CONSIDERATIONS FOR DETERMINING FAIR MARKET VALUE PHYSICIAN COMPENSATION UNDER STARK'S FINAL RULES

On January 19, long-awaited adjustments to the Centers for Medicare and Medicaid Services' ("CMS") Physician Self-Referral Law (commonly referred to as the "Stark Law") and the Department of Health and Human Services Office of Inspector General's ("OIG") Anti-Kickback Statute ("AKS") took effect that make it easier for hospitals and health systems to transition from volume to value-based care. [1]

This article focuses more specifically on the changes made to the Stark Law, and how organizations should be thinking about establishing fair market value ("FMV") for physician compensation under the new regulations. Although there are some important differences between guidance under the Stark law and AKS, it is important to note that CMS and the OIG coordinated efforts in their regulatory updates, both providing a consistent message in their support for the "Regulatory Sprint to Coordinated Care." [2]

Together, the new regulatory guidance provides important information that should be considered when establishing physician compensation. The most pertinent topics include new definitions for FMV, clarifications related to the value or volume guidelines, insight related to survey reliance, and what to consider when paying for quality outcomes.

FAIR MARKET VALUE – DEFINITIONS IN THE NEW RULE

Under the old rules, the Centers for Medicare and Medicaid Services ("CMS") defined fair market value as "the value in arm's-length transactions, consistent with the general market value."

In the final rule that took effect this month, the Centers for Medicare and Medicaid Services ("CMS") made changes that significantly expanded the definition and clarified how the definition applies to equipment rental and the rental of office space in addition to the more broad, general definition of fair market value.

Under the new rule, there are now three definitions, one for general services, one for equipment rental, and one for office space rental, allowing organizations to review the appropriate definition for the particular type of arrangement being reviewed with a physician or physician group. According to Stark's final rule, fair market value for physician services is defined as:

General (Compensation). The value in an arm's length transaction, consistent with the general market value of the subject transaction.

Similar changes were made to the definitions for general market value, intended to simplify the language and to differentiate between the general market value of compensation, assets, or the rental of equipment or office space. General market value of compensation in the final rule is defined as:

Compensation. With respect to compensation for services, the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other.

The revamped definition of fair market value should help organizations better understand what fair market value means in the context of the various arrangements organizations commonly enter into with physicians.

VOLUME AND VALUE CLARIFICATION

One of the most significant changes made to the definition of general market value was the removal of the "volume or value" standard from the definition. Under the prior definition, physician compensation "must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician." [3]

With the final rule, CMS clarified that the "Big 3" guidelines (fair market value, commercial reasonableness, and the volume or value standard) are separate and distinct concepts that must be met to determine compliance with the regulations. Organizations must continue to demonstrate that compensation is not set in a way that accounts for the volume or value of referrals or other business generated, however CMS affirmed that is a separate test and is not related to the fair market value of an arrangement.

While not the subject of this article, CMS did include a new objective test for the volume or value standard that makes it easier to meet. Specifically, compensation will only be determined to take referrals or other business into account if the compensation formula includes those factors as a variable and the amount of compensation correlates with these variables. Most importantly for typical provider compensation models that pay physicians based on work relative value units ("wRVUs") or collections, CMS reaffirmed its previous position that productivity-based compensation models used by most organizations today do not take into account the volume or value of a physician's referrals.

IMPLICATIONS OF BUYER-NEUTRALITY ASSUMPTION ON FAIR MARKET VALUE

As part of its effort to un-link the volume or value standard from the definition of fair market value, CMS had proposed removing the language regarding bargaining between well-informed buyers and sellers who are not otherwise able to generate business for the other party. Several commenters asserted that this removal would lead to the consideration of the value of a physician's referrals or other downstream revenue when determining fair market value to be an admissible practice. As a result, CMS retained the language in the final definitions of general market value.

In the final rule, CMS reiterated the importance of fair market value determinations not including any downstream revenue or other benefits a certain employer may enjoy for employing a physician. CMS specifically stated that "compensation to or from a physician should not be inflated or reduced simply because the entity paying or receiving the compensation values the referrals or other business that the physician may generate more than a different potential buyer of the items or services. This means that a hospital may not value a physician's services at a higher rate than a private equity investor or another physician practice simply because the hospital could bill for designated health services referred by the physician under the OPPS [Outpatient Prospective Payment System], whereas a physician practice owned by the private equity investor or other physicians would have to bill under the PFS [Physician Fee Schedule], which may have lower payment rates." [4]

With this designation, CMS is reiterating its position that the value of a physician's services should be the same regardless of whether the employing entity is a health system, a private-equity firm, or a physician-owned entity. This position is shared by third-party valuators that value physician service agreements.

NO SAFE HARBORS OR REBUTTABLE PRESUMPTIONS

CMS received several comments on the proposed rule asking CMS to define some safe harbors or rebuttable presumptions that would establish that compensation is always fair market value if certain quantitative definitions were met. However, for many reasons outlined in the "establishing fair market value compensation" section of this article, CMS refused to include any safe harbors or rebuttable presumptions in the final rule.

With clarified definitions of fair market value, but no real guidance on how to safely operate within fair market value, how should organizations proceed in setting their compensation policies in 2021 and beyond?

Fortunately, in most instances, organizations can continue to assess fair market value as they always have, by using salary surveys as a guide to establish compensation and compensation per wRVU rates. CMS confirmed in the final rule that consulting salary schedules or other data sources is still an appropriate starting point, and that surveys may be the only determinant of fair market value that is needed for most physicians.

But given all the changes happening due to the impacts of the COVID-19 pandemic, the 2021 Medicare physician fee schedule, the limitations of the physician compensation surveys themselves, and the industry's continued move from volume to value, VMG Health advises organizations [5] to take a more cautioned and considered approach to surveys when determining fair market value compensation levels, which will be discussed further in a subsequent section.

ESTABLISHING FAIR MARKET VALUE COMPENSATION

The new rules have many organizations questioning what, if anything, they may need to do differently when determining fair market value physician compensation levels going forward. This section discusses the importance of facts and circumstances in an analysis, why a cautioned approach to surveys is warranted, and considerations for value-based payments.

THE IMPACT OF FACTS AND CIRCUMSTANCES

One of the most subtle, but important changes to the definition of fair market value is in the addition of the clause that an arrangement must be consistent with the general market value "of the subject transaction." In adding this clause to the definition of fair market value, CMS has reinforced its belief that fair market value is subject to the unique facts and circumstances associated with a particular transaction being valued, and not necessarily just a data point in a national market salary survey. By doing this, CMS has affirmed what organizations like VMG Health have always believed about fair market value, that facts and circumstances matter and must be carefully considered before finalizing a physician compensation arrangement.

In explaining its decision to add the clause "of the subject transaction" to the definition of fair market value, CMS affirmed two examples the agency previously shared with the proposed rule. Specifically, the organization highlighted that an orthopedic surgeon might typically expect to earn approximately $450,000 in compensation per year according to the physician salary surveys. If an organization is recruiting one of the top orthopedic surgeons in the country, who is highly sought after by professional athletes with knee injuries due to his specialized techniques and high success rates, the physician might command a substantially higher salary than the $450,000 that might be indicated by the median of the physician salary surveys.

CMS used a second example to show that, while the surveys might report compensation values that are too low for some physicians, the surveys might be too high for others. In this example, CMS highlighted a family medicine physician, who according to the salary surveys might typically earn approximately $250,000 per year. An organization recruiting a family medicine physician to an area in which the cost of living is low with good schools and other positive factors, but in which the organization has a poor payor mix and the organization's economic position is tenuous, the value of that physician's compensation may be less than $250,000.

The main take away from these examples is that organizations can use salary surveys as a guidepost for setting physician compensation levels, but organizations must also carefully consider the unique facts and circumstances that apply to each particular arrangement when determining a fair market value level of compensation.

CAUTIONED USE OF COMPENSATION SURVEYS

CMS made several other comments in the final rule that call into question an overreliance on surveys when setting physician compensation. According to the final rule document, CMS received several comments from organizations that suggested it is CMS policy that as long as an organization relies on surveys when setting compensation levels, or if an organization pays its physicians at or below the 75th percentile of the market, the resulting compensation will always be fair market value. CMS vigorously declined those allegations, reiterating that the agency has made no such policies.

Clearly, from the examples of the orthopedic surgeon and the family medicine physician previously discussed, CMS has reiterated that there may be instances where compensation at the very top end of the market (i.e., exceeding the 90th percentile) might be warranted, just as there may be instances where compensation at the median of the market surveys is not warranted.

Based on this, organizations should carefully review their compensation and fair market value policies to determine if their current policies and procedures result in an appropriate level of scrutiny of physician compensation arrangements. Organizations that consider it acceptable to pay up to the 75th percentile of the market as "fair market value" compensation should consider expanding their definition to add checks and balance relative to productivity, quality, or other performance metrics that may support those higher levels of compensation. Fair market value is not a particular percentile of the market, and organizations should err on the side of reviewing more arrangements to ensure continued compliance.

FMV CONSIDERATIONS FOR VALUE-BASED PAYMENTS

Since there has been tremendous growth in payments to physicians associated with value-based goals such as improved quality and cost savings, it is encouraging to have additional guidance for these payments. [6] There are several themes around Stark's exceptions and the AKS' safe harbors that demonstrate what regulatory authorities consider acceptable as it relates to physician compensation associated with value-based arrangements. [7] Further, it is comforting to know that much of the direction provided is consistent with previous favorable gainsharing/shared savings arrangements opinions issued by the OIG. The following provides a summary of salient points to consider when establishing a physician compensation arrangement containing payments for value-based initiatives:

1. Value-based metrics need to be selected based on clinical evidence or credible medical support
2. Value-based payments for outcomes should be based on objective and measurable data
3. Payments for improvement in cost or quality should be rebased annually
4. Be cautious of compensation tied to maintenance goals
5. If the physician takes on downside-risk, it may support higher compensation
6. Include safeguards for quality in arrangements focused on cost savings

Perhaps the most meaningful new guidance as it relates to including value-based compensation in a physician arrangement is that the OIG has loosened the requirement for setting aggregate compensation in advance by requiring only that the "methodology" be set in advance. This allows for true outcomes-based payments. Arrangements can now be structured so that if a physician reaches superior performance for a quality metric contained in an agreement, he or she can earn a higher amount than if only a small improvement in quality was achieved.

KEY TAKEAWAYS

With all the changes happening in the health care industry, organizations must carefully review the processes by which they manage their physician compensation arrangements and determine what changes may need to be made to ensure continued success in 2021 and beyond.

While the new definition of fair market value provides some additional clarity on physician compensation arrangements, by stopping short of providing safe harbors or rebuttable presumptions, CMS did not make it any easier for organizations to determine what is and is not fair market value. However, in formalizing the new rules, CMS did provide some guidance for organizations to consider.

Most importantly, organizations must review the facts and circumstances that apply to a particular engagement before determining what level of compensation should be provided. In many cases, consulting with the industry surveys may be all an organization needs to do. But in other cases where the facts and circumstances vary from the typical physician in the organization, survey values may be insufficient.

In its final rule document, CMS thoroughly covered compensation surveys and how their use (and, frankly, their misuse) might result in compensation arrangements that are not fair market value. Organizations should consider what surveys they use in their compensation plans, the methodology behind those surveys, and the organization's internal fair market value guidelines to make sure that compensation arrangements are given an appropriate level of review prior to being enacted. This exercise will not get any easier in 2021 – 2023, as the surveys will be impacted by COVID-19 (2021) the CMS physician fee schedule (2022-2023) and the continued move away from volume and towards value-based care (2021-2023).

With all the changes happening in the healthcare industry right now, 2021 might just be the perfect time to consider strategic changes to an organization's physician compensation plans. A contemporary compensation plan can ensure that compensation continues to be consistent with fair market value while also moving an organization further along the volume-to-value curve.

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