

MEDICARE COMPLIANCE

Hospitals Navigate Fair-Market Value Under Stark as Feds Scrutinize Arrangements

Financial relationships between hospitals and physicians are apparently the most neglected area of compliance oversight despite the growing number of Stark and anti-kickback settlements and the 80 applications pending at CMS's new self-referral disclosure protocol.

The question is: Could your hospital's physician compensation arrangements survive the scrutiny of fraud investigators? Their judgment probably will turn on the fair-market value of compensation, which is more subjective than you may think and more vulnerable to mistakes by appraisers who lack health care experience, experts say.

"If compensation is above fair-market value, the government could allege the excess compensation is really intended to induce patient referrals," says Mishawaka, Ind., attorney Bob Wade, with Krieg Devault. "Likewise, under the Stark law, if compensation exceeds fair-market value, you can blow many exceptions, including exceptions for employment, personal service arrangements and rental of office space."

Whether hospitals guarantee a full salary to physicians or pay partly based on productivity, everything boils down to the alignment of productivity with the resulting compensation, says Wade, who does valuations from a legal perspective. Compensation should be aligned with benchmark data (e.g., Medical Group Management Assn. salary surveys).

There are three ways to evaluate productivity:

(1) **Physician collections:** Collections are based on actual revenue flowing into the organization.

(2) **Work relative value units (wRVUs):** The more RVUs, the harder the physician worked and the more patients he or she treated. All it takes is adding the number and types of CPT codes (e.g., 99212, 99213, 99214) and converting them to wRVUs.

(3) **Gross charges:** This refers to the charges on paper listed by the hospital or practice.

Wade says the work RVU model is preferable for most organizations because it involves payment for work effort and is not contingent upon collections. With collections, physicians have a disincentive to see the Medicare and Medicaid patients who generate lower

reimbursement than commercial-payer and true self-pay patients. Gross charges don't necessarily have a relationship to the reality of actual collections. That means hospital-employers can arbitrarily increase physicians' reward based on charges with no regard for an increase in productivity — an invitation to Stark violations, Wade says.

Whatever method your hospital chooses, make sure it can be defended (see chart, p. 3). "A good way to defend compensation arrangements is to show that productivity justifies the amount paid," Wade says. For example, if physicians' work RVUs are at the 25th percentile, their compensation should be roughly at the 25th percentile, unless extenuating circumstances exist. "You don't want to see a disconnect — compensation at the 90th percentile but productivity below the 25th percentile," he says.

'Subjective Factors' Change Compensation

However, exceptions — "subjective factors," Wade calls them — can justify payment that doesn't square with productivity. For example, if a rural hospital has spent five years trying to recruit a general surgeon in vain because the proposed compensation was too low, "it may be defensible to pay the surgeon at the 90th percentile to convince him or her to set up shop in the remote area," he says. Otherwise, the hospital will have no surgeon. This is a supply and demand issue. A surgeon in a rural area may not be as busy as a surgeon in a major metropolitan area, "but it still may be commercially reasonable for the hospital to employ the general surgeon and compensate [him or her] at a higher rate than his projected productivity." A hospital also may be able to defend compensation that benchmarks higher than productivity for a high-profile specialist who is in the upper echelons of his or her specialty and a prolific writer in the field, Wade says.

Also, for productivity arrangements based on wRVUs, the per-wRVU unit payment is the magic number. "If the unit is reasonably based, then the aggregate compensation should be fair-market value," he says. In other words, a physician's payment may seem outsized because she works like a dog — 80 hours a week. But if

the unit is appropriate, then the fact that compensation is at the 200th percentile doesn't mean it's out of fair-market value bounds if the physician's productivity is also at approximately the 200th percentile.

Fred Lara, a partner in HealthCare Appraisers in Philadelphia, says hospitals are starting to learn the ropes. "There seems to be more understanding and appreciation in the marketplace of fair-market value and what it means in health care, and I think that is the result of various cases the government has brought against health care facilities," including false claims lawsuits against Bradford Regional Medical Center and Tuomey Healthcare (*RMC 3/21/11, p. 1*). But fair-market value remains an area of vulnerability for hospitals and other health care organizations, partly because it is so complex. "You have non-experienced health care valuation folks doing health care valuations," Lara says. "The challenge there is they miss something someone else might know."

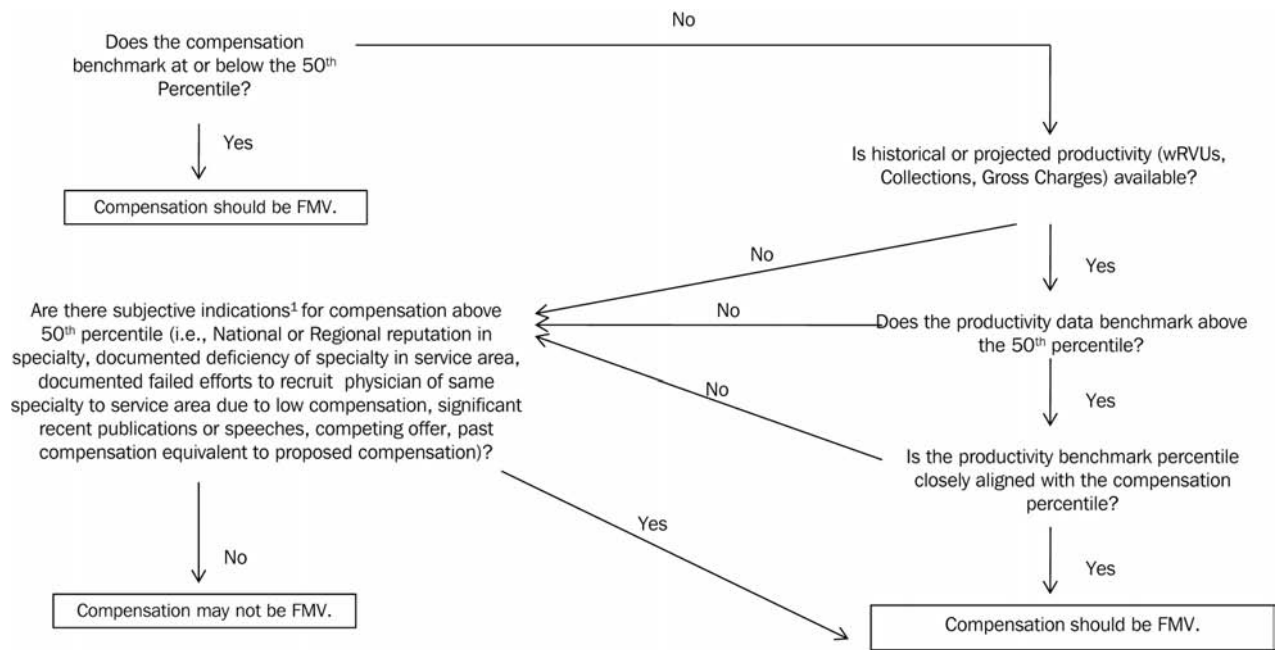
For example, Lara says appraisers who don't focus on health care may inappropriately advocate a pure market approach to valuations. In the regulatory context, the market approach won't fly, but he understands

the inclination to use it because it's an acceptable way to establish fair market value in other industries. In real estate, the value of a house is correlated to how much money comparable houses in the neighborhood have sold for. But a market approach that relies solely on physician/hospital transactions is not supportable to establish fair market value given its definition within regulated health care because the government views transactions with physicians who refer designated health services (DHS) as effectively being related party transactions, Lara says. If a value established under this type of approach turned out to be reasonable, it would be a coincidence, he says. In the absence of independent market comparables, Lara says that the government encourages alternate approaches to value, such as the cost or income approach.

"Stark and the anti-kickback statute are well-intentioned, but they create scenarios where natural market forces are not allowed to play out the same way they would in other industries. There are a lot of reasons for physicians and hospitals to do business together, but the challenge comes when the party with referrals wants to exercise that power to obtain greater compen-

Fair Market Value Algorithm

This decision matrix can help hospitals determine whether they are dependent on benchmark data or subjective factors when defending the fair market of their compensation arrangements. It was developed by Bob Wade, an attorney with Krieg Devault in Mishawaka, Ind. Contact him at rwade@kdlegal.com.



¹ The higher the benchmark percentile the greater the significance required of the subjective indicators.

sation than a hospital might otherwise pay to an independent vendor offering the same services,” Lara says.

The market approach, however, can be applied when hospitals contract with vendors for certain ancillary services. For example, hospitals can purchase perfusion services — the pumping of fluid through an organ or tissue — from cardiovascular groups on their medical staff or employ or contract with perfusionists. “The easiest way to establish fair market value is to put it out to bid, and to get bids from independent providers of perfusion services,” Lara says. “Ideally there is the ability to identify providers in the market who don’t have referral relationships with [hospitals].”

The market approach may work in establishing the fair-market value of a per-click lithotripsy arrangement, but it depends on the circumstances, Lara says. If there are five physician-owned lithotripsy arrangements in a marketplace — all of which are charging hospitals \$2,100 per click — it would seem reasonable to conclude that charging the same amount is fair-market value, Lara says, “but not necessarily.” Absent specific independent comparables in a marketplace, Lara says there are two ways to establish value.

One is the *cost approach*, which bases appraisals on the aggregate costs of the resources provided in the arrangement based, for example, on publicly available data of companies providing equipment and staff on a part-time basis.

The second is the *market approach*, which focuses only on independent providers of lithotripsy, which may rely upon data from other geographic markets.

If the fair-market value rate is established at a level below the existing contracted rate, the news is an unwelcome surprise to both physicians and the hospital. The hospital may be faced with the prospect of a competitor in the marketplace willing to pay a higher rate. “If the doctors will get the amount the hospital is not allowed to pay, how is that not fair-market value? If

there’s a willing provider to pay?” And therein lies the rub created by the Stark and anti-kickback laws, he says.

What if the doctors are the only providers of the service in that region? Lara says that might change the fair-market calculus. In a rural area, for example, “we might consider in establishing the value of the services how much would an alternate provider charge who might not be in the marketplace? If we had to get them to drive four hours to provide services, what would they charge?” That could be a factor in the appraisal, Lara notes.

It’s Possible to Win the Stark Game

Hospitals sometimes win when they stick to their Stark guns. Lara says he has seen facilities effectively end lithotripsy rather than pay above-market rates to a physician-owned provider. In smaller markets, there may be periodic starting and stopping of lithotripsy at a facility when a physician-owned venture shops its business to other providers.

Fair-market value is inherently a loaded gun. “Physicians realize they have a lot of leverage,” Lara says. They can use it to attempt to extract above-fair market value compensation under the threat of quitting the medical staff and abandoning emergency department on-call coverage, which puts the hospital’s EMTALA compliance at risk. Hospitals may feel their hands are tied, he says. “We hear different stories from different hospital executives,” Lara says. “Some are more focused on keeping physicians well compensated. Others are firm when it comes to physician compensation disputes even when it may result in potential operational disruption. In some situations, physicians will accept that a hospital adhering to the perceived limitations of fair market value is not unreasonable, and in fact benefits both parties in the long run,” he says.

Contact Wade at rwade@bdlegal.com and Lara at flara@hcfmv.com. ✧