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FAIR MARKET VALUE AND COMPENSATION ISSUES

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Having fully explored the legal analysis of fair market value, it is also appropriate to focus on the methodology and application thereof. Legal counsel representing clients undertaking arrangements restricted to fair market value should strive to identify the skills of the valuation analyst, communicate clearly with that person and be prepared to make a cursory evaluation of the quality of the work upon which counsel will be relying in advising clients, negotiating arrangements and preparing documents to memorialize arrangements restricted to fair market value.

This section of the materials is designed to help counsel flesh out flawed fair market value conclusions by outside experts or internal analysts and help foster clear communications necessary to provide defensible support for legal arrangements.

Understanding the Issues and Risks

In-house or outside counsel often come to the table with a good working knowledge of the risks associated with the proposed transaction, including Stark exceptions and AKS safe harbors applicable to the transaction. In evaluating the quality of the conclusions of fair market value, however, internal or, in particular, external analysts may not have a complete understanding of the issues or risks associated with the arrangement. The following are a few points of significance to consider:

- Without good working knowledge of legal constraints, the conclusion of value may lack credibility.

- Analysts, appraisers, consultants or other experts employed or retained by counsel or the organization in the determination of fair market value should possess a level of knowledge of the legal restrictions associated with the proposed arrangement and how the legal environment affects the definition and determination of fair market value.
- Without understanding the entities that make up the parties to the contract, the value conclusion may lack credibility.

- The relationship of parties to the agreement is of significance to the arrangement, particularly when a referral relationship exists. Those responsible for fair market value determination should be keenly aware of this fact and how the relationship between the entities affects the transaction. For example, synergies between a physician and a hospital to which the physician refers patients, if considered in the value conclusion, could lead to an illegal arrangement. Consider the

regulatory definition of fair market value found in the Stark statute[1], which prohibits synergistic value adjustment based on the proximity or convenience where a potential referral relationship exists.

• Without understanding the billing ramifications of the contract, the conclusion of value may lack credibility.

• Many arrangements, such as those involving physicians and hospital systems, may be significantly impacted by the nature of the billing arrangements. Overlooking nuances in billing for a specific arrangement, such as identifying the party responsible for billing and collecting technical component fees, can have a detrimental effect on the conclusion of value.

• Billing and reimbursement issues often drive the structure of the arrangement. Under certain arrangements, independent contractors may bill and collect their professional fees, while the employer most often bills the professional fees of employed physicians. Under call coverage arrangements, the billing of physician professional fees may vary depending on arrangements, such as whether the call coverage is “restricted” or “unrestricted.” In the cases in which technical component billing is a consideration, properly matching costs (i.e., equipment depreciation, supplies, technician, etc.) to the technical component is critical. And in the case of administration or medical direction, it is likely that billing and reimbursement of physician professional fees are of little consequence.

• Without experience in working with market data and financial and statistical reports, the value conclusion is likely to be significantly flawed.

• A plethora of data is available related to the medical practice of physicians, but failure to understand and properly apply this data could result in a significant error in the conclusion of value. Likewise, misunderstanding historical financial and statistical data can create substantial errors. The following represent some errors that can occur when evaluating the productivity of a physician in the practice of medicine:

• Improperly measuring the productivity of a physician in a rural health clinic setting, when a portion of the physician's production includes incident-to charges generated by a nurse practitioner.

• Incorrectly including physician technical component production in an analysis of physician charges or collections or misinterpreting global billings for professional component charges.

• Misuse of market data, such as using market data from the wrong physician specialty (e.g., cardiology sub-specialization) or using data reported by providers in a different setting (e.g., academic physicians, freestanding group practices, hospital-employed physicians).

- Failure to consider the payer mix, competitive market forces and patient acuity when assessing the productivity of physicians.
- Applying an incomplete understanding of data provided by physician practice management system reports when studying physician productivity.

Applying survey or other market data on physician compensation to a particular arrangement may not consider other compensatory arrangements outside the subject agreement, such as expert witness fees, administrative arrangements or consulting income.

Failure to recognize multiple components of a single contract can spell trouble for the value conclusion.

Many arrangements between health systems and physicians contain multiple components, including the following example of a recent physician contract:

- Physician clinical compensation
- Call coverage
- Medical direction

The above example is one of many distinct possibilities involving physician contracts. Other arrangements with physicians may include leases of real property or equipment, or provide for special administrative services required on the part of the physician. An effective, defensible value conclusion considers the existence of multiple arrangements and employs the necessary methodology to arrive at a conclusion of value that is consistent with the specific duties, responsibilities and terms.

Failure to recognize the significance of community need can cause a distorted perception of value.

The dynamics of the physician marketplace are very real and have a distinct impact on how physician arrangements should be structured to most effectively deliver health care to the patient population. In many cases, market shortages indicate a need for higher compensation and the payer mix and patient acuity can provide invaluable information about the makeup of the market. Markets with poor payer mix may not clearly reflect the value of the physicians, particularly when benchmarking to national or regional data.

A good working relationship between counsel and analyst will help ensure that substantive matters applicable to the analysis are given adequate consideration. Counsel often plays an effective role in educating the analyst on these and other issues pertinent to the proposed transaction; thus, it is important to consider and communicate those items in a way that fosters credibility in the process.

Market Research and Materials

Much of the internal or external analyst's credibility in developing a

conclusion of fair market value is derived from the quality of the market analysis conducted. With the wide range of data available in many cases, the consultant or analyst is responsible for ensuring that the market data is relevant to the case at hand, and that it is properly applied in arriving at a credible conclusion. The following is a list of some of the tools at the disposal of the valuation consultant in evaluating the market for physician compensation:

- National and regional surveys

- Among the most often quoted of these surveys is the survey on physician compensation and productivity published by the Medical Group Management Association (MGMA)[2]. The *Physician Compensation and Production Survey,* published annually by MGMA, reports the results obtained from survey instruments collected from physician practices across the nation. A number of other, more specialized survey reports by MGMA provide data on costs in physician practices and give specific management and financial data applicable to a variety of health care entities and physician specialties. Other notable surveys include the following:

- *Medical Group Compensation and Productivity Survey* , American Medical Group Association
- *Physician Compensation and Productivity Survey Report* , SullivanCotter and Associates, Inc.
- *Medical and Dental Income and Expense Averages* , Society of Medical-Dental Management Consultants
- *Hospital and Health Care Management Compensation Report* , Watson Wyatt Data Services
- *Physician Salary Survey Report* , Hospital and Healthcare Compensation Service
- *Physician Socioeconomic Statistics* , American Medical Association
- *Physicians Compensation Survey,* Hay Group

Physician recruiting and staffing firms also report useful market information on physician compensation and recruitment incentives. Some of these firms include the following:

- Merritt, Hawkins & Associates
- Martin Fletcher
- Jackson & Harris
- Pinnacle Health Group
- Goddard Health Care
- MD Network

Formal or informal surveys of other institutions with similar arrangements

In the area of hospital/physician compensatory arrangements, surveying the practices of other facilities represents one means for studying marketplace activity. This can involve a formal process of a survey or study of the practices of other facilities in the market or it can take on a more informal approach, including telephone polls and other means of informal contact. Care should be taken to avoid antitrust implications, however, when making contact with other organizations in the market, and the analyst should be aware that referral relationships existing in those comparable arrangements could taint the data under the Stark definition of fair market value[3].

Ad hoc surveys of physician recruiting and staffing firms

Physician recruiting and *locum tenens* firms often have information on other physician recruitment offers made or accepted in the marketplace. These organizations may be helpful in providing information on physician subspecialties or offers particularly relevant to a specific market.

Surveys and inquiries of physician specialty organizations

Physician specialty organizations, such as the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists, can be particularly helpful with specialty-driven data about the practice of medicine in a particular specialty or in providing contacts among consultants with specific expertise in matters related to certain physician specialties.

State and local market economic research, with focus in health care

State and local market research is particularly essential to a credible conclusion of value. Market conditions, particularly as they apply to health care entities, have a significant bearing on value and compensation, and detailed research in this area is especially important in understanding the nature of the market.

For example, a market with Health Professional Shortage Area[4] status may experience significant difficulties in recruiting and retaining physician talent. Likewise, in the valuation of health care facilities, states with Certificate of Need requirements or a moratorium on health facility licensure may place significant restrictions to investors entering the market.

State licensing boards and similar organizations often maintain information about comparable transactions and can serve as a resource in the research of market activity.

Regulatory research

Federal and state laws impacting reimbursement, compensatory

arrangements and limitations on transfers of assets or provider numbers may also impact a transaction and should be carefully researched. For example, rural health clinic regulations have a significant bearing on the value of physicians working in those settings, in light of preceptor requirements, incident-to billing rules and cost-based reimbursement.

Billing and procedural coding research

As previously discussed, an understanding of the ramifications of billing arrangements is key to a successful conclusion of value. Determining the party responsible for billing physician professional fees and technical component/facility fees is critical to understanding the value inherent in the relationship between the parties. Furthermore, knowledge of billing requirements may also be essential, particularly when billing anomalies could create a false sense of value. Physician procedural coding patterns may also impact value, particularly if coding patterns lead to a risky inflated measurement of physician productivity.

Community needs assessments and documentation of facility staffing requirements

In considering the fair market value of its arrangements with physicians, facilities such as hospitals and health systems are at a significant disadvantage without knowledge of the need for various physician specialties in the market. A comprehensive needs assessment, prepared internally or externally, is of significant value in documenting community need for physician specialties, or in helping determine a hospital's staffing requirements. Such documentation may also be of significant benefit in defending an IRS challenge to reasonable compensation[5].

Competent market research data may comprise any combination of the above, depending upon the parties to the agreement and the arrangements involved. Counsel's awareness of available data and its applicability to the subject arrangements can help ensure a defensible conclusion of value.

Proper Application of Research Data

Critical to a competent conclusion of fair market value is the proper application of data obtained as a result of economic and market research. Misused data and mistaken analyses create significant risk to the parties to the agreement. Legal counsel, while perhaps lacking proficiency in financial analysis, should remain attuned to the possible misapplication of data when considering the work of internal or outside analysts. Consider the following:

- Simply applying broad compensation survey data may not be sufficient for a competent conclusion of value. Paying a physician at an average or median level of compensation may not properly reflect the value of the physician's contribution to the contractual arrangement.

For example, an underperforming physician may not be contributing sufficient value to the arrangement, while a high-performing physician may be worth significantly more. Likewise, regional disparities in compensation data make a comparison to broad, national survey data problematic. State and local trends in payer mix, costs, reimbursement and tort defense also impact reliance on national and regional surveys.

- Understand how surveys report compensation and benefits. Not all surveys report compensation in an identical manner. Consider the reporting of fringe benefits, which may be part of most national surveys, but may be considered in the package offered a physician by another facility in the market. Furthermore, physician productivity metrics may vary in logic from one survey to the next. For example, many physician productivity surveys report gross charges after reducing technical component charges. A misstep in this area could render useless a conclusion of fair market value.
- Market conditions dictate supply and demand, which can translate into value. In rural markets, for example, physician supply may generally consist of those born and raised in the area. A short supply of a particular specialty may make it exceedingly difficult to recruit and retain quality providers from a considerably smaller pool, thereby affecting access to quality care for the population. Traditional market data, such as those found in national and regional surveys, may not give substantive consideration to this fact, thereby requiring further research into local market conditions, physician need and federal health access designations.
- Research must be pertinent to the proposed arrangement. Consider an arrangement involving call coverage, one of the trends in recent years. Simple application of physician compensation data to the arrangement could lead to a mistaken conclusion, as the physician party to the call coverage agreement may be permitted to bill for and collect his or her professional fee. Blindly applying physician compensation market data, without a clear understanding of the nature of the arrangements behind the data, can lead to a faulty conclusion of value.

By demonstrating various ways to misapply research materials to the contractual arrangements, the above examples help explain why counsel should understand the basis for the conclusion of value and look for missteps in the process. Furthermore, clarity in communicating the arrangements with the parties to the arrangements and to the analyst helps lessen the risk that a mistaken conclusion of value may result from an improper understanding of the arrangements or the inexperience of the analyst.

Competent Analysis of the Data

As discussed, a credible value conclusion is oftentimes the result of the application of multiple valuation approaches. In general terms, three basic approaches exist, both in the business valuation community, and in arriving at a conclusion of the fair market value of compensatory arrangements. These include the following:

- *Cost Approach*

- The cost or asset-based approach determines value based on the cost associated with the proposed arrangement. This may involve a consideration of the alternative costs avoided by failure to entering into the arrangement, or may consider the costs necessary to replace the arrangement with a similar one.
- *Income Approach*

- The income-based approach generally considers the subject arrangement as an investment mechanism, the purpose of which is to produce a monetary return or reach a break-even point as a result of the arrangement.
- *Market Approach*

- The market-based approach incorporates data obtained from a variety of market resources to establish a value of the subject arrangement. This methodology most closely follows the commentary from CMS on the issue of fair market value determination, particularly that found in the Phase I rulemaking[6].

Within each of these general approaches is a wide range of methodology, which may vary significantly depending on the nature of the arrangement. The following more fully describes many of the methods used within each of the three broad approaches, with examples of some of the types of arrangements for which these methods may be useful, and often when combined with other methods.

Cost Approach

Methodology employed under the cost approach is often useful in assessing the value of the following arrangements:

- Per-click arrangements for equipment leases
- Management service (“MSO”) arrangements
- Leasing of personnel
- Leases for purposes of technical component billing
- Valuing inactive certificates of need
- Physician call coverage

Methods under the cost approach often used in valuing these arrangements include:

- Avoided cost of replacing the physician, service, etc.
- Cost to recruit and retain personnel
- Cost to obtain licensure
- Cost of alternative physician coverage

Income Approach

Methodology employed under the income approach is often useful when valuing the following arrangements:

- Physician recruiting and income guarantees
- Valuing active licenses or active certificates of need
- Per-click arrangements for equipment leases
- MSO arrangements
- Leases for technical component billing

Methods under the income approach often used in valuing the above arrangements include:

- Projections of earnings (income or cash flows)
- Discounted or capitalized earnings methodology

Market Approach

Methodology found under the broader market approach is often useful in assessing the value of the following arrangements:

- Physician compensation, including clinical compensation and call coverage
- Administrative (e.g., medical director) compensation arrangements
- Valuing joint ventures, active ancillary services or CON entities
- MSO arrangements

Methods often used under the market approach include the following:

- Analysis from published surveys
- Ad hoc surveys
- Comparable arrangements

It is important to note that, depending upon the contractual arrangement and the availability of reliable data, some arrangements require a single method as part of a singular approach to arriving at a value conclusion; others are more effectively valued with a combination of several methods under various approaches to valuing the arrangement.

Developing the Conclusion of Value

To produce a sound and defensible conclusion, it is important to consider as many or as few of the different methods as are appropriate under the given circumstances of the situation and for which the necessary information is available. Each method may serve as a reasonableness check on the results of the other methods. Because this is not an exact science, it is to be expected that the results of the various methods will not be in exact agreement, but instead will differ from one another to a greater or lesser extent. Often, this results in a subjective weighting of the results obtained through various methods.

Objectivity, informed judgment and reasonableness are essential to determining the aggregate significance of the individual methodologies

considered. Quantitative results and the numerous subjective factors pertinent to the arrangement must also be adequately considered, without giving consideration to the various synergistic relationships that may exist.

Case Studies in Fair Market Value

Case Study 1: Trauma Surgeon Call Coverage

Situational Analysis

A trauma center in a competitive market negotiated with a surgery group to furnish two physicians to provide unrestricted[7] surgical call coverage to patients in the Hospital's service area. Under the proposed agreement, the group would furnish physicians to cover call in 24-hour shifts, 365 days per year.

Under the arrangement, the group would bill for and collect the physicians' professional fees while assigned to provide said coverage; therefore, the amount to be paid to the physicians' group under the arrangement was to be made in consideration for physician availability, rather than for the professional services of the assigned physicians.

Information Obtained

- Medical Group Management Association ("MGMA") *Physician Compensation and Production Survey,*
- SullivanCotter and Associates, Inc. ("SCA") *Physician Compensation and Production Survey,*
- California Medical Association *On-Call Survey Summary,* and
- Market data supplied by *locum tenens* and agency firms related to physician call compensation.

Methodology and Analysis Performed

Method One: Survey Data

In this method, the analyst relied on survey data listed in the SullivanCotter and Associates, Inc. ("SullivanCotter") *Physician On-Call Survey Report* and compensation data for general surgeons, as published in the Medical Group Management Association ("MGMA") *Compensation and Production Survey,* to arrive at an estimated average hourly call coverage rate for unrestricted call for a general surgeon.

Method Two: On-Call Survey Summary Conducted by the California Medical Association

In this method, the analyst relied on survey data listed in the California Medical Association's *On-Call Survey Summary* [8]. Because average or median data were not reported in the survey, the analyst calculated an average of the high and low values for unrestricted call for a physician specializing in general surgery to arrive at a value for a 24-

hour shift.

Method Three: Locum Tenens and Agency Rates, Adjusted for Agency Fees and Provision for Collections of Professional Charges

For this method, research was conducted into the rates charged by several locum tenens and physician staffing firms for the provision of surgical call coverage. This research produced an average daily rate that included the costs of agency fees, physician compensation, and medical malpractice insurance coverage. These results were then adjusted to remove agency fees and reasonable costs associated with billing and collection services, and the median of the adjusted responses was computed to arrive at an adjusted hourly rate.

Result Obtained

In determining fair market value for physician call coverage, a weighting was applied to the results obtained by the various methods presented above. Consideration was given to survey sample sizes and geographical focus of the survey data. The result was a fair market value hourly and shift rate for surgical unrestricted call coverage.

Case Study 2: Orthopedic Independent Contractor

Situational Analysis

A hospital negotiated to hire a board certified orthopedic surgeon as an independent contractor to provide physician services to patients within an off-site medical clinic. In addition to his work as an independent contractor, the physician was also to provide services to patients in a separate unit within the hospital. The physician's work in the hospital unit was not intended to be part of his work as an independent contractor serving patients within the off-site clinic. The physician would continue to personally bill and collect for services provided in the unit. In addition, the physician owned the clinic building and employed the clinic's medical staff, which included two nurses and a receptionist. As part of a separate agreement, the physician was to also provide administrative duties as the hospital's director of orthopedic rehabilitation services.

Information Obtained

To determine the fair market value compensation for the above scenario, the following information was requested:

From the practice:

- Details of the physician's productivity for the past 24 months
- Amount of the physician's annual malpractice insurance premium
- Breakdown of the physician's annual benefits
- The physician's curriculum vita
- The physician's current compensation

From the hospital:

- Description of the physician's responsibilities under the proposed agreement
- Details on the employment of clinic employees
- Information on the party responsible for billing and collecting for the physician's services
- Description of the hospital lease arrangements for the clinic building
- Details regarding other financial arrangements with the physician
- A copy of the proposed agreement (if drafted)
- Call rotation and coverage requirements

Initial Findings

Through the information gathering process, which included various conversations with hospital management and a review of the information received, the analyst identified several key issues that would greatly affect the analysis and opinion:

1. Although the physician's CV noted that he was a board certified orthopedic surgeon, it was learned that under this particular agreement, he would only provide non-invasive orthopedic services.
2. Initial analysis of the physician's productivity report indicated that the physician was a low producer. Based on additional inquiries, the analyst learned that the practice produced two separate productivity reports for the physician, tracking his work in the clinic and hospital separately. These reports, when combined, presented the physician's complete productivity picture.
3. The hospital would lease the clinic building from the physician under a separate lease agreement based on a fair market value rate determined by a local real estate appraiser.
4. Under the proposed agreement, the hospital would employ the clinic's nurses and receptionist.
5. The physician's medical director services were established under separate contract with the hospital.

Methodology Employed

Productivity Analysis:

The methodology behind the analysis was to first determine the physician's productivity as compared to the market. Based on this assessment, the physician's compensation was adjusted upward or downward to reflect the physician's compensation relative to specialty data. Of particular importance was establishing how much of the physician's time would be spent working as an independent contractor under the proposed arrangement, as opposed to working in the hospital. This was done by first totaling the physician's productivity from each

location and computing each as a percentage of the total. For this purpose, the analyst relied on work relative value units (WRVUs). The WRVU was chosen as a good indicator of productivity, as it eliminated fee schedule issues associated with gross charges and payer mix issues affecting revenues. This analysis provided an estimate of the physician's full-time equivalent (FTE) status in each of the two areas of practice.

Independent Contractor Issues:

To provide a rate that reflected fair market value for an independent contractor, certain costs not normally associated with employed physician compensation were considered, including out-of-pocket costs particular to an independent contractor. These included malpractice insurance expense and physician benefits.

Analysis Performed

To determine fair market value compensation, the analyst first calculated and compared the physician's gross charges, net of technical component charges, WRVUs and patient encounter volume to market data from survey data and other sources. Based on this analysis, and adjusted for a partial FTE, the physician's compensation was adjusted to reflect the value commensurate with physician's relative productivity and for the independent contractor arrangements. The administrative duties of the medical directorship were evaluated and assigned a rate equivalent to the Stark fair market value safe harbor hourly rate.

Results

The above analysis resulted in a fixed compensation figure for the physician's role as an independent contractor working in the clinic. The various measurements resulting from the benchmarking analysis also provided the analyst with the background information needed to recommend to the hospital a market-based incentive compensation formula.

Case Study 3: Rural Health Clinic Physician

Situational Analysis

A hospital entered into employment negotiations with a physician to work in a rural health clinic (RHC) in a rural, low-income area. The physician was to be compensated under an arrangement that set forth a fixed component of compensation and a non-fixed incentive provision, based on clinic revenues and overhead control.

Information Obtained

To determine the fair market value compensation for the above scenario, the following information was requested:

- Reports on productivity of the physician, by CPT code
- Reports on base and incentive compensation previously paid to the physician

- Financial statements of the RHC
- Interviews of hospital and clinic management
- The physician's curriculum vita
- Information as to the business hours of the practice
- Call rotation and schedule
- State and federal RHC staffing and patient requirements
- State and county population, population-to-physician ratio, and poverty rate
- Non-metropolitan health professional shortage area (“HPSA”) designations for primary care in the service area
- Reports on indicators related to a physician's choice of specialty and practice
- Medical Group Management Association (“MGMA”) *Physician Compensation and Production Survey*
- American Medical Group Association (“AMGA”) *Medical Group Compensation and Productivity Survey*
- RHC fiscal intermediary information on RHC physician cost guidelines; and
- Information provided by physician staffing firms, including surveys and interviews.

Initial Findings

Through the information gathering process, which included various conversations with hospital and clinic management and a review of the information received, the analyst identified several key issues that would greatly affect the analysis and opinion:

- The local market was a health professional shortage area and community need for a physician in the local market was a significant issue;
- The rural area was a difficult area for physician recruitment and retention;
- The physician lived and had family ties to the area and was familiar with the people there; and
- The physician's procedural coding patterns were of concern, as they did not reflect the expectations for patient acuity in the market; consequently, the physician's productivity in terms of gross charges and work RVUs did not meet expected levels.

Methodology Employed

Market-based methodology was initially employed in the determination of the value of this provider. As a result of the analysis described below, initial findings indicated that information on comparable RHC payment arrangements and survey market data would be most applicable to establishing fair market value for the subject arrangements. Further into the project, the analyst determined that additional cost-based methodology, such as the avoided cost to the

facility to replace the physician, or in providing the physician with a Stark-compliant retention bonus, would be an appropriate supplement to the market methods employed.

Analysis Performed

An initial benchmarking of the physician's productivity was useful in determining a number of facts about the practice and physician, including procedural coding patterns, reimbursement in the RHC setting as it related to physician gross charges, physician productivity in terms of patient encounters (a driving force in RHC reimbursement) and the profitability of the RHC. Relative analysis of physician compensation to production statistics included studies of compensation in relation to WRVUs, collections, patient encounters and charges.

Subsequent to the analysis of physician productivity, market research into the compensation of RHC physicians and the practices of physician staffing firms in recruiting to these areas was given substantive attention. Community need and the economics of the local area were given attention in determining the relative difficulty in recruiting and retaining physicians.

Results

Influencers on physician choice, staffing issues facing RHCs, the physician's ties to the area, the nature of the local population, limited financial resources to pay for care, and community need resulted in a significant challenge to recruit and maintain a physician in the environment when compensation remained at or even above typical levels of compensation found in less rural markets or in urban settings. These facts were considered into determining the amount of recommended remuneration, including the associated financial premium.

Case Study 4: Mobile MRI and Related Physician Services

Situational Analysis

A hospital entered into negotiations with a physician group for the provision of a mobile MRI unit to be regularly scheduled on the hospital campus. The physician group leased the MRI unit and furnished physician supervision and interpretive services. The hospital provided parking space for the unit, use of the facility and support services. The hospital also furnished the availability of an emergency room physician during the scheduled hours of operation of the MRI unit. The hospital and group desired guidance on the fair market value of the arrangements involving the use of the MRI unit and the services provided by the hospital.

The proposed arrangements for compensation between the hospital and physician group included a payment by the physician group to the hospital for the use of hospital facility space, parking pad, and support services, as well as for ER physician availability. The arrangements also included payments by the hospital to the physician group for a

per-click use of the MRI equipment for Medicare patients. The physician group paid a per-click rental to the lessor.

The physician group billed the global fee for the furnishing of diagnostic imaging services to non-Medicare patients, while the hospital billed the technical fee for services furnished to Medicare patients. When the hospital billed the technical fee, the physician group only billed the professional fee associated with the reading and interpretation of the MRI scans.

Information Obtained

To determine the fair market value compensation for the above scenario, the following information was requested:

- The agreements between the hospital and physician group;
- A copy of the unrelated lease agreement between the physician group and the lessor of the MRI unit;
- The schedule for the mobile MRI unit;
- Information about the hospital facilities and support services provided, including a listing of the support services furnished by the hospital and the cost of constructing the parking pad for the mobile unit;
- A report on the frequency of imaging services furnished by the physician group to the hospital, by CPT code and payer;
- A report on payments made by the hospital to the physician group and by the physician group to the hospital, and the nature of such payments; and
- Financial statement information on the revenues and expenses associated with the operation of the mobile MRI unit.

Methodology Employed

Payments by the Physician Group:

Payments by the physician group to the hospital included payments for the following:

- Use of the parking pad;
- Use of hospital facility space, including reception areas;
- Use of hospital personnel;
- Standby availability of ER physician (physician employed by the hospital); and
- Other support services.

Given the varied components of the arrangement, it was necessary to apply separate methodology to many of the components to arrive at an overall conclusion of the value of the aggregate arrangement. For example, cost approach methodology was employed in the valuation of the parking pad, facility space and personnel costs. Physician standby services were valued using market data on physician call rates. Other support services were based on the costs associated with those specific

services.

Furthermore, as a test of reasonableness, methodology under an income approach was employed to compare the aggregate of the various components of the technical fee billing, including the external lease payments for the rental of the unit, to market-based technical component reimbursement.

Payments by the Hospital:

- Per-click rental of the unit (Medicare patients)

- The rental value of the unit by the hospital from the physician group was appraised using income and cost-based approaches to valuing the arrangement.

Analysis Performed

For the use of the parking pad, the cost and annual depreciation of the parking pad was obtained to determine the annual rental value, which was divided over the period of use of the pad by the mobile unit. For the use of hospital facility space, the fair market rental rate, obtained from a qualified real estate appraiser, was used in the determination of the rental value of the space, while an allocation of the space was made to account for the part-time use of that space when the mobile unit was scheduled. With respect to the use of hospital personnel, information about the cost and local market wage and benefit rates was accumulated to determine the costs associated with the supply of personnel, which was then apportioned to the arrangement based on the scheduled availability of the mobile unit. Other support services, such as appointment scheduling and housekeeping, were evaluated based on data from the hospital's cost report and market information on the value of the services provided.

As a test of reasonableness, costs associated with the various components of the payments made by the physician group to the hospital, and in addition, the costs of equipment rental were accumulated and compared, with a reasonable allowance for markup, to technical component reimbursement in the market. This required an analysis of the CPT codes and frequencies, to which market based technical component reimbursement was applied, yielding a pro forma revenue stream associated with the TC portion of the billing.

The availability of physician personnel, as required of the hospital during the scheduled hours of operation of the unit, was evaluated based on the market data available for physician call coverage. As the physician was required to be on the hospital's campus during scheduled operating hours, this availability was valued based on market data related to restricted call coverage (physician on-site). Survey data on physician call coverage was employed in a market-based approach to determine the value of the availability of the physician during scheduled hours.

With respect to the per-click rental paid by the hospital to the physician

group, a two-pronged approach was used in establishing value. First, from a cost-based approach, methodology was used to accumulate the avoided costs to the hospital resulting from the rental of the equipment, including the cost of equipment rental and the costs of supplies and other items of goods and services furnished by the physician group as part of the use of the equipment. Second, using an income approach, the value of the technical component service associated with the equipment was studied with data on Medicare reimbursement applicable to the scans performed for those patients.

Results

The results of the valuation of the components of this arrangement indicated some small variances that mandated adjustment of the contract payment rates to remain within the limits of fair market value.

FAIR MARKET VALUE SAFE HARBOR PITFALLS

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Experience with the new fair market value safe harbor has highlighted some weaknesses that must be considered when evaluating the effectiveness of the methodology. Below are listed several shortcomings applicable to the two methods identified by CMS in the new safe harbor.

Shortcomings of the ER Physician Market Methodology

- CMS does not define the “relevant market” identified in the preamble or regulations;
- Finding three hospitals in the relevant market with emergency services is difficult; finding three that are willing to share this information has proven to be even more difficult; and
- The compensation of ERPs ignores wide ranges of compensation among specialties and disregards the nuances of shortage specialties.

Shortcomings of the National Survey Method

- National survey data is not region-specific; some regions have significant variances, either above or below national data; many markets have their own unique features;
- Some surveys have limited subspecialty data, such as cardiology (invasive, interventional and non-invasive) and maternal/fetal medicine;
- Some surveys may be more applicable to the market or transaction than others; others may be tainted by small number of responses;
- Other widely recognized surveys are omitted (e.g., American Medical Group Association); and
- Cost.

Shortcomings Applicable to Both Methods

- Both methods apply only to hourly payments to physicians; neither apply to productivity incentive methods;
- Neither method addresses aggregate compensation;
- Both are ineffective when circumstances dictate higher compensation, such as when community need or physician shortage affects physician recruitment, or in the case of highly qualified or highly productive physicians; and
- Average methodology may distort the results, particularly if surveys vary widely.

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[1] 42 U.S.C. 1395nn (h)(3).

[2] Medical Group Management Association, Englewood, Colorado.

[3] 66 Fed. Reg., page 944–945. CMS response to commenters included the statement that “to establish the fair market value (and general market value) of a transaction that involves compensation paid for assets or services, we intend to accept any method that is commercially reasonable and provides us with evidence that the compensation is comparable to what is ordinarily paid for an item or service in the location at issue, by parties in arm's-length transactions who are not in a position to refer to one another.”

[4] Health Resources and Services Administration, U.S. Department of Health and Human Services. The Shortage Designation Branch in the HRSA Bureau of Health Professions National Center for Health Workforce Analysis develops shortage designation criteria and uses them to decide whether or not a geographic area or population group is a Health Professional Shortage Area or a Medically Underserved Area or Population.

[5] Revenue Ruling 97-21 provided three examples (Situations 2, 3 and 4) of acceptable arrangements involving physician employment and recruitment arrangements that were substantiated by a qualified community needs assessment or by hospital staffing requirements.

[6] 66 Fed. Reg., page 944–945. CMS response to commenters included the statement that “to establish the fair market value (and general market value) of a transaction that involves compensation paid for assets or services, we intend to accept any method that is commercially reasonable and provides us with evidence that the compensation is comparable to what is ordinarily paid for an item or service in the location at issue, by parties in arm's-length transactions who are not in a position to refer to one another.”

[7] In restricted call coverage, the physician is required to stay on the hospital's premises, as opposed to unrestricted call coverage, in which the physician is not required to stay on the hospital's premises.

[8] Survey data was extracted from the *American Governance Leader, April/May 2003, pg. 4* .