perhaps be better for them going forward?"

Jana Kolarik

Yeah. Interesting. Tell me a little bit about how differing that impact and sort of sticking with the 2020 RVUs potentially could cause issues for folks later sort of “kicking the can,” especially with what you mentioned about the 2022 changes that are coming down the pike.

Angie Caldwell

So we're in August and looking out then into 2022. Again, think about what communication was made to your physicians about the timing related to the deferral. Was the communication just one year, or was it indefinitely? Because at some point, a decision is going to have to be made. If 2022 sticks to the same proposal as they have it now, then you're going to really be two years away from the measurement that you're using. In 2022, you're going to be looking back to the 2020 fee schedule for your wRVU measurements. At some point, just philosophically, the organization will need to think about how far they want to get away from that measurement, because those measurements and the changes that CMS made were not made in a vacuum. There were reasons behind why those work RVU values were increased. CMS recognized that the services provided by these primary care are taking longer, and they require more effort than what they had previously estimated. So at what point, how far out does the organization want to get away from the most current and contemporary measurement? That's the question. We have some benchmark data concerns, right? And you know how I love to talk about benchmark data, too.

Jana Kolarik

I know you do! Tell me how it's been affected, Angie.

Angie Caldwell

So think about everything that has happened in our industry. The surveys that come out in 2020 are reporting on 2019 data. Your 2020 surveys, reporting on 2019 data, do not have the impacts of the pandemic in it. The surveys coming out in 2021 will have the impact of the pandemic in 2020 in that data. So that data is going to be a little bit “mushy” (as a technical term), because of the pandemic. So then, 2021 data, which will come out in 2022, you're going to have the mushiness from the Medicare Physician Fee

Schedule impact. So then the question becomes, when is the next time that the benchmark survey data won't have this mushiness in it?

The 2019 data, reported in 2020, might be the last time for a while that we don't have that noise in the data, especially if the 2022 Medicare Physician Fee Schedule proposal does what it says it's going to do it. We could be out some time. So it's just another indication in the regs and the commentary. I read the Stark and Anti-Kickback commentary. CMS talked about benchmark data and how fair market value wasn't a percentile. So, in further support of that, as the survey data gets mushy, we're just really going to have to pay attention to how much mushiness is in that survey data as we're taking a look at it for fair market value.

Jana Kolarik

Well, and I think that's a good point, Angie. I mean, because a lot of people...for some of these decisions, it's nice to have you there counseling folks. But for some of these general decisions - or these sort of things that in the past have been decisions that were made very quickly by looking at some of the survey data and usually, hopefully, multiple surveys, not just one - how are folks going to be dealing with that? Because they may get their MGMA data, or they may get their—I'm not going to name other ones, but—several different sources of survey data. Will there be guidance within the data that they receive that lets them know how they need to be interpreting it? Is that something that folks should be talking to you about with regard to, "Should I take 2019 data and then look at this many months of 2020?" How should folks really be thinking about that?

Angie Caldwell

That's an outstanding question. So the surveys that are coming out in 2021 are reporting on 2020 data - the surveys are doing a very good job with their commentary. Again, they always do a great job providing information on the data respondents - who's answering the survey and where they're from. The surveys that have come out so far in 2021 are providing a brief executive summary, if you will, about how they gathered their data, which is similar to prior years. They are also providing some commentary on how that data may have been impacted by the pandemic. Really for those folks, most entities, have a process. They receive their surveys annually, and they have a process by which they review them and look at them and accumulate the data.

In this year, especially, they'll just have to have a more mindful eye as they're comparing year over year. Significant changes need to be investigated and need to be really thought through. To the extent they want another set of eyes on it or some other interpretation or clarification, of course, we do that and have done that, including just taking a look at the impact of the pandemic and on the virus on those specialties and the data.

Jana Kolarik

I think that's super helpful, and hopefully, will be helpful in guiding folks that are listening. Let's talk a little bit about the pandemic's impact on practices selling and maybe how that has affected physician's expectations related to what practices are worth, or what compensation they should be receiving? Because I know we've spoken about this in the past. I wanted to get some insight from you as to maybe how that has changed or affected the landscape.

Angie Caldwell

Yes. Wowie, right, and bless those providers out there that had to pivot on an absolute dime at the onset of all of the chaos really that occurred over 12 months ago at this point. Significant impacts to their independent private practices. They had to worry about their professional staff. They had to worry about their patients and getting them in. Perhaps these independent private practices made a switch what probably felt like overnight to a telemedicine platform. So much going on. Then all of the other business concerns. Maybe these independent private practices applied for and received a PPP loan that became available. They received PRF funds.

So all of a sudden, there are all of these new business and environmental pressures on these independent physician practices, as if managing patients and managing the healthcare and the lives of their patients wasn't enough. The management of their practice - they have all of this too. Honestly, we've seen some physicians say, "That's it. I'm out. I cannot do this anymore. I want to spend the time with my patients, and I cannot do both well anymore. And so I have to sell. I have to get out." Some practices said, "We managed. We got through it. We're going to be okay." And an absolute, wonderful kudos to them. But we have seen some practices say, "That's it. I'm out." Those independent private practices on the other side of all of this, of course, they are looking into all of the things that they have to do for their PPP, their PRF reporting, and all of that.

So they continue to have these environmental and industry pressures and things that they have to take care of. But it's just interesting to watch whether folks are going to sell or whether they're going to move. Of course, that introduces to them the whole private equity part of our industry and how active private equity was prior to the pandemic. They are very active now related to the acquisition and accumulation of private practices.

Jana Kolarik

Because I'm sure you've dealt with the private equity aspect with this, which, I think is just part of the environment now, but how has it affected prices or what practices are selling at as well as how has it affected compensation? Because that's one of the things you and I have spoken about a little bit and how private equity and how their compensation model may be a shift, a big shift in some of these environments that a hospital system, a health system, has to then react to.

Angie Caldwell

Absolutely. So when private equity is looking at an independent practice, they are able to perhaps do things from an economic standpoint that others in the market from a purchase perspective may not be able to do. They may be able to financially, from a capital perspective and from a regulation perspective do some things differently. It's created a pressure out there from a hospital perspective, who was also looking to perhaps employ these physicians and integrate with these physicians. It has caused them to look at the balance between what that not-for-profit health system can do and what the private equity organization can do. So when you're thinking about the value of a physician practice. Clearly, it's more complicated than what we have time to go through on this podcast today. But other than for the tangible assets, for the touchable assets within the practice, and of course, the ancillary services, which we have to set over to the side and take a look at differently, a lot of the value of the physician practice rests with the physician. That value then rests and is measured in what the physician is able to pay themselves through their practice, as well as what they would be able to earn in compensation outside their practice. So then that's where it becomes a little bit more complicated than when you're looking at that physician compensation within the practice, because then other factors come into play, right? From an operations perspective (for example) why wasn't that physician able to pay themselves more? Well, because of all these other things, and then that comes into the equation. So then it becomes really interesting because private equity comes in with a different model, with a different perception and the ability to do some things differently from a compensation structure perspective than perhaps what others can.

Then the compensation is different. It can become very different than from a recruiting perspective. Everyone has to be on their toes, right, because private equity is saying, "Oh, we can give you this much in a compensation package," and then the not-for-profit health system has to say, "We can offer you a different amount in compensation." Then, the physician is left to compare the two. From a recruiting perspective, it's going to be very important for the not-for-profit health system, to the extent they want to continue to employ and integrate in that space, to be able to show the value of their competitive offer. Why it is competitive, not just from a dollars perspective, but from maybe a mission perspective, or maybe from a long-term perspective, all of the ways that then they have to show that their offer is competitive.

It's going to be very interesting to see how all of this shakes out. Of course, there are supply and demand issues as well in this. We've all heard for years that the number of physicians in the market is declining. Physicians are retiring, and they're not being replaced. We have more people that need more healthcare services. So again, as the supply and demand plays out in markets with heavy private equity, it's just going to be interesting to see where the compensation and where all of that shakes out. I wish I had

the magic crystal ball on this one. But it's going to be a long-term shake out as far as where all of this ends up.

Jana Kolarik

No, it makes sense, and I agree with you. So one thing that you mentioned and all very helpful, but this is really comparing apples to oranges when you compare private equity to health system, to nonprofit health system. I mean, it is a different mindset. The sale based just on comp can turn out one way. But looking at it holistically, I agree with you is important, and it's important for health systems to be focused on that.

Angie Caldwell

Absolutely. It's about the messaging regarding that offer and all of the elements within it. And it does become very confusing for the physicians. So we often help physicians when they are taking a look at multiple offers. We will help them compare the offers because depending upon how they are presented and how they are brought forward, sometimes it's not clear. So, in the fruit salad - the apples and oranges - you try to align the fruit as best as you can, and sometimes you can't. Then that's when you get into the qualitative factors behind the offer as well.

Jana Kolarik

That makes total sense. So is there anything that we haven't touched on? You and I, again, have had multiple conversations about these issues, is there anything that we've touched on in our conversations that we want to make sure that our listeners benefit from?

Angie Caldwell

Jana, I think we've hit on the biggest hot topics right now, and we'll just keep our eye on other hot topics going forward and, who knows, may have an opportunity for another podcast with those hot topics in the future.

Jana Kolarik

I would love it. Always enjoy this. Thank you, Angie. As always, it's been so great spending time with you and discussing these hot topics. And thanks so much for your time.