PHYSICIAN COMPENSATION REGULATIONS - WHAT ARE FAIR MARKET VALUE OPINIONS AND WHEN AND WHY DO YOU NEED THEM?

Georgia Hospice & Palliative Care Organization

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BACKGROUND
DEFINITIONS

HOSPICE CARE

Hospice care is an approach to caring for the terminally ill individual that provides palliative care rather than traditional medical care and curative treatment.

PALLIATIVE CARE

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other issues.

Hospice care and palliative care are not the same thing. Hospice care includes palliative care. Not all palliative care is hospice care.
DISTINCTIONS

HOME CARE

Hospice care allows the patient to remain at home as long as possible by providing support to the patient and family, and by keeping the patient as comfortable as possible while maintaining his or her dignity and quality of life.

INTERDISCIPLINARY APPROACH

A hospice uses an interdisciplinary approach to deliver medical, social, physical, emotional, and spiritual services through the use of a broad spectrum of caregivers.
Centers for Medicare & Medicaid Services (CMS) develops Conditions of Participation (CoPs) that healthcare organizations, including hospices, must meet in order to begin and continue participating in the Medicare and Medicaid programs.

**A hospice must routinely provide substantially all core services. These services must be provided in a manner consistent with acceptable standards of practice.**

The hospice is required by the CoPs at Section 418.100 to make nursing services, physician services, drugs, and biologicals routinely available on a 24-hour basis, 7 days a week. It also has to make all other covered services available on a 24-hour basis, 7 days a week, when reasonable and necessary to meet the needs of the patient and family.
MEDICARE REQUIREMENTS

§418.64(a) PHYSICIAN SERVICES

The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient’s attending physician, are responsible for the palliation and management of the terminal illness, conditions related to the terminal illness, and the general medical needs of the patient.

- (1) All physician employees and those under contract, must function under the supervision of the hospice medical director.

- (2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician.

- (3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.
PHYSICIAN ROLES

- Medical Director
  - A single individual doctor of medicine or osteopathy who leads and bears responsibility for the medical component of the hospice’s patient care program. Employed or contracted by hospice.

- Hospice Physicians
  - Doctors of medicine or osteopathy designated by the hospice who assume the same responsibilities and obligations as the medical director when the medical director is not available. Employed or contracted by the hospice.

- Attending Physicians
  - The physician who is identified by the individual as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care. Not employed, contracted, or compensated by the hospice.
MEDICAL DIRECTOR/HOSPICE PHYSICIAN RESPONSIBILITIES

- Certify and Re-Certify Terminal Illness:
- Face-to-Face Encounters
- Cover for the Attending Physician
- IDG Participation
- On-Call Coverage
- Many Others
REIMBURSEMENT — PHYSICIAN SERVICES

• Each hospice is reimbursed at a daily rate for each patient, depending on the patient’s level of care. In its “FY 2016 Hospice Wage Index and Payment Rate Update,” CMS established a two-tiered payment system for patients receiving routine home care. The Medicaid hospice benefit is required to be the same in amount and method as the Medicare hospice benefit, although there are slight variations
  • Routine Home Care: Patient Days 1-60 $186.84
  • Routine Home Care: Patient Days 61+ $146.83

• Hospices pay medical directors and designees for their services. These physicians cannot bill payers or patients for their services. When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her
REIMBURSEMENT — PHYSICIAN SERVICES

- (continued) terminal illness during any period his/her hospice benefit election is in force, except for professional services of an independent attending physician who is not an employee of the designated hospice nor receives compensation from the hospice for those services.

- Independent attending physician services are billed through Medicare Part B to the Medicare contractor, provided they were not furnished under arrangement with the hospice.

- The hospice FTF encounter is part of a hospice's administrative services and is not billable. However, if the physician or NP (who was identified by the patient as their attending physician) provides services that are medically reasonable and necessary while conducting the FTF, that portion of the visit can be billed by the hospice.
COMPLIANCE
ANTI-KICKBACK

Because kickbacks can distort medical decision making, result in overutilization, and have an adverse effect on the quality of care patients receive, they are prohibited under the Federal health care programs, including Medicare and Medicaid. Under the anti-kickback statute, it is a criminal offense to knowingly and willfully solicit, receive, offer, or pay anything of value to induce referrals of items or services payable by a Federal health care program.

2 Safe Harbors
- Bona Fide Employment
- Personal Services and Management Contracts Safe Harbor
  - the agreement is set out in writing, specifies the services covered by the agreement and provides that the services are being provided for the term of the agreement;
  - the agreement specifies the schedule, length and exact charge for intervals of services, if not full-time services;
  - the term of the agreement is not less than one year;
  - the compensation paid under the agreement is set in advance, consistent with fair market value in an arm’s length transaction, and does not take into account the volume or value of referrals or other business generated between the parties for which payment may be made in whole or in part by Medicare or Medicaid;
  - the services performed under the agreement do not involve the promotion of business arrangements or other activities that violate any state or federal law; and
  - the aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.
ANTI-KICKBACK

- Problems
  - Compensating a physician above fair market value for medical director or hospice physician services
    - U.S. v. Lipkis, 770 F.2d 1447, 1449 (9th Cir. 1985): To the extent that a payment exceeds FMV, it can be inferred that the excess amount over FMV is intended as payment for the referral of health-program business.
  - Compensating a physician for services that are not needed or are inappropriate
  - Compensating a physician for services that are never provided
    - USA v. Eugene Goldman, M.D., 2013: Dr. Goldman was recently sentenced to 51 months in a federal prison, ordered to pay $300,000 in fines, and excluded from participating in Medicare and Medicaid for violating the federal Anti-Kickback Statute.
      - The government proved that Goldman, a hospice medical director, received payment for referring patients to the hospice and not for services rendered.
      - From January 2003 to July 2011, Dr. Goldman received approximately $309,000 in illegal payments for patient referrals. In January, February, and March 2009, Dr. Goldman was captured on tape receiving kickbacks for patient referrals.
COMMERCIAL REASONABLENESS

Questions

- Does the arrangement make business sense even if the parties were not in a position to refer business to one another?
- Is a physician/specialist required to perform the service?
- Can you get the same services from a less expensive source?
- Are the duties and responsibilities of the physician clearly identified in the agreement?
- Does the size and scope of the hospice warrant the number of physicians you have in the same role?
- Are you paying the physician for 2 activities at the same time?

*If even one purpose of the arrangement is to induce referrals there is a problem. Even if other, legitimate reasons exist.

*Both FMV and Commercial Reasonableness are required.
ANTI-KICKBACK PENALTIES

Criminal:
Fines up to $25,000 per violation
Up to a 5 year prison term per violation

Civil/Administrative:
False Claims Act liability
Civil monetary penalties and program exclusion
Potential $50,000 CMP per violation
Civil assessment of up to three times amount of kickback
**RISK AREAS**

When:

- hospice pays a fee to a physician for each certification of terminal illness
- when the physician bills for services that are duplicative of the care that the hospice is required to provide its patients
- instances where a hospice provides nursing, administrative, and other services for free or below fair market value to physicians, with the intent to influence referrals
- contracting with a physician medical director with no palliative care experience who also is in a position to be a significant referral source
- contracting with multiple medical directors whose combined aggregate services are unnecessary
- contracting with a medical director who also is a nursing home medical director in a position to generate significant referrals.

https://www.healthlawyers.org/Members/PracticeGroups/Documents/EmailAlerts/Physicians_Sep11.pdf
RECENT ENFORCEMENT ACTIONS
FAIR MARKET VALUE
PHYSICIAN
COMPENSATION
FAIR MARKET VALUE

Fair market value means the value in arm’s-length transactions, consistent with the general market value. “General market value” means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals. 69 FR 16093
What is it?

- The price interested, not desperate, well-informed buyers and sellers would agree to pay/accept.
- The price paid under a reasonable timeframe.
- The value of the physician’s personally performed services.
- What buyers and sellers would pay/accept when the two are not in a position to refer business to one another.
- Prospective pay and set in advance

What is it not?

- What you hear the other hospice down the road is paying.
- The revenue the physician will lose in his practice because he’s at the hospice.
- A percentage of the hospice’s revenues or profits.
- A commission
- Retrospective pay
BASIC VALUATION STEPS

- Identify the services being valued
- Identify the purpose of the valuation
- Specify the standard of value
- Determine the appropriate valuation date and valuation period
- Consider the three valuation approaches
  - Cost Approach
  - Market Approach
  - Income Approach
- Choose the appropriate approach(es)
- Perform the analysis
- Describe the assumptions made
- Reconcile the values
MARKET DATA

- Physician Group Associations
  - Medical Group Management Association
  - American Medical Group Association

- Data Companies
  - Hospital & Healthcare Compensation Service

- Consulting Companies

- Industry Associations Government Sources
  - Bureau of Labor Statistics ("Careers in Hospice Care")
  - General Services Administration (GSA.gov)
  - Form 990s (Guidestar.org)
  - Recruiting (USAJOBS.gov)

- Online Resources
  - Medscape Physician Compensation Survey
  - Online classifieds (indeed.com, practicelink.com)
  - Salary databases (payscale.com)
**MARKET DATA**

**Using the Data**

- Defining compensation
- Picking the comparable specialty
- Choosing the appropriate benchmark percentile range
  - Premiums for board certification
  - Impact of tenure, experience, qualifications
- Converting data into a useable format
  - Independent Contractors
  - Part-time
  - Hourly

**Guidance**

- Stark II Phase II safe harbor for calculating hourly compensation for physicians
  - Average of median compensation
  - 2,000 hours denominator

- The DOJ/FTC Antitrust Safety Zone: Participating in salary surveys/exchanging salary information
  - The survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);
  - The information provided by survey participants is based on data more than 3 months old; and
  - There are at least five providers reporting data upon which each disseminated statistic is based, no individual provider’s data represents more than 25% on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.
Avoid Confusion....

Define "Compensation" Before Discussing It

**Paystub Definition**
- Base Pay
- Bonuses
- Gross Pay
- Employee-Paid Benefits
- Taxes Withheld
- Net Pay

**W2 Definition**
- Base Pay
- Bonuses
- Taxable Non-Cash Benefits
- Employee's Non-taxable 125 Plan Expenses
- Medicare Wages (Box 5)
- Employee's Retirement Contributions & Deferred Comp
- Wages, Salaries, Tips, Etc. (Box 1)

**HR Definition**
- Total Cash Compensation
- Employer-Paid Benefits & Expenses
- Job Perks (Training, Flexible Schedule)
- Other Intangibles
- Total Compensation Package

**Tax Return Definition**
- Wages, Salaries, Tips, Etc. (Line 7)
- Business Income
- Dividends
- Capital Gains
- Other Taxable Income
- Total Income (Line 21)
- Adjustments and Deductions
- Adjusted Gross Income (Line 31)
COMPENSATION BENCHMARKS

### Cost of Physician Staffing Services

**Hourly Rates for On-Site Work and On-Call Coverage**

2016  
BUCKHEADFMV.com

### Physician On-Site Hourly Rates

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<th>SN</th>
<th>Specialty Description</th>
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<th>25th %ile</th>
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### Physician Weekend On-Call Hourly Rates

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Compensation Benchmarks

Blend of 2016 Physician Survey Data
Hospice - Palliative Care

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<th>25th Percentile</th>
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<td>$210,000</td>
<td>$238,500</td>
<td>$248,700</td>
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NOTE:
Median MGMA compensation for hospice physicians increased 4.8% from 2014-2015 and 11.5% from 2015-2016 surveys

*Data reflects total annual compensation paid to physicians (salaries and bonuses), but does not include benefits.
**COMPENSATION BENCHMARKS**

Blend of 2016 Physician Survey Data
Hospice Palliative Care –
Converted to Hourly Rates

![Bar graph showing hourly rates for different percentiles and hours.]

- **25th Percentile**
- **Median**
- **Mean**
- **75th Percentile**
- **90th Percentile**

- **1,840 Hours**:
  - 25th Percentile: $114
  - Median: $130
  - Mean: $147
  - 75th Percentile: $178
  - 90th Percentile: $135

- **2,000 Hours**:
  - 25th Percentile: $105
  - Median: $119
  - Mean: $124
  - 75th Percentile: $135
  - 90th Percentile: $163
COMPENSATION BENCHMARKS

- Should these benchmarks be used for administrative and clinical work?
  - Administrative work
    - Part A Work
      - Medical director
      - Designee work
      - FTF encounters
      - IDG work
  - Clinical work
    - Part B Work

- Clinical work can be compensated several different ways
  - Hourly
  - Fee schedule
  - Percentage of Medicare
  - WRVU
    - Why you can’t use hospice benchmarks in surveys ($123/WRVU example)
BEST PRACTICES

- Pay (or tie back to) an hourly rate
- Cap administrative hours
- Acknowledge independent contractor expenses (payroll, etc.)
- Use a defendable denominator in hourly rate calculations
- Understand that not all physician time is equal and not all physician activities are equal
- Recognize that a physician’s opportunity cost is not necessarily fair market value
- Think about how you will administer the plan.
- Keep it simple.
- Review and monitor work effort and hours.

- Don’t pay without documentation that substantiates services were provided.
- Pay only for what you legitimately need.
- Consider the aggregate expense.
- Model your changes before implementing.
- Monitor agreements and compensation.
- Use an attorney
  - Employment law issues
  - State law issues
PHYSICIAN COMPENSATION CHALLENGES FOR HOSPICE PROVIDERS
Q1 — HOW DO WE PAY OUR PHYSICIANS AN HOURLY RATE IF THEY WILL NOT DOCUMENT THEIR TIME?
DISCUSSION

- Stipend problem: physicians don’t document hours so hard to justify FMV
- Hourly rate problem: physicians don’t document hours so they don’t get paid enough
- Task pay: assumes it is easier to track meetings, encounters, on-call shifts
- Time documentation does not go away
- You have to do some work. What is the standard for:
  - On-call shifts?
  - Encounters?
  - Meetings?
  - Different across locations?
Q2 — HOW DO WE COMPENSATE OUR MEDICAL DIRECTOR FOR BEING AVAILABLE 24/7?
**DISCUSSION**

- Different types of on-call
  - Restricted: on-site requirement
  - Unrestricted: response time requirement (telephonically and/or in person)

- How is on-call compensated?
  - Per-diems
  - Hourly
  - Proxies
  - Fee-for-service

- On-Call compensation drivers
  - Phone calls
  - Return to work
  - Rotation
  - First responder
  - Back-up

- Considerations
  - Average time of services provided while on call – not otherwise compensated
  - On-call rates for nurses, other professionals, locums
    - % of hourly rate
    - $1-$6 hour
    - Hour of pay for certain number of on-call hours
Q3- HOW DO WE COMPENSATE OUR PHYSICIANS FOR ALL THE DRIVE TIME?
DISCUSSION

- Employee v. independent contractor issues
- How are independent contractors typically compensated for travel time?
- When is travel necessary?
- How consistent are the travel requirements?
- Considerations:
  - Task pay that factors in travel time
Q4- CAN I PAY PHYSICIANS TO BE ON AN ADVISORY COMMITTEE?
DISCUSSION

United States ex rel. DePace v. Cooper Health System resulted in a $12.5 Million Settlement related to a “sham” advisory board

Checklist:

- There is a clearly identified purpose for the meeting
- Participants were chose based on objective selective criteria
- Participant referrals or potential referrals were not a criteria
- The specialties of the physicians are necessary based on purpose/agenda
- Meeting materials were provided ahead of time
- Active participation is required
- Hospice services will not be marketed during the meeting
- Attendance will be tracked
- Participants will not be paid for downtime
- The venue is appropriate; meals are appropriate for a business meeting
- A FMV compensation rate has been established based on the work the physicians will perform during the meeting
WHAT IS AN FMV OPINION?

- An opinion that a physician’s compensation (past, present, future) is within the fair market value range.

  Conclusion: The proposed compensation is fair market value.

- An opinion of how much a physician’s services are worth assuming the fair market value standard.

  Conclusion: Fair market value for the duties or services described herein is $100,000 per year.

- Opinion = Appraisal = Valuation

- Opinion can be verbal (caution); emailed; in written report form.
**WHEN TO GET AN FMV OPINION?**

- If you need an opinion – get an opinion – not a calculation of value.
- If you set it up right; you don’t need an FMV opinion every time.
- Develop a Compensation Philosophy Statement
  - Goals of the compensation program
  - Tools to achieve goals
  - Fair Market Value ranges
  - Approach to special situations and updates
- Get a FMV opinion:
  - For any new or creative arrangement
  - Highly compensated physicians
  - For special situations
  - At regular intervals
WHY WOULD YOU WANT AN OUTSIDE FMV OPINION?

- There is no statutory requirement for an outside appraisal and no rebuttable presumption
- Demonstrate good intent
  - “good faith reliance on a proper valuation may be relevant to a party’s intent, [however] it does not establish the ultimate issue of the accuracy of the valuation figure itself.” 69 Fed. Reg. 16107 (March 26, 2004)
- Avoid skepticism about independence / objectivity
- Better access to data and industry practices
- Use of sounds valuation principles and methodologies
- Courts have relied on persuasive evidence from appraisers
- Appraisers have skin in the game
  - Reputation
  - Liability
  - Ethics / professional standards
WHAT YOU SHOULD ASK YOUR APPRAISER

Before

- Experience with valuation and valuation credentials
- Experience with healthcare law and hospice providers
- Which professional valuation standards will be used?
- Who will sign the report?
- Will a commercial reasonableness assessment be included?
- How much can I rely on this opinion?
- What are the professional fees and how long will it take?

After

- Appraiser’s perception of transaction risk
- Appraiser’s level of confidence in conclusion
- Limiting conditions and assumptions
WHAT THE APPRAISER WILL ASK

- What services do you need appraised?
  - 1 physician or 20 physicians
  - 1 market or 20 markets

- How are physicians paid now?

- What time period do you need reviewed?

- Background information
  - Overview of market (demographics, geography)
  - Census, LOS
  - Unique attributes of market

- Number of medical directors and annual expense

- Physician information
  - Background
  - Contract terms
  - Visits, meetings, time logs
  - Payments
  - Census Covered

- Timeframe and budget
# DO'S AND DON’TS

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<tr>
<th>DOs:</th>
<th>DON’Ts:</th>
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<td>Provide the appraiser with organized data</td>
<td>Hand over a mess</td>
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<tr>
<td>Fulfill the data request plus any important information not requested</td>
<td>Withhold data</td>
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<tr>
<td>Provide context and explain situations/circumstances</td>
<td>Assume the appraiser understands the innerworkings of your organization</td>
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<tr>
<td>Have reasonable time and cost expectations</td>
<td>Waste your time and money</td>
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<tr>
<td>Provide more information if you believe the appraiser is being shortsighted or is missing something</td>
<td>Strong-arm or plead with the appraiser</td>
</tr>
<tr>
<td>Take accountability and responsibility for the decisions made</td>
<td>Think the appraiser is going to be the scapegoat</td>
</tr>
<tr>
<td>Find an appraiser that is reasonable to work with and learns your organization</td>
<td>Appraisal shop</td>
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QUESTIONS?

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