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Fair Market Value and Commercial Reasonableness—2021 and Beyond

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This article is intended to highlight some of the most noteworthy revisions, clarifications, and modifications provided by the Centers for Medicare & Medicaid Services (CMS) through the Stark Law Final Rule and by the Office of Inspector General (OIG) through the Anti-Kickback Statute (AKS) Final Rule. HSG is not a law firm; we are a health care consulting and compensation valuation firm, so this article is not an exhaustive legal interpretation, summary, or review of all of CMS and OIG's updates, but rather a review of selected areas—particularly those elements and areas we view as having the most impact in the world of physician and advance practice provider (APP) compensation and transactions valuation. This piece concludes with thoughts regarding the COVID-19 pandemic's effect on the immediate future of physician and APP compensation valuation.

The Stark Law and Anti–Kickback Statute

On November 20, 2020, the U.S. Department of Health and Human Services (HHS) published Final Rules for the Physician Self-Referral Law (Stark Law), the federal AKS, and the Civil Monetary Penalties (CMP) Law. These new rules, which significantly amend the existing laws, are a direct result of HHS' Regulatory Sprint to Coordinated Care. HHS, through the Regulatory Sprint to Coordinated Care, has a stated goal of reducing regulatory barriers within our nation's health care system and accelerating "the transformation of the health care system into one that better pays for value and promotes care coordination." As HHS' statement indicates, value-based arrangements and transactions are the focus of this episode of Stark Law and AKS revisions, but other areas and central ideas of the Stark Law and AKS are significantly impacted as well.

On December 2, 2020, OIG published its Final Rule, "Revisions to the Safe Harbors Under the Anti-Kickback Statute and Rules Regarding Beneficiary Inducements," and CMS published its Final Rule, "Modernizing and Clarifying the Physician Self-Referral Regulations" in the *Federal Register.*

The Stark and AKS Final Rules became effective January 19, 2021, with the exception of certain changes to the definition of a "group practice" that have an effective date of January 1, 2022 to give physician practices time to adjust their compensation methodologies.

The AKS Final Rule creates new safe harbors for entities participating in a "value-based enterprise" (VBE) and amends existing safe harbors. OIG's proposed new safe harbors are:

- Three new safe harbors for remuneration exchanged between or among participants in value-based arrangements:
  - Value-based arrangements with full financial risk.
  - Value-based arrangements with substantial downside financial risk (at least 5%).
  - Care coordination arrangements to improve quality, health outcomes, and efficiency without requiring the parties to assume any financial risk.
- Arrangements for patient engagement and support to improve quality, health outcomes, and efficiency. This safe harbor permits patient engagement tools and/or other support furnished directly by a VBE to a patient in a target patient population that are directly connected to the coordination and management of care.
- CMS-sponsored model arrangements and CMS-sponsored model patient incentives. This safe harbor is intended to provide greater predictability for model participants and uniformity across models.
- Cybersecurity technology and services safe harbor for remuneration in the form of cybersecurity technology and services. This safe harbor is designed to facilitate improved cybersecurity in health care through donations of cybersecurity technology and services.

Additionally, OIG is finalizing changes to the following existing safe harbors:

- Electronic health records (EHR) safe harbor updates and removes provisions regarding interoperability; removes the December 31, 2021 sunset provision and prohibition on donation of equivalent technology; and clarifies protections for cybersecurity technology and services included in an EHR arrangement.

- Personal services and management contracts and outcomes-based payments safe harbor creates protection under safe harbor for part-time or intermittent arrangements and arrangements for which total compensation is not known in advance—it eliminates a requirement that part-time arrangements have a schedule of services specifically set out in advance in the agreement.
- Warranties safe harbor was modified to revise the definition of warranty and provide protection for bundled warranties for one or more items and related services provided they are paid for under the same payment.
- Local transportation safe harbor was revised to expand mileage limits for rural areas (to 75 miles) and eliminate mileage limits for transporting patients discharged from the hospital to their home.
- The AKS Final Rule further codifies statutory revisions by adding the statutory exception to remuneration related to Accountable Care Organization Beneficiary Incentive Programs for the Medicare Shared Savings Program. OIG also amended the definition of remuneration in the Beneficiary Inducements CMP statute to integrate a new statutory exception to the prohibition on beneficiary inducements for certain "telehealth technologies."

CMS' modifications and additions to the Stark Law rules were equally significant. CMS indicated that many of the changes to the Stark Law rules are intended to provide new flexibility and reduce administrative burden on health care organizations and providers in the structuring of arrangements, making it easier and less expensive to comply with the Stark Law. Below is a listing of some of the key changes:

- Finalized new, permanent exceptions for value-based arrangements that will permit physicians and other health care providers to enter into value-based arrangements without fear that their legitimate activities to better coordinate care, improve quality, and lower costs would violate the Stark Law.
- Provided additional guidance on key requirements of the exceptions to the Stark Law to make it easier for healthcare providers to take steps to ensure compliance, such as:
    - Guidance on identifying compensation formulas that take into account the volume or value of a physician's referrals.
    - Guidance on reconciliation of payment variances.
- Modified the rule related to profit sharing and productivity bonuses such that distribution of profits from designated health services directly attributable to a physician's participation in a value-based arrangement are deemed not to take into account the volume or value of the physician's referrals.
- Finalized a new exception to protect compensation not exceeding an aggregate of $5,000 per calendar year to a physician for the provision of items and services, without the need for a signed written agreement and compensation that is set in advance if certain other conditions are met (i.e., fair market value and does not take into account volume and value of referrals).
- Finalized protection for arrangements that will apply regardless of whether the parties operate in a fee-for-service or value-based payment system, such as donations of cybersecurity technology.
- Reduced administrative burdens, such as:
    - Providing additional flexibility related to signature and writing requirements.
    - Eliminating the period of disallowance rules and correcting discrepancies during the arrangement.
    - Modifying the definition of "set in advance" used in many Stark exceptions to allow modification of compensation during the term of an arrangement (including in the first year).

Salary Surveys

For those in the physician and APP compensation valuation arena, and for any hospital or health system that compensates a health care provider for administrative and/or professional services (which would be all hospitals and health systems in the country), there are other aspects of the Stark Law revisions that are of particular interest. These Stark Law updates may not alter the approach to production of a compensation fair market value and commercial reasonableness opinion (i.e., we are still going to consult industry salary surveys), but it certainly has us doubling down on the lengths to which we go to describe and document the uniqueness of a provider, the market, or the situation. In reading CMS' comments in the *Federal Register*, there is no doubt that CMS views each case as unique and there is not a set formula or methodology for determining fair market value. Yes, consulting "multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value," as stated in Stark II, Phase III, but salary surveys are not automatic—regardless of the percentile at which the compensation in question falls.

According to CMS, "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. In other words, the rate of compensation set forth in a salary survey may not always be identical to the worth of a particular physician's services." This is something that we have experienced from time to time for uniquely trained or experienced physicians and/or challenging markets, but more recently and frequently for Certified Registered Nurse Anesthetists (CRNAs) who practice autonomously—usually in rural markets. Often traditional salary survey sources do not provide datasets based on level of physician involvement or oversight for CRNAs, making it difficult to find an apples-to-apples comparison. This has required abandoning, or at least augmenting, traditional surveys with anesthesia-related job posting sites to find comparable salary offerings and ranges. This has also been true in markets in which the demand and competition for CRNAs has exploded. Traditional survey sources have proven to be

dated and inadequate for the CRNA salaries being offered. Again, job posting sites have been invaluable to determining fair market value for high-demand services. Note this requires a valuator being able to find enough comparable postings with posted salary offers—less than ten is typically not enough. CRNAs are only one example—the same challenges could easily apply to any physician specialty or market. This is the art and the work involved in determining fair market value. We also think this is an appropriate reflection and representation of what CMS recognized and articulated when it said: "It is not CMS policy that salary surveys necessarily provide an accurate determination of fair market value in all cases."

"Floors" and "Ceilings"

Many hospitals and health systems across the country have drawn a line in the sand and set a base compensation threshold at the 75th percentile for physician compensation. If base or guaranteed compensation does not exceed the 75th percentile for the physician's specialty, as published by a survey source like the Medical Group Management Association's Provider Compensation Survey, then they do not seek a fair market value opinion because they consider the compensation to be fair market value. Others have been slightly more conservative and mandated in their physician contracts that they will not provide total compensation (base compensation plus all bonuses) above the 75th percentile (a true "ceiling"). According to CMS, some of the commenters on the Final Rule asserted that, "a 'safe harbor' based on a range of values in salary surveys would be consistent with what they stated was established CMS policy that compensation set at or below the 75th percentile in a salary schedule is appropriate and compensation set above the 75th percentile is suspect, if not presumed inappropriate." To these comments CMS responded, "For the reasons explained in Phase I, Phase II, and Phase III, we decline to establish the rebuttable presumptions and 'safe harbors' requested by the commenters. We are uncertain why the commenters believe that it is CMS policy that compensation set at or below the 75th percentile in a salary schedule is always appropriate, and that compensation set above the 75th percentile is suspect, if not presumed inappropriate. The commenters are incorrect that this is CMS policy." Clearly, from CMS' perspective, both referenced policies are misguided. It is inaccurate for a hospital or health system to believe that just because base compensation is below the 75th percentile there is no risk and that the compensation they are providing is automatically fair market value. Likewise, a belief that paying a provider above the 75th percentile is not fair market value is also misplaced.

Via the Final Rule, CMS has also indicated that salary surveys, regardless of percentile, are not automatic determinates of fair market value, stating, "Consulting salary schedules or other hypothetical data is an appropriate starting point in the determination of fair market value, and in many cases, it may be all that is required. However, we agree with the commenter that asserted that a hospital may find it necessary to pay a physician above what is in the salary schedule, especially where there is a compelling need for the physician's services." Despite the request and urging of commenters, CMS declined to "establish rebuttable presumptions that compensation is fair market value or 'safe harbors' that would deem compensation to be fair market value if certain conditions are met." Bottom line, CMS affirmed that there is no guarantee to fair market value determination—there is no universal formula or proverbial rubberstamp as it pertains to provider compensation. Rather, each case must be evaluated and considered in the context of the situation. As CMS stated, "In our view, each compensation arrangement is different and must be evaluated based on its unique factors." Virtually every provider compensation exception under the Stark Law requires that the compensation paid reflects fair market value. So, while it may require effort, and in some cases could be difficult to achieve, finding fair market value is a must. Not that CMS made it easy by providing a bright line or even a floor that would allow us to say, "if we go above this level, then we must get a formal thirty-party fair market value opinion." According to CMS, "We wish to be perfectly clear that nothing in our commentary was intended to imply that an independent valuation is required for all compensation arrangements."

What the Heck Is the "Big Three"?

Another key Stark Law change that will certainly influence fair market value and commercial reasonableness opinion approach and deliverable is the uncoupling or disentanglement of the "volume or value standard (and the other business generated standard)" from the definitions of fair market value and commercial reasonableness. As a result, fair market value, commercial reasonableness, and the volume or value standard are "separate and distinct requirements, each of which must be satisfied when included in an exception to the physician self-referral law." CMS refers to these three "cornerstones" of the exceptions to the Stark Law as the "Big Three." CMS redefined the Big Three as follows:

- **Fair market value** means the value in an arm's-length transaction, consistent with the general market value of the subject transaction.
- **Commercially reasonable** means that the 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.
- **Volume or value standard and the other business generated standard** requires that the compensation paid under the arrangement is not determined in any manner that takes into account the volume or value of referrals by the physician who is a party to the arrangement, and some exceptions also include a requirement that the compensation is not determined in any manner that takes into account other business generated between the parties.

In addition to the general definition of fair market value above, CMS' revisions to the Stark Law also provide definitions of fair market value that are specific to the rental of equipment and the rental of office space. The definitions are as follows:

- With respect to the rental of equipment, fair market value means the value in an arm's-length transaction of rental property for general commercial purposes (not taking into account its intended use), consistent with the general market value of the subject transaction.

» With respect to the rental of office space, fair market value means the value in an arm's-length transaction of rental property for general commercial purposes (not taking into account its intended use), without adjustment to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee, and consistent with the general market value of the subject transaction.

Central to the definition of fair market value is the definition of "general market value." General market value is also restated in the Final Rule. Not only was the definition of general market value amended, but it was also given three unique definitions related to the context of a specific type of transaction. The three types of transactions are asset acquisition, compensation, and rental of equipment or office space. The general market value definitions are:

1. Assets. With respect to the purchase of an asset, the price that an asset would bring on the date of acquisition of the asset as the result of bona fide bargaining between a well-informed buyer and seller that are not otherwise in a position to generate business for each other.
2. 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.
3. Rental of equipment or office space. With respect to the rental of equipment or the rental of office space, the price that rental property would bring at the time the parties enter into the rental arrangement as the result of bona fide bargaining between a well-informed lessor and lessee that are not otherwise in a position to generate business for each other.

What does it mean for a compensation arrangement to be commercially reasonable? The answer to that question has often been more elusive and not as immediately apparent as fair market value—and we know how nebulous and elusive fair market value can be at times. Unlike fair market value determination, commercial reasonableness is not as readily determined by standardized methodologies, practices, or sources. To determine what is commercially reasonable, we first must start with a basic definition. According to CMS in the Final Rule, "commercially reasonable means that 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." In the Final Rule, CMS also reiterated that "the determination of commercial reasonableness is not one of valuation." An arrangement can be fair market value, but that does not mean that it is commercially reasonable. On the other hand, an arrangement must be considered fair market value in order to be commercially reasonable. In a simple example, we can determine that fair market value for compensation of a medical director for a cardiac catheterization laboratory is $150 per hour. That determination may be fairly conservative and well within a reasonable range, but if said physician is the second of two medical directors for this service and the duties are already handled by the first medical director so the second is not needed, then the $150 per hour medical directorship, while fair market value is not commercially reasonable.

As stated above in our discussion of fair market value, CMS continues to make it clear that the commercial reasonableness determination is also accomplished through consideration of an arrangement's context and from the perspective of those involved. According to CMS in the Final Rule, "We continue to believe that this determination should be made from the perspective of the particular parties involved in the arrangement." Another key factor to commercial reasonableness is answering the question: Does the arrangement make sense to accomplish the parties' goals? Documenting the organization's goals with the arrangement or transaction must be a priority.

Losing Money

For the past 30 years, a key consideration for health care organizations entering into transactions and arrangements for the employment and compensation of physicians has been the profitability of the practices in which the physicians, their staff, and other practice-related resources are housed—or more precisely the losses of the practices in which physicians and APPs are housed. Many hospitals and health systems around the country have employed physicians and then struggled, or at least had to come to grips with the fact that, the practices are losing money. Their concern has been financial, yes, but also an increasing concern of compliance risk. Many organizations are frequently asking: Do we have greater compliance risk because our practices are losing money according to our internal financial statements and accounting? Do our losses mean the compensation we are paying, while fair market value, is not commercially reasonable? How can we lose so much money and still consider our arrangement commercially reasonable?

There are a myriad of reasons that hospital-owned practices lose money—higher practice costs, poor revenue cycle operations, mismatched compensation incentives, poor management, etc. Many of these reasons are out of the hospital or health system's control. For a vast number of health care entities, employment of physicians and APPs is the only option for attracting and maintaining providers in their community. HSG has written articles about practice losses and how to address them. That is a topic for another day. The fact is hospital-owned practices typically lose money—it is more the rule than the exception. Since the Stark Law was enacted in 1989 this been a compliance concern in the back of the minds of hospital executives. Through the Final Rule, CMS has addressed the topic of losses and profitability, stating "the determination that an arrangement is commercially reasonable does not turn on whether the arrangement is profitable; compensation arrangements that do not result in profit for one or more of the parties may nonetheless be commercially reasonable." CMS offers several examples of reasons parties may enter into an arrangement or transaction despite financial "losses to one or more parties." According to CMS, those reasons 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, the provision of charity care, and the improvement of quality and health outcomes." In our opinion,

this means health care organizations must go the extra mile to document their reason(s) for compensating physicians and APPs, if those arrangements and transactions are exhibiting or are expected to yield financial loses. Strategy, market growth, and larger referral bases were not among the examples. What are your reasons? What are your goals? These are two critical questions that must be answered. While CMS has indicated that the presence of losses does not automatically call into question an arrangement's commercial reasonableness, the agency noted that each arrangement or transaction's circumstances will ultimately determine its commercial reasonableness. We also believe there has to be a limit to what is reasonable in terms of losses. Referring to survey data regarding practice losses per physician and per provider can be enlightening. If a hospital is losing three times the national average in its employed primary care practice ask:(1) Why?; (2) How can it be fixed?; and (3) Does it mean the compensation is not commercially reasonable?

The COVID Impact

A factor that is certain to affect fair market value determination during the coming year is not new or revised legislation. Instead, it is the impact of the COVID-19 pandemic on the industry's salary and production survey data. The same survey data that many compensation valuators rely on as a central component to their fair market value analysis and opinion. Our hypothesis is that COVID-19 will appreciably affect the salary, production, and other data reported by physicians and their practices—in some instances, to a significant degree.

Specialties like critical care, hospital medicine, emergency medicine, and pulmonary medicine may have experienced increases in patient volume due to the pandemic. Some providers in these four specialties may have seen an increase in compensation to reflect their increased workload, while others, those paid salary and shift rates, may not have seen an increase in compensation. Office-based primary care has been significantly affected as offices were closed for a period of time and then had to adjust to telehealth and virtual visits. Proceduralists such as dermatologists, orthopedic surgeons, ophthalmologists, otolaryngologists, plastic surgeons, urologists, etc. have been significantly impacted by decreased patient volume. On the revenue side, many practices had the benefit of the Paycheck Protection Program, but unfortunately, for many that was not enough to outweigh the additional personal protective equipment cost and lost revenue due to decreased patient volume.

Bottom line, 2021 surveys, based on 2020 data, are likely going to be challenging. In some cases, the alignment between compensation and production may be distorted. Typical compensation per Work Relative Value Unit rates could be significantly off from traditional levels for given specialties. Ultimately, valuators likely will have to be creative and look back into past years' surveys to evaluate trends and validate current survey data. CMS has stated that compensation between certain percentiles does not provide a safe harbor. If ever there was a time in which that is true on so many levels, this is it. Grabbing a 2021 survey and finding a percentile might be enough, then again, it might not. There is no fair market value calculator that takes in a couple datapoints and spits out a positive or negative fair market value answer. Get ready and roll up your sleeves for the work ahead.

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