



WHEN FMV IS NOT ENOUGH: *How to Not Get Crushed Between a Competitive Hiring Market and Regulatory Constraints*

Presented by:
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-  **Help!**
How to effectively work with high-pressure operators
-  **Vogue**
The tried and true, the new flavors, and the “so last season”
-  **Wide Open Spaces**
What flexibility do entities have, really, when it comes FMV and CR
-  **Money, Money, Money**
Creative ways to increase compensation, while staying on the right side of the law
-  **Level Up**
Practical tips to level up your provider compensation function from hiring to start

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Help!

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Help! I need somebody.

**Is this really an
emergency?**

□ □ □ □ □

How to effectively work with high-
pressure operators



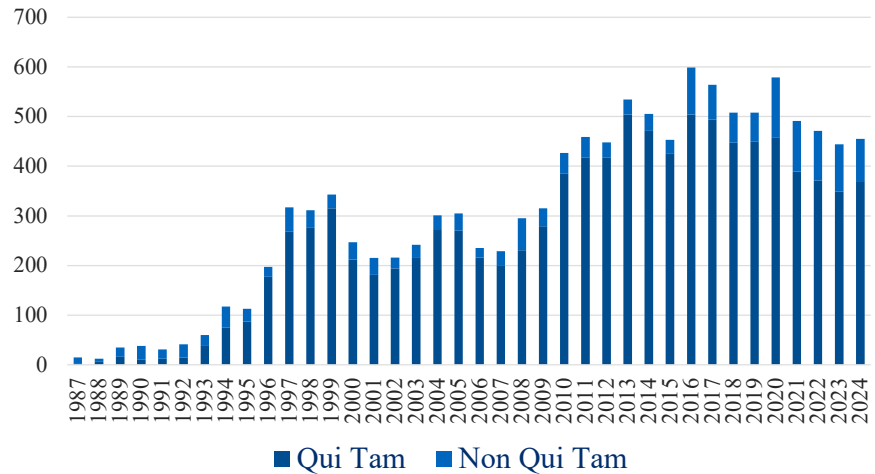
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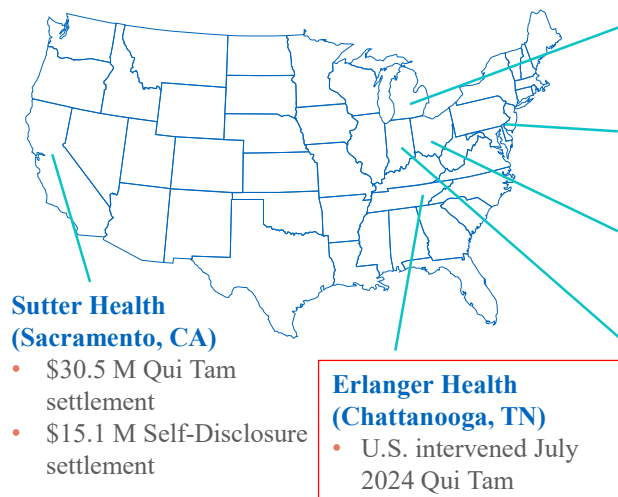
Enforcement

- **FCA total recoveries**
 - \$2.9B in FY 2024
 - \$2.7B in FY 2023
 - \$2.2B in FY 2022
 - \$5.7B in FY 2021
 - \$2.3B in FY 2020
- **Healthcare represents 57% of FCA recoveries**
 - \$1.7B in FY 2024
 - \$1.9B in FY 2023
 - \$1.8B in FY 2022
 - \$5.1B in FY 2021
 - \$1.9B in FY 2020

False Claims Act Filings



Settlements



Sutter Health (Sacramento, CA)

- \$30.5 M Qui Tam settlement
- \$15.1 M Self-Disclosure settlement

Erlanger Health (Chattanooga, TN)

- U.S. intervened July 2024 Qui Tam

William Beaumont Hospital (Detroit, MI)

- \$84.5 M settlement and CIA
- Qui tam

ChristianaCare (Wilmington, DE)

- \$42.5 M settlement
- Qui tam

Mercy Health (Cincinnati, OH)

- \$14.25 M settlement
- Self-Disclosure

Community Health Network (Indianapolis, IA)

- \$345 M settlement and CIA
- Qui tam

Lessons Learned

CHN – CFO Whistleblower:

- CIA
- IRO for claims **AND** physician financial payments
- **Compliance expert hired**

Red Flags:

- Doubled salaries
- False info to FMV firms
- Ignored FMV firm advice
- Incentives for service line revenue
- Many paid > 90th percentile

Erlanger

- 2005 \$40M FCA Settlement & CIA 2010
- 2024 U.S. intervenes 2024 in qui tam case filed by CCO and CFO

Red Flags:

- Two to three times Median
- False info to FMV firms
- Ignored FMV firm advice
- Changed processes and eliminated CCO
- Compensation for services not performed
- Exorbitant sign-on and retention bonuses

Compensation Models and Policies

A

Benchmarks and Industry Standards by Service

B

Internal FMV Assessment and CR Documentation

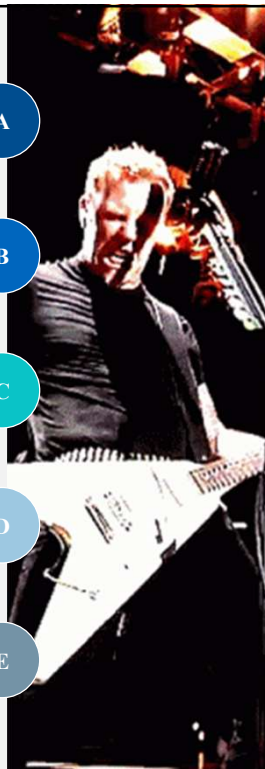
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Technology Resources

D

Third-Party Partners

E



*Help me get my feet back on the ground
Won't you please, please help me?*

Fight Fire with Fire

Emergencies will always arise. The best way to respond quickly to organizational needs, while remaining compliant, is to prepare by developing policies, processes, systems, resources, and partners to help.



Vogue

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*What are you looking at?
Strike a pose.*

Provider Compensation Model Trends

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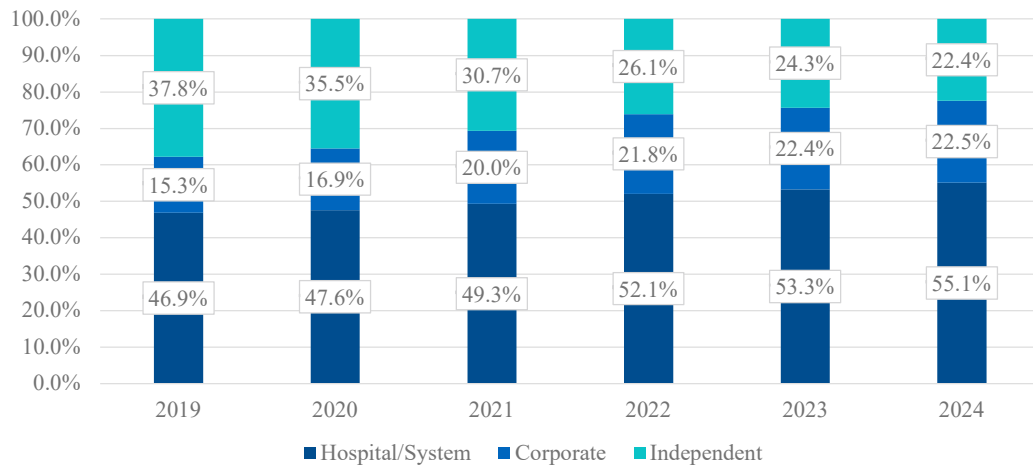
The tried and true, the new flavors, and
the “so last season”



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Physician Employment Trends



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Tried and True

Clinical Compensation

- wRVU-Based Productivity Models are your LBD
- Base Salaries are timeless

Call Coverage

- Required, uncompensated level of call are timeless (approximately 5 days per month)
- Compensation only for additional, excess call is iconic

Medical Director

- Primarily hourly with time sheet requirements in stylish (best practice)

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Tried and True – Compensation Trends

- **Compensation continues to increase steadily:**

- Year-Over-Year on par with cost of living
- But than productivity increases have outpaced compensation
- Compensation per wRVU has declined

TCC	2023 to 2024	2020 to 2024
Primary Care	3.17%	14.90%
Surgical	5.57%	17.44%
Non-Surgical Specialists	4.74%	12.56%
APP	3.80%	19.39%
CPI	2.90%	21.20%

Tried and True – Compensation Trends

Specialty	2023 to 2024			2020 to 2024		
	Δ TCC	Δ wRVUs	Δ TCC/wRVU	Δ TCC	Δ wRVUs	Δ TCC/wRVU
General Cardiology	7.33%	8.54%	-2.10%	20.56%	35.51%	-9.90%
Internal Medicine	2.80%	3.76%	-0.58%	13.93%	35.05%	-10.98%
Hematology/Oncology	5.92%	7.36%	3.70%	22.41%	42.29%	-12.38%
Neurology	1.10%	4.55%	-2.82%	11.57%	15.74%	-5.80%
Radiology	4.05%	7.82%	2.36%	18.41%	36.03%	-8.55%

So Last Season

Clinical Compensation

- Pure Salary Models are dated
- Pure Productivity Models are dated
- Collection-Based Productivity Models are passé

Quality Compensation

- Not paying for quality is square
- Co-Management Arrangements are getting a wardrobe refresh

APP Supervision

- Not paying for APP Supervision is old-fashioned

So Last Season

Compensation Methodology Trends



New Flavors

Clinical Compensation

- Base Salaries plus quality are in vogue
- Productivity (based on wRVUs) are in vogue
- Base Salaries with work standards are trending

Quality Compensation

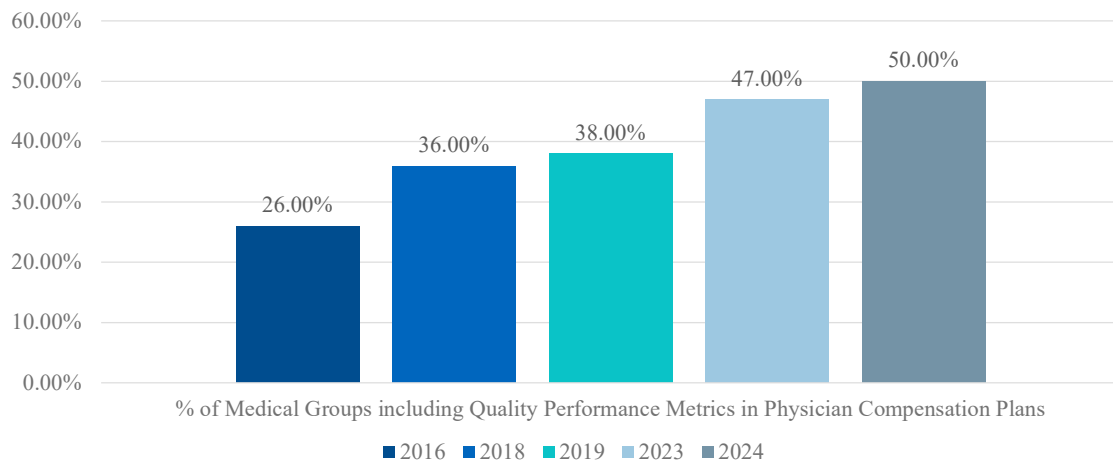
- Quality is emerging as a consistent compensation component like a good pair of jeans
- VBAs/OBPAs and ACOs/CINs are snazzy

Other Compensation

- Medical Director – Protected FTEs or Annual Stipends are modern
- Call Coverage – Increasing Across Specialties, Rates and Days compensated are hot
- APP Supervision – Annual Stipend is all the craze

New Flavors - Quality

MGMA Stat poll Trend



New Flavors: AKS - OBPA's

- **Personal Services and Management Contracts** safe harbor new protection for **Outcomes-Based Payment Arrangements** ("OBPA"): where payments are "tied to achieving measurable outcomes that improve patient or population health or appropriately reduce payor costs."
- Requirements to comply with the OBPA safe harbor include:
 - Measures must be based on clinical evidence or credible medical support
 - Measures must have benchmarks that are used to quantify:
 1. Improvements in, or the maintenance of improvements in, the quality of patient care;
 2. A material reduction in costs to or growth in expenditures of payors while maintaining or improving quality of care for patients; or
 3. Both.
 - Measures must be assessed and revised periodically

New Flavors: AKS - OBPA's

- The **compensation methodology** must be:
 - set in advance
 - CR
 - consistent with FMV
 - not take into account the VOV of referrals
- There must be a **written agreement** with a term of at least **one year** that includes:
 1. A general description of services;
 2. The outcome measures that must be achieved for payment;
 3. The clinical evidence or credible medical support used to select the outcome measures; and
 4. The schedule by which the outcome measures will be regularly monitored and assessed.

New Flavors: AKS - OBPA's



Metric strength
Score

Strength of Metric Considerations		Example Metric Assessment
Selection and number of meaningful metrics: ≥ 5		4 metrics
Metric Type: outcomes vs process		4 metrics
Metric Source: national vs internal		National
Superior Quality Performance:	top decile vs stretch	2 metrics at 90 th tile 2 metrics at 75 th %tile
	stretch goal vs maintenance	2 metrics maintenance
		2 metrics stretch

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New Flavors: AKS - OBPA's



Incentive
Percent

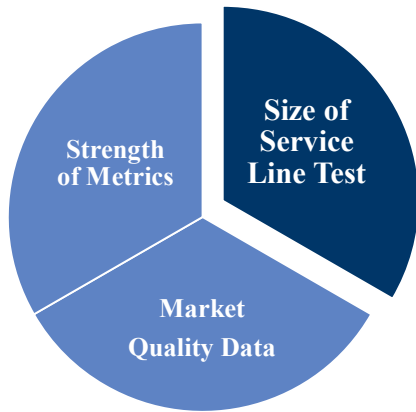
Market Quality Data Consideration	Example Quality Data
Quality Payment Program (QPP)	2%-10%
Industry Publications	3%-15%
National Surveys - Physicians	2%-35%
National Surveys – Healthcare Executives	7%-28%
Other	1%-10%

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New Flavors: AKS - OBPA's



Test
MET

Service Line Size Consideration	Example Service Line Revenue
Service Line Revenue ("SLR"):	\$5,000,000
FMV Conclusion – Outcomes-Based Payments	\$50,000 / Physician (2 Total)
FMV Conclusion as a % of SLR	2.0%



Wide Open Spaces

My heart wants to sing

Flexibilities for Entities in FMV and CR

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“Fo real” flexibilities systems,
facilities, and practices have when it
comes to FMV and CR



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DEFINITIONS

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DEFINITIONS SOME ARE EASY



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“Transportainment”



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“Transportainment”

A made-up word meaning exactly what it sounds like.

□ □ □ □ □ □

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DEFINITIONS SOME ARE EASY

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DEFINITIONS

SOME ARE ~~EASY~~ HARD



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Level-set: Updated FMV and CR Definitions

- **Fair Market Value**: The value in an arm's-length transaction, consistent with the **general market value** of the subject transaction.
 - **General Market Value**: 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**.
- **Commercially Reasonable**: The particular arrangement furthers a **legitimate business purpose** of the parties to the arrangement and is **sensible**, considering the characteristics of the parties, including their size, type, scope, and specialty. An arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties.

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FMV-Free: Getting Out From Under the Elephant

These 16 Stark Compensation Exceptions Do Not Include an FMV or a CR Requirement:

- Physician recruitment
- Certain arrangements with hospitals
- Charitable donations by a physician
- Nonmonetary compensation
- Medical staff incidental benefits
- Risk-sharing arrangements
- Compliance training
- Referral services
- Obstetrical malpractice insurance subsidies
- Professional courtesy
- Retention payments in underserved areas
- Community-wide health information systems
- Electronic prescribing items and services
- Electronic health records items and services
- Arrangements that facilitate value-based health care delivery and payment
 - Full Financial Risk; Value-Based Arrangements with Meaningful Downside Risk
- Cybersecurity technology and related services

3 More Requiring FMV, but Not CR:

- Personal service arrangements
- Payments by a physician
- Assistance to compensate a NPP

1 More Requiring CR, but Not FMV:

- Arrangements that facilitate value-based health care delivery and payment
 - Value-Based Arrangements

FMV-Free, A Deeper Dive: **Value-Based**

Full Financial Risk

Value-Based Arrangements with Meaningful Downside Risk to Physician

Value-Based Arrangements

FMV-Free, A Deeper Dive: **Value-Based**

Full Financial Risk

FMV-Free, A Deeper Dive: **Value-Based**

Full Financial Risk

- Value-based enterprise is at **full financial risk during entire duration** of value-based arrangement
 - Value-based enterprise is financially responsible on a prospective basis for cost of all patient care items and services covered by applicable payor for each patient in target patient population for a specified period of time.
 - Value-based enterprise has assumed financial responsibility for cost of all patient care items and services covered by applicable payor prior to providing patient care items and services to patients in target patient population.
- Payment is for value-based activities undertaken for **patients in the target patient population**
- Payment is **not an inducement to reduce or limit medically necessary items or services** to any patient
- Payment is **not conditioned on referrals of non-VBE patients or other unrelated business**
- If Payment to physician is conditioned on referrals to a particular provider, value-based arrangement must:
 - Set out referral requirement in writing and signed by parties
 - Make referral requirement inapplicable if patient expresses a preference for a different provider; patient's insurer determines provider; or referral is not in patient's best medical interests
- **Must maintain records of methodology for determining actual amount of payment** under value-based arrangement for at least 6 years and make available to Secretary upon request

FMV-Free, A Deeper Dive: **Value-Based**

Value-Based Arrangements with Meaningful Downside Risk to Physician

FMV-Free, A Deeper Dive: **Value-Based**

Value-Based Arrangements with Meaningful Downside Financial Risk to Physician

- Physician is at **meaningful downside financial risk for failure to achieve value-based purpose(s) during entire duration** of value-based arrangement
 - Physician is responsible to repay or forgo no less than 10 percent of the total value of the payment physician receives under value-based arrangement
- Description of nature and extent of physician's downside financial risk is **set forth in writing**
- Methodology used to determine amount of payment is **set in advance of undertaking of value-based activities**

Plus All Same Requirements as for Full Financial Risk (Except Meaningful Downside Risk (Above), Instead of Full Financial Risk)

FMV-Free, A Deeper Dive: **Value-Based**

Value-Based Arrangements

FMV-Free, A Deeper Dive: Value-Based

Value-Based Arrangements

- Arrangement is **set forth in writing** signed by parties, including description of:
 - Value-based activities and how they will further value-based purposes
 - Target patient population
 - Type or nature of payment and methodology used to determine
 - Measurable and clinically based outcome measures related to quality or cost against which performance is assessed
- Methodology used to determine amount of payment is **set in advance of undertaking of value-based activities**
- Arrangement is **commercially reasonable**
- At least **annual monitoring** (and termination of activities, where appropriate) of:
 - Whether value-based activities have been furnished
 - Whether and how continuation will further value-based purposes
 - Progress toward attainment of outcome measures

Plus All Same Requirements as for Full Financial Risk (Except No Full Financial Risk)

FMV-Free, A Deeper Dive: Recruitment, Retention

Physician Recruitment

- Payments directly to physician and intended to induce physician to relocate medical practice to geographic area served by hospital, FQHC, RHC, or rural emergency hospital to become a member of facility's medical staff, if:
 - Arrangement is set out in writing and signed by both parties;
 - Arrangement is not conditioned on physician's referral of patients to facility;
 - Payment under arrangement is not determined in any manner that takes into account the volume or value of actual or anticipated referrals by physician or other business generated between parties; and
 - Physician is generally allowed to establish staff privileges at any other hospital(s) and to refer business to any other entities.
- There are also:
 - Exceptions to relocation requirement for residents and new physicians, former public servants
 - Additional requirements where recruited physician joins a practice

FMV-Free, A Deeper Dive: Recruitment, Retention

Physician Retention

- Payments by hospital, FQHC, RHC, or rural emergency hospital directly to physician on medical staff to retain physician's medical practice in geographic area, if:
 - Either:
 - Physician has a bona fide firm, written offer from another hospital or physician organization requiring physician to leave the geographic area and payment is subject to same obligations related to repayment or forgiveness as bona fide written offer; OR
 - Physician provides a written certificate, satisfying certain requirements, stating that physician has a bona fide opportunity for future employment by another hospital or physician organization requiring physician to leave the geographic area and the facility takes reasonable steps to verify the opportunity;
 - Payment is capped at levels set out in regulation;
 - Same requirements for physician recruitment exception are satisfied.
 - Physician's current practice is in a rural or HPSA or an area with demonstrated need or at least 75% of physician's current patients are medically underserved;
 - Retention payment is not paid to same physician more than once every five years
 - Amount and terms of payment are not altered during the term to reflect volume or value of referrals or other business generated

Flexibility in Determining FMV (*If You Must*)

- Industry benchmarks and surveys are not dispositive
- CMS allows a more contextual, fact-based analysis
 - “We continue to believe that the fair market value of a transaction—and particularly, compensation for physician services—may not always align with published valuation data compilations, such as salary surveys.”

Flexibility in Determining FMV (*If You Must*)

- Industry benchmarks and surveys are not dispositive
- CMS allows a more contextual, fact-based analysis



Flexibility in Determining FMV (*If You Must*)

Actual Words from CMS, For Real:

- Assume a hospital is engaged in negotiations to employ an orthopedic surgeon.
- Independent salary surveys indicate that compensation of \$450,000 per year would be appropriate for an orthopedic surgeon in the geographic location of the hospital.
- However, the orthopedic surgeon with whom the hospital is negotiating is **one of the top orthopedic surgeons in the entire country** and is highly sought after by professional athletes with knee injuries due to his specialized techniques and success rate.
- Thus, although the employee compensation of a hypothetical orthopedic surgeon may be \$450,000 per year, this particular physician commands a significantly higher salary.
- In this example, **compensation substantially above \$450,000 per year may be fair market value.**

Flexibility in Determining FMV (*If You Must*)

Can't Get Enough? More Words from CMS:

- In an area that has two interventional cardiologists but no cardiothoracic surgeon who could perform surgery in the event of an emergency during a catheterization, **a hospital may need to pay above the amount indicated at a particular percentile in a salary schedule to attract and employ a cardiothoracic surgeon.**

Note, though, CMS has indicated this goes both ways: appropriate compensation may be below the survey data.

- A variety of factors could affect whether the amount shown in a salary schedule is too high or too low to be fair market value for the services of the subject transaction. In some instances, it is exactly right.
- **Parties do not necessarily fail to satisfy the fair market value requirement simply because the compensation exceeds a particular percentile in a salary schedule; nor are parties required to pay a physician what is shown in a salary schedule if the specific circumstances do not warrant that level of compensation.**

Flexibility in Determining FMV (*If You Must*)

- Allowable Evidence of FMV (Per CMS):
 - Internal cost data
 - Historical compensation records
 - Business case rationale

Flexibility in Determining CR (*If You Must*)

- CR is not a valuation question
- Whether arrangement is profitable is not determinative
 - “Compensation arrangements that do not result in profit for one or more of the parties may nonetheless be commercially reasonable. . . . We acknowledge that, even knowing in advance that an arrangement may result in losses to one or more parties, it may be reasonable, if not necessary, to nevertheless enter into the arrangement. Examples of reasons why parties would enter into such transactions include community need, timely access to health care services, fulfillment of licensure or regulatory obligations, including those under the Emergency Medical Treatment and Labor Act (EMTALA), the provision of charity care, and the improvement of quality and health outcomes.”



Money, Money, Money

Dollar, dollar, bills y'all

Creative, Compliant Compensation

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Creative ways to increase compensation, while staying on the right side of the law



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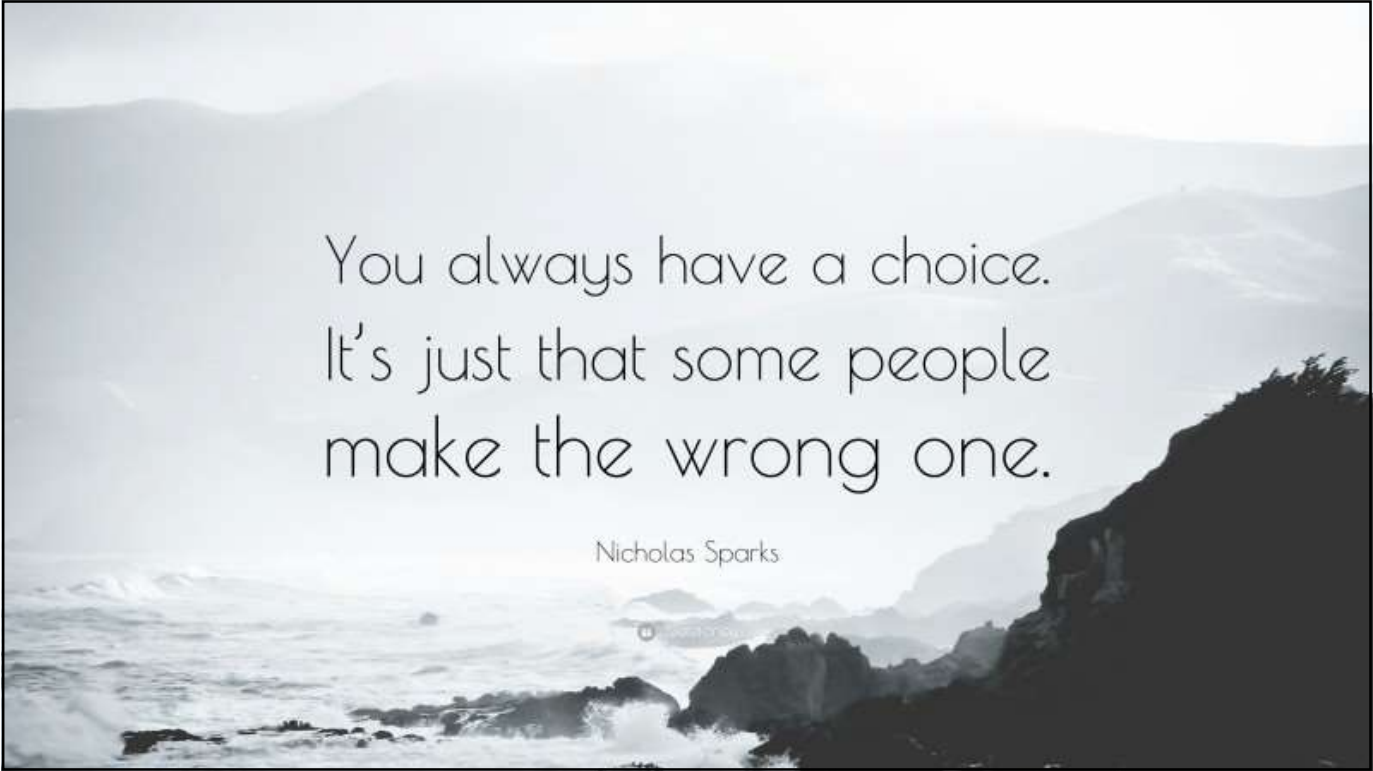
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Good News: We Have Options!

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You always have a choice.
It's just that some people
make the wrong one.

Nicholas Sparks

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Good News: We Have Options!

- Additional services (clinical or non-clinical)
- One-time payments
- Forgivable loans
- Creative relationship structuring
- Premiums

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Services Beyond Base Clinical

Additional Clinical Services:

- Call coverage

Non-Clinical Administrative Roles:

- Medical directorships
- Service line leadership

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Services Beyond Base Clinical

Additional Clinical Services / Non-Clinical Administrative Roles:

- **Stacking:**
 - If you are relying on survey data to set base compensation, do the numbers in the survey include “extras” (*i.e.*, “TCC” or “Total Cash Compensation”)?

Services Beyond Base Clinical

Additional Clinical Services / Non-Clinical Administrative Roles:

- **Stacking:**
 - If you are relying on survey data to set base compensation, do the numbers in the survey include “extras” (*i.e.*, “TCC” or “Total Cash Compensation”)?
 - If yes, need to back estimated additional compensation out of survey numbers when setting base compensation—and inaccurate estimates of additional compensation (*e.g.*, call) can create big problems





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Payments Outside TCC: Signing Bonus

- Other types of payments may NOT be included in TCC in a survey, often the case for a one-time signing bonus
- Know what's in and what's out of TCC, and if it's out, may be a separate comp source (*SCORE!*)
 - Note depending on how extra-TCC payments are structured, they may need to be FMV individually, separate from TCC

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Forgivable Loans

- Examples include:
 - Income guarantee
 - Non-compete buy-out
 - Housing allowance
- Often structured under the recruitment exception (*i.e.*, forgivable if the physician stays for a certain period of time)
 - Remember: If structured under recruitment exception, no FMV requirement
- Must take into consideration as compensation interest physician would have paid for a commercial loan

Other Possibilities

- Contracting vs. employment (not paying benefits may create additional room in cash compensation)
- Public Service Loan Forgiveness (PSLF) program (but in flux)
- Outreach stipends
- Rural premiums

WHEW.



Level Up

*I turned nothing to something, my
comeback on one hunnid'*

Practical Takeaways

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Practical tips to level up your provider
compensation function from hiring to
start



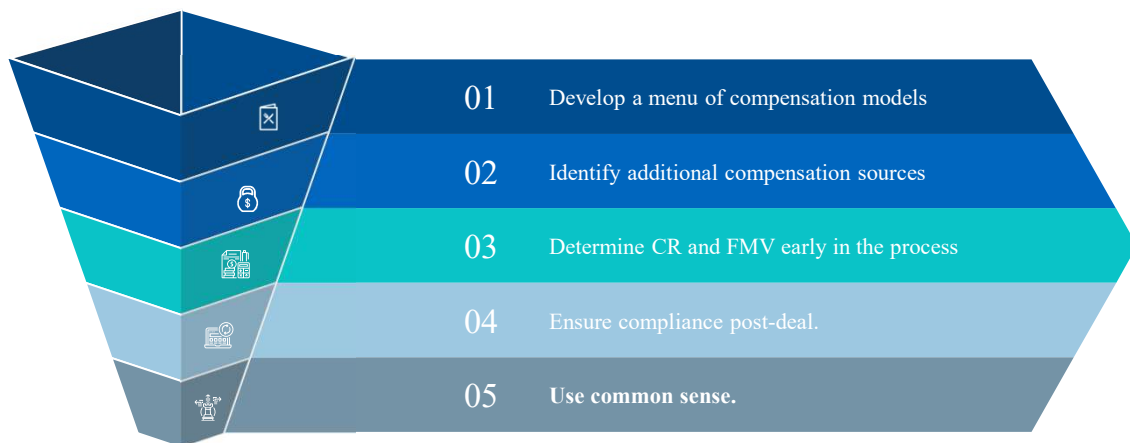
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Practical Takeaways

I turned nothing to something, my comeback on one hunnid'



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