

# THE FAIR MARKET VALUE IMPLICATIONS OF HEALTH SYSTEMS – LOSING MONEY ON THEIR EMPLOYED PHYSICIANS

Timothy Smith  
American Appraisal  
Dallas, TX

## Introduction

The recent cycle of physician employment by hospitals and health systems has resurrected one of the perennial questions in healthcare valuation: can the compensation paid to employed physicians be fair market value (“FMV”) when hospital systems lose money on their physician practices? A related question is whether it is commercially reasonable for health systems to lose money on their employed physicians.<sup>1</sup> In thinking

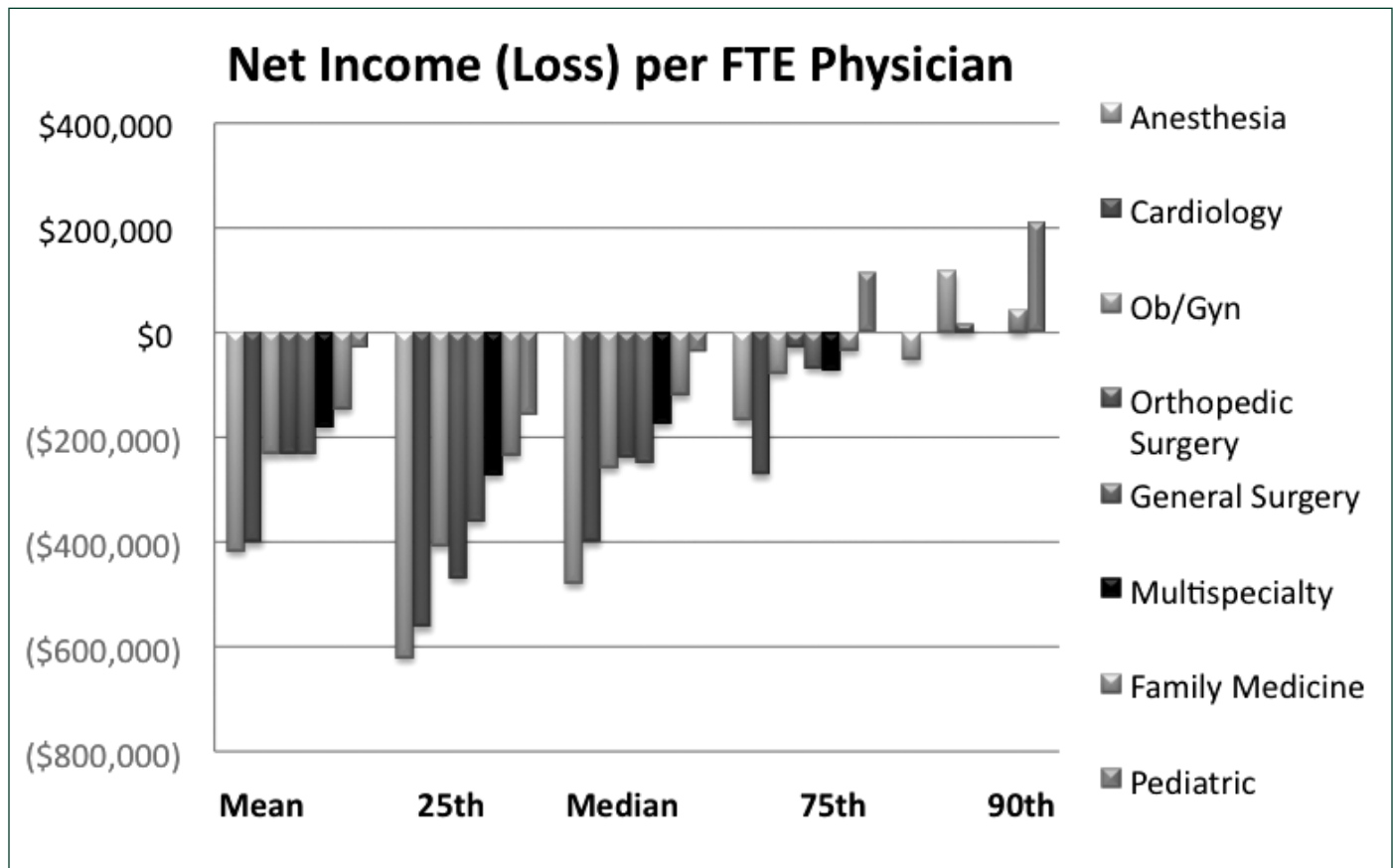
about these critical compliance questions, it may be a helpful starting point to examine the causes of financial losses in hospital-owned practices (“HOPs”). Understanding the economics of HOP losses can provide a context for assessing FMV compliance. Since these economics are driven by a variety of factors, multiple answers are possible in examining the question of FMV for HOPs operating in the red.

It is worth looking at publically available data on HOPs in comparison to physician-owned practices (“POPs”) to gain a general understanding of market trends relative to practice losses. Data from the 2012 Medical

Group Management Association (“MGMA”) *Cost Survey* for single specialty and multispecialty practices are presented in Charts 1 and 2 below.<sup>2</sup> The charts report the net income or loss per full-time equivalent (“FTE”) physician for practices owned by hospitals/integrated delivery systems (“IDS”) and by physicians.

What is readily apparent from these charts is that, for the HOPs included in the MGMA *Cost Survey*, losses per FTE physician are the norm. Indeed, some of these losses are substantial. In citing this survey, however, it should be noted that the data was not gathered using statistical sampling methods; it is based on voluntary

**Chart 1: Net Income/(Loss) per FTE Physician for Hospital/IDS-Owned Practices**



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responses to a trade group's annual survey. Whether the above data is fully representative of all HOPs in the United States is not known. What is nonetheless striking about this data is that POPs do not report similar losses. It is here – the absence of losses in POPs – where the inquiry into the FMV implications of losses in HOPs begins.

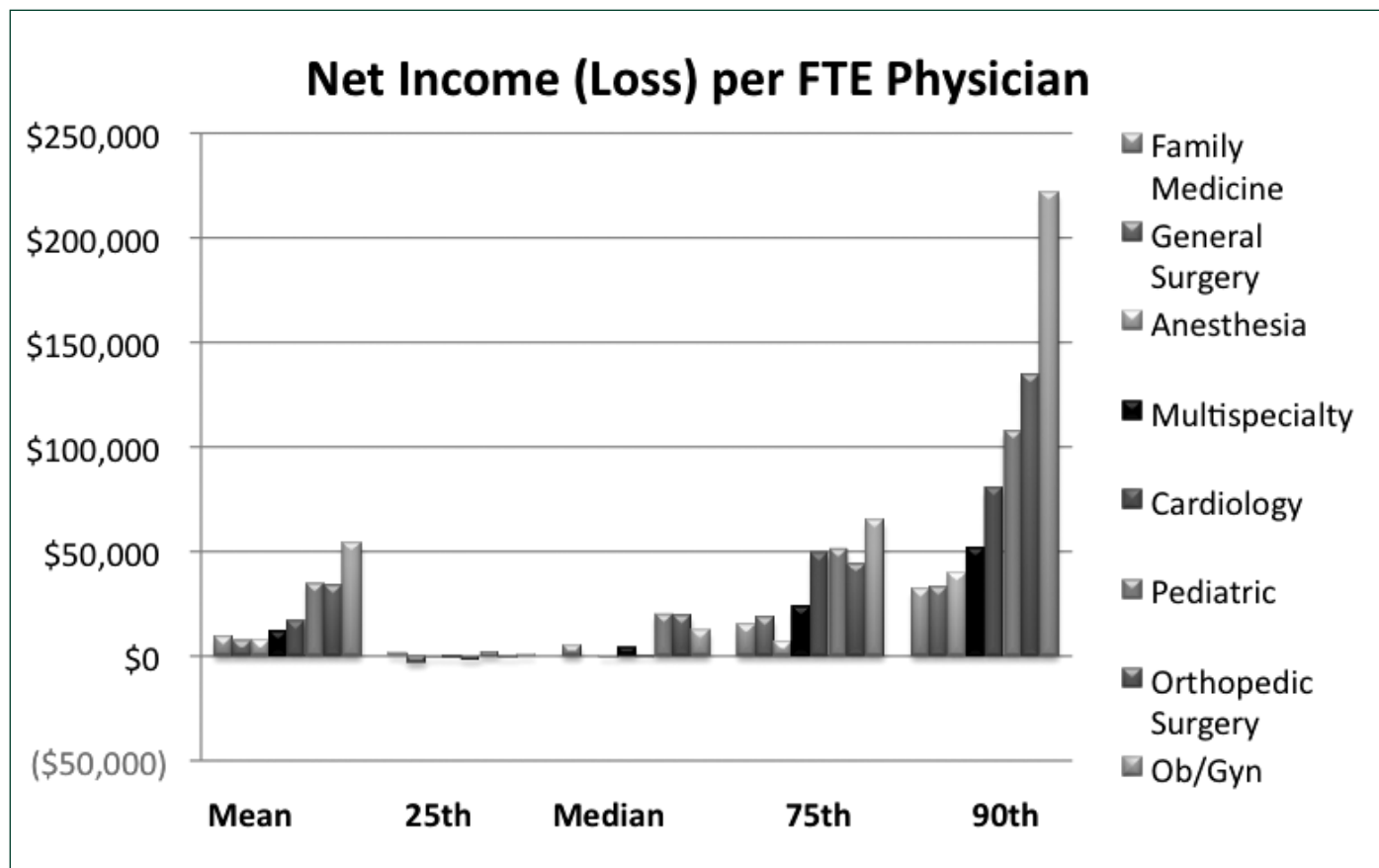
## Earnings-Based Compensation: The Historical Paradigm for Physician Compensation

When evaluating issues related to physician compensation, it is important to understand how physicians have been traditionally paid. Most physicians in the United States have historically worked in POPs, primarily comprised of one to two physicians.<sup>3</sup> In this practice setting, physician

compensation is determined based on the net practice earnings generated by the practice, *i.e.*, collections for services rendered less the cost associated with generating the services. In today's marketplace, this model is known as "eat what you catch" or "eat what you treat" or the ironic "eat what you kill" (which is hopefully not the patient). Such net earnings from services rendered, or earnings-based compensation, has been the historical paradigm for physicians compensated in the United States. Indeed, earnings-based compensation is a long-established concept for determining the value of professional services, including those of physicians, attorneys, accountants, and consultants. In other words, the value or compensation for professional services is the revenue received from providing the services less the cost to generate the services.<sup>4</sup>

Earnings-based compensation is an "elegant" concept because it simplifies the complexity of economic factors in a physician practice into a single value. It consolidates the impact of multiple variables on the economics of physician services in the healthcare marketplace. Net practice earnings result from the range of services provided by a physician, including the service mix of medical procedures, as well as other services, including compensated hospital call coverage, medical directorships, research, and other professional services. It also reflects the physician's productivity, and more importantly, reveals the value of medical services in the local market *viz-a-viz* the reimbursement paid for services by insurers. This value indicator is critical: physician services are paid at varying levels by payers from one market to the next, and indeed,

**Chart 2: Net Income/(Loss) per FTE Physician for Physician-Owned Practices**



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within a local market.<sup>5</sup> Embedded in net practice earnings, therefore, is an indication of the local market value of physician services, albeit one that might be hidden beneath the “noise” of poor revenue cycle management by the physician’s practice.

Earnings-based compensation also indicates a physician’s economic efficiency: at what cost did the physician use resources in providing services. Physicians are not created equal with respect to their overhead spending and support levels. Some physicians are high resource utilizers when it comes to support staff, office space, supplies, and other operating expenses. Other physicians, by contrast, may require less staff and space to produce the same level of services as their higher consuming colleagues. Physicians with high economic efficiency make more money, given the same levels of productivity and reimbursement, than their less efficient peers.

Physicians have historically understood these practice dynamics and economics.<sup>6</sup> They made operational decisions in relation to improving their practices in terms of increasing revenues and lowering costs, while maintaining quality patient care. Their horizon of decision-making consisted of their individual practices and net practice earnings. The impact of operational changes, moreover, was immediate and direct. Increased productivity or revenue meant increased compensation; increased overhead meant reduced compensation. Compensation based on net practice earnings was self-adjusting and self-leveling. Increased net practice earnings generally allowed for higher compensation. Conversely, reduced earnings usually required a reduction in compensation. In short, “eat what you catch” created a natural boundary for compensation. Consequently, earnings-based compensation generally explains why

POPs in the MGMA data do not show net losses.<sup>7</sup> The critical question now becomes: Why do HOPs lose money?

## Losses Arising from Employer and Physician Performance Issues

In examining the causes of HOP losses, one should not fail to note a common cause of losses in many business endeavors: shortcomings in management and employee performance. Sometimes mistakes and misjudgments are made in the course of a hospital system operating a physician practice. Many hospital systems underestimate the complexity of issues involved in operating physician practices. At the same time, physicians and experienced practice managers may not be prepared for the difficulties associated with organizational integration. Often, these mistakes occur as part of the transition of a practice from physician to hospital system ownership. Typical issues that can go poorly in a transition include:

- Obtaining new third-party payer provider numbers,
- Timely credentialing with commercial payers,
- Converting to new health IT systems for billing/collections or electronic health records (“EHRs”),
- Transfer of “back office” functions to centralized management or service centers,
- Negotiation of favorable reimbursement rates with commercial payers,
- Changes in participation in networks or in referral patterns from other physicians in the community,
- Changes in practice location sites after being acquired,
- Assignment of contracts.

In addition, the transitioning of physicians from entrepreneurs to employees who are paid on base salaries or guaranteed compensation may not provide an environment with sufficient incentives for productivity. One of the key lessons from the prior market cycle of integration in the 1990s was that the motivations for highly productive physicians can change once a physician is no longer at risk under “eat what you catch.” Depending on the compensation structure, practice losses may simply result from physicians not producing commensurate with their historical levels, while hospitals continue to compensate them at historic levels or higher.

Another potential cause results from productivity-based compensation that is not tied to operational cost considerations. If physicians are allowed to increase their resource utilization in order to generate higher productivity, but have no compensation consequence for using more resources, losses can accrue in the practice. A prime example is the extender use of nonphysician providers (“NPPs”), where the NPPs do not perform independent patient encounters but rather are used to reduce physician contact time with patients. Under a productivity-based compensation plan where there is no offset for the incremental cost of the NPP, physicians can increase their productivity and resulting compensation at the expense of the employer.

## The Unintended Consequences of Hospital-Physician Integration

The ownership and operation of physician practices by hospital systems can affect the underlying services and economics of physician practices in ways that are distinct from POPs. The reason for this difference is that ownership by other types

of healthcare entities can introduce business and operational considerations that are not intrinsic or related to the economic and operational optimization of a practice. The larger concerns and objectives of a healthcare organization can override goals and plans that would maximize physician practice earnings. As part of a larger healthcare organization, physician practices become one resource or service line within a larger continuum of services and product lines. Optimization of the organization can take precedence over that of the practice in terms of the healthcare entity's goals, strategies, and priorities. For example, IDS considerations can influence decisions related to the number of providers, the type and specialty/subspecialty of providers, practice locations, and the level and extent of hospital emergency department and inpatient call coverage. Such changes can affect practice operations and economics in ways that are both favorable and unfavorable from the singular perspective of the physician practice.

As part of integration, a practice becomes a participant in the hospital system's economics in terms of access to contracts, resources, policies, practices, and corporate culture. Such participation can have an impact on both the revenues and overhead of a practice. A review of these factors can be summarized as follows:

- **Participation in Payer Contracts:** Studies have shown that large health systems can have greater leverage on commercial payers in a local market, providing a practice with higher reimbursement on commercial patients.<sup>8</sup> On the other hand, some hospital systems lack experience in negotiating physician fee schedule rates, or they may sacrifice physician rates for gains in other areas for the system.
- **Centralized Billing and Collections:** Billing and collections for a practice are often moved to a centralized

office or absorbed into the hospital's billing and collection function. This move could negatively affect the practice's revenue cycle if the centralized function is inefficient or inexperienced with respect to physician practices.<sup>9</sup>

- **Payer Mix:** When a physician practice is owned by a hospital system, it may be required to expand its payer mix to less favorable payers or locations, thereby decreasing practice revenues on a per unit of service basis.
- **Technical Component/Ancillary Services:** Hospital systems frequently move or consolidate technical component or ancillary services from physician practices into existing hospital facilities in order to maximize reimbursement and/or to eliminate duplicative services. A potential effect, however, of converting these services to provider-based status is to create operating losses in physician practices. The effect occurs when physician compensation levels, whether established by market survey data or by historical practice net earnings, include the net earnings from in-office ancillaries provided by physician groups, for those specialties in which ancillaries are usual and customary.<sup>10</sup> Once those earnings streams are removed from the practice, physician compensation levels can generate losses.
- **Corporate Pay Grades for Support Staff:** Hospital systems and large healthcare organizations often have formal and structured pay grades for employees. These rates can exceed those paid by smaller physician groups or solo physicians for the NPP staff of a practice, causing overhead to thereby increase.<sup>11</sup>
- **Employee Benefits:** Smaller physician-owned practices often do not offer benefit packages that are comparable to larger, corporate organizations in the employment marketplace. As a result, benefit costs for the practice staff can increase after integration.

In summary, ownership of physician practices by hospital systems can alter the operations and economics of these practices in ways that reduce revenue or increase cost. As a result, the net earnings from a practice may not be optimized from the perspective of the practice as an operational and accounting unit. HOP losses may result from operating dynamics that do not relate to the actions of physicians or their compensation. They simply result from the choices made by the hospital system in how to best utilize practice resources within the IDS.<sup>12</sup>

## The Move to Survey-Based Compensation using wRVUs

The migration of physicians into employment arrangements with health systems has produced a move away from earnings-based compensation towards the focus on physician compensation surveys. Indeed, survey-based compensation appears to have become a prevailing paradigm for establishing physician compensation in many employment deals.<sup>13</sup> Some of the key factors in this paradigm shift include the following:

- Recommended use of the survey data as a "prudent practice" in the commentary to the Stark Phase III regulations,<sup>14</sup>
- Availability of various physician compensation surveys to the general public,<sup>15</sup>
- Wide use and acceptance of survey-based compensation by valuers, consultants, and health systems,
- The apparent objectivity of using survey data,
- The belief that the survey data is a reasonable or fully accurate reflection of the physician marketplace.

Concomitant with the use of the surveys is a particular focus on physician work relative value units ("wRVUs") as the sole means of applying survey data to subject physicians in

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employment arrangements.<sup>16</sup> A major contributor to this trend is the fact that wRVU-based compensation models are usually the compensation structure of choice for this recent cycle of hospital-physician consolidation. It was natural, therefore, to apply and utilize physician compensation survey data in terms of wRVUs and wRVU-related benchmarks. More importantly, wRVUs reflect a universal scale by which the productivity of all physicians could be measured and ranked. Using wRVUs, compensation can be assigned using the concept of productivity-matched compensation: a physician should be paid commensurate with his or her level of productivity. A critical presupposition of this approach is that wRVU productivity fully accounts for compensation levels in the marketplace.

The uninformed use of survey data, however, can be one potential cause of losses in HOPs. The reason such use causes losses is that many common methods of applying survey data can ignore critical elements in the economics of physician services relative to the subject physician in the local marketplace. Under survey-based compensation, physicians are usually paid based on the range of compensation reported in a survey using various economic models that range from picking a given percentile as FMV to matching percentiles of compensation with percentile benchmarking of wRVUs. Such methods, however, can ignore the full array of economic drivers of value for physician services. The financial reality of physician services is that their value is a function of several key factors, including productivity, reimbursement, service mix defined as both clinical and nonclinical services, and resource or cost utilization.<sup>17</sup> Ignoring these factors and focusing solely on wRVU productivity and/or median compensation, for example, can lead

to losses in a particular practice under certain circumstances.

A prime example is the failure to take into account local market reimbursement in a compensation analysis. One of the key drivers of value in physician services is local market reimbursement. Two published analyses have demonstrated the impact of reimbursement rates on physician compensation. A ground-breaking article in 2008 modeled the impact of different payer mixes and commercial rates on physician compensation based on RVUs. It showed the significant impact that reimbursement rates can have on compensation per RVU rates. This analysis also noted how exclusive reliance on survey data can lead to results that are not reflective of local market conditions.<sup>18</sup>

Another recently published analysis used the data from the Center for Studying Health System Change (“HSC”) to analyze the impact of reimbursement rates on physician compensation. Until recently, reliable data on commercial reimbursement levels across the country was not readily available to the public. A recent study by HSC, however, provided this data for eight different U.S. markets. This study shows a wide range of commercial reimbursement rates for physicians across various local markets in the United States and within those local markets.<sup>19</sup>

The analysis applied reimbursement rates from the HSC study to a model cardiology group constructed from the 2010 RVU values for an actual nine-physician cardiology group. Assuming a simplified payer mix and an overhead level based data from the *MGMA Cost Survey*, expected revenues and practice net earnings were estimated for each reimbursement level by market.<sup>20</sup> The analysis also included a national average. The resulting practice net earnings were converted to a compensation-per-wRVU rate and

compared to the MGMA median compensation per wRVU for invasive-interventional cardiology. The difference in the two rates was multiplied by the group’s total wRVUs to compute the total difference in compensation between the median and the net practice earnings. As shown in the Table on the following page, paying the physicians the median produces practice losses for over half of the reimbursement levels.<sup>21</sup>

A key implication of this analysis is that ignoring local market reimbursement in compensation-setting practices may result in significant losses on employed physicians. Certain compensation levels are not economically sustainable or viable in various markets because reimbursement levels cannot support these levels of physician pay, at least not without generating material red ink in the practice. Alternatively, if employed physicians are in a high reimbursement market, one may be underpaying what the market can afford by failing to recognize these local economic dynamics. Divorcing physician compensation from the local market raises the specter of high practice losses, or alternatively, undercompensated physicians.<sup>22</sup>

Many attempt to factor local market conditions into their valuation analysis by using regional or state data as a better approximation of local market conditions.<sup>23</sup> However, review of the HSC study and its implications indicates that it is unlikely that the survey data can be applied with any meaningful degree of precision to reflect the dynamics of any one particular market. Variations across a region, or even within a state, may not allow a reasonable level of specificity to a given market.<sup>24</sup> In the state of Texas, for example, there is a material difference in physician reimbursement between Houston and the Dallas/Fort Worth area.<sup>25</sup> There is also

a significant variance between reimbursement levels in Northern California markets in comparison to Southern California.<sup>26</sup>

Perhaps the most precise statement one can make about the surveys is that they reflect the markets of those who responded. Since the respondents are not included based on statistically valid sampling techniques and since the surveys do not report data by individual market, it is indeterminate as to what markets are represented in the survey data. This reality should give pause in the use of survey data to establish physician compensation levels in employment arrangements. Failure to recognize these characteristics of the survey data can be one source of potential losses in HOPs.

A third recently published analysis has also called into question the commonly held idea that wRVUs are the definitive driver of compensation levels in the physician marketplace. This analysis used linear regression to study the relationship between compensation and wRVUs in the MGMA

data over a five-year period (2008 through 2012 surveys) for 28 individual specialties representing surgical, medical, and hospital-based specialties, along with primary care. The analysis showed that wRVUs were found to explain or be predictive of only 30 to 40 percent of compensation levels in these specialties, based on the R-squared values of the regression lines.<sup>27</sup> While wRVUs certainly explain a material percentage of compensation, the question becomes whether these levels are sufficient to warrant the exclusive use and reliance on wRVUs alone to establish compensation for physicians. The reality of the MGMA data is that 60 to 70 percent of compensation is not explained by wRVUs.<sup>28</sup>

While much could be debated and discussed about the use of survey data, it is perhaps sufficient to say that the use of survey-based compensation has certain limitations and disadvantages. Survey-based compensation-setting practices can be imprecise in view of the variety of factors that can affect physician compensation in the marketplace because they may not take these factors into account. In general,

the physician compensation surveys do not usually include information on local market reimbursement or other key factors that would allow the data to be applied to specific physicians with greater precision.<sup>29</sup> Note that these limitations are not necessarily cause for abandoning survey data in establishing FMV compensation. Rather, these limitations frequently necessitate the use of additional valuation methods and techniques that use the concept of earnings-based compensation under the cost and income approaches. Use of these methods can mitigate the limitations experienced in using survey data.<sup>30</sup>

## Implications for Fair Market Value

The foregoing discussion has provided three potential factors that can contribute to losses in employed physician practices: over-reliance on survey-based compensation-setting practices; integration into hospital systems; and ordinary mistakes and shortcomings on the hospital or physician side of the practice equation. It is

**Table:**

Market / Rate Level	Revenue per wRVU	Model Compensation per wRVU	MGMA Median Compensation per wRVU	Variance per wRVU	Total Difference in Model and Median Compensation
Milwaukee, WI - 75th %tile	\$122.44	\$80.40	\$52.41	\$27.99	\$2,399,017
Milwaukee, WI - Standard	\$99.79	\$57.75	\$52.41	\$5.34	\$457,549
Cleveland, OH - 75th %tile	\$98.62	\$56.58	\$52.41	\$4.17	\$357,262
San Francisco, CA - Standard	\$97.54	\$55.50	\$52.41	\$3.09	\$264,688
Indianapolis, IN - 75th %tile	\$96.47	\$54.43	\$52.41	\$2.02	\$172,972
Richmond, VA - 75th %tile	\$92.83	\$50.79	\$52.41	(\$1.62)	(\$139,034)
Miami, FL - 75th %tile	\$90.07	\$48.03	\$52.41	(\$4.38)	(\$375,610)
National Average	\$87.05	\$45.01	\$52.41	(\$7.40)	(\$634,472)
Los Angeles, CA - Standard	\$82.26	\$40.22	\$52.41	(\$12.19)	(\$1,045,052)
Richmond, VA - Standard	\$79.52	\$37.48	\$52.41	(\$14.93)	(\$1,279,914)
Indianapolis, IN - Standard	\$78.07	\$36.03	\$52.41	(\$16.38)	(\$1,404,202)
Miami, FL - Standard	\$77.15	\$35.11	\$52.41	(\$17.30)	(\$1,483,061)
Cleveland, OH - Standard	\$76.45	\$34.41	\$52.41	(\$18.00)	(\$1,543,062)

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also possible that a combination of these various factors, even in relatively small increments, can be the culprit in physician losses. For hospital systems with practice losses, the pressing question is what implications for FMV compliance can be drawn from identifying the specific causes of the losses. Are there some causes for losses that render the compensation paid to employed physicians to be inconsistent with FMV?

## Defining Fair Market Value

FMV for healthcare regulatory purposes has been defined by two sets of federal healthcare regulations. The federal physician anti self-referral law and regulations, commonly known as the “Stark Law,” define FMV as follows:

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.<sup>31</sup>

In addition, the regulations promulgated under the federal anti-kickback statute include a definition of FMV that is specific to the leasing of real estate and equipment:

Note that for purposes of paragraph (b) of this section, the term fair market value means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs.<sup>32</sup>

Note that for purposes of paragraph (c) of this section, the term fair market value means that the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.<sup>33</sup>

Depending on whether the regulations apply to a subject arrangement, these definitions should be used to determine FMV for compliance purposes.

In practice, however, many appraisers will also incorporate the “classic” definition of FMV as established by various authoritative bodies in the professional practice of appraisal.<sup>34</sup> They will also use standard appraisal methodology as understood and practiced by professional appraisers across multiple

valuation disciplines.<sup>35</sup> They incorporate the classic FMV definition and standard appraisal methodology because they think that regulations under the Stark Law and the anti-kickback statute do not provide sufficiently detailed and systematic guidance for the credible determination of FMV.<sup>36</sup> Where standard appraisal methodology appears to conflict with healthcare regulations related to the determination of FMV, appraisers make a jurisdictional exception and cede to the regulatory requirements.<sup>37</sup>

As part of this composite definition of FMV, professional appraisers will generally focus on a key element of the classic definition, which is the idea of the exchange price between a *hypothetical* buyer and seller in a transaction. For example, the International Glossary of Business Valuation Terms defines FMV as follows:<sup>38</sup>

The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.

The idea of the hypothetical buyer and seller is readily convertible into the healthcare regulatory definition of FMV that excludes the value or volume of referrals by assuming that the hypothetical buyer and seller are at arm’s length without any referral relationships. Thus, the FMV analysis does not take into consideration referrals because the analysis is based on hypothetical parties who are not in a position to refer. This adjustment or addition to the classic definition, in which the hypothetical parties are assumed not to have a referral relationship, affords a significant reconciliation and bridge between the two definitions

of FMV. For purposes of this article, the adjusted definition will be used to examine the issue of FMV as it relates to the various causes of losses in HOPs.<sup>39</sup>

### **Losses Resulting from Performance Issues**

In looking at the FMV implications of various causes of losses in HOPs, some causes are easier than others to analyze from the perspective of FMV. Perhaps the most straightforward case is the one in which a hospital system simply makes mistakes in transitioning or operating the practice. Bumbled operations are not usually part of the expectations between the hypothetical buyer and seller for a transaction. The hypothetical buyer and seller are assumed to have reasonable operational ability consistent with *typical* buyers and sellers in the marketplace. Thus, the hypothetical buyer of the services (the employer) would be expected to operate the practice in a reasonable manner, and the hypothetical seller of the services (the physician) would expect compensation to be commensurate with reasonable operation. Any downside resulting from operational errors would accrue to the party at fault, which in this case in the hospital system. The fact that a particular health system dropped the ball does not alter the fundamental FMV analysis between the hypothetical parties.

Losses resulting from physicians with poor productivity or performance outcomes raise a different set of issues. In these fact patterns, the compensation was typically established based on historical productivity, which was significantly higher than the current level. The question of FMV becomes focused on expectations relative to the employee. Would the hypothetical buyer of services expect to pay compensation at the current level based on the physician's current level of productivity or performance? If the downturn in productivity or performance relates to the physician, it may be difficult to argue that productivity from years past is determinative of current or prospective FMV compensation.

### **Losses Resulting from Integration**

A similar line of reasoning can be applied to the unintended consequences of hospital-physician integration. If losses are the result of a particular hospital system's integration of a practice to further the goals and strategies of that individual system, one can argue that such losses do not impact the FMV analysis of the hypothetical parties. The hypothetical or typical employer may not necessarily operate a physician practice in the way that the specific hospital has. Thus, the losses are a function of what a particular buyer did with a practice, not what the hypothetical buyer would do.<sup>40</sup>

One might raise the objection that market expectations exist for integration changes. While the market is certainly riding this most recent wave of integration, one cannot effectively argue that the current marketplace of employers for physicians is comprised *solely* of health systems. POPs still exist. In addition, not all HOPs experience adverse financial consequences from integration issues. Moreover, the typical health system may or may not decide to operate its physician practices the same way that a particular health system has.

It is difficult to argue, therefore, that the hypothetical buyer and seller exist in a marketplace defined solely by HOPs which, in effect, operate physician practices for the greater good of the IDS in the manner that a particular health system has done. Similar to the case of operator mismanagement, it can be argued that hospital system changes that serve to benefit the IDS at the expense of the practice relate to the particular system only. The hypothetical seller or physician would not expect to give up compensation merely for the greater good or profitability of the IDS.<sup>41</sup>

### **Losses from Compensation-Setting Practices based on Survey Models**

Situations where losses have resulted from the uncritical use of

survey-based models can give rise to questions about whether such compensation is consistent with FMV. The fundamental question is whether FMV compensation can be established by ignoring local market factors and conditions, such as those related to reimbursement. It may be difficult to justify compensation levels, and any related losses, when these drivers were ignored in light of the recent studies and data that have emerged in the professional literature showing that local market factors produce varying physician compensation levels.

Moreover, one should also not fail to note that the Stark regulations point to location as one of the factors that should be considered in determining FMV for regulatory compliance purposes.<sup>42</sup> In short, there are significant arguments to be made that losses from narrowly conceived compensation models call into question the FMV of the underlying compensation.

It may be possible to make an argument in defense of past compensation and losses along the following lines of reasoning: Until the aforementioned studies and data related to the impact of local market reimbursement and physician compensation were made publicly available, the impact of reimbursement, for example, was not fully understood by the marketplace. As a result, the marketplace believed that survey-focused compensation practices had a greater degree of precision and validity than was actually warranted by the data. Yet, this argument may not suffice for future compensation in many arrangements, now that better information on use of the survey data is available. For these reasons, losses generated by certain survey-based valuation methods may present a FMV risk for health systems because they did not take into account the full array of factors that affect physician compensation in the local market setting.

At the same time, one should not fail to note the potential difficulties that hospital systems can have in

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implementing new compensation-setting practices that return to earnings-based compensation. Putting a practice back on a hypothetical basis before the impact of integration may be difficult. It requires identifying relevant operational areas for adjustment and calculating the financial impact of integration decisions. It may also involve complex regulatory and legal issues, such as those relating to the compensation value of ancillary services. One alternative is to use multiple surveys and multiple methods to determine FMV compensation using more sophisticated valuation methods and techniques.<sup>43</sup>

## Conclusion

The causes of losses in HOPs can be varied, ranging from the unintended consequences of integration to survey-based compensation practices that were inadequate to address the range of factors affecting the economics of physician practices. Ordinary mishaps and physician disincentives can also be causes. Losses resulting from some causes may be more defensible than other causes from an FMV perspective. The critical factor for FMV is to be able to identify these causes and evaluate them along the lines of analysis discussed in this article. It should be noted that there have not been any recent and known lawsuits or investigations related to this specific issue of FMV compensation in HOPs with losses. With physician employment by health systems on the rise, however, the regulatory concerns related to this issue should be given thoughtful consideration.



**Timothy Smith** is the national director of American Appraisal's healthcare valuation practice. Mr. Smith has over 19 years of

experience in the healthcare industry,

including more than 14 years at Hospital Corporation of America, Inc. ("HCA"), the nation's largest hospital company. During his tenure at HCA, he worked on hundreds of physician practice acquisition, divestiture, and employment deals. He also completed regulatory compliance reviews on hundreds of appraisals for acquisitions, divestitures, and compensation arrangements.

Following his HCA tenure, Mr. Smith has worked in the appraisal profession with a focus on physician compensation arrangements. He has emerged as a thought leader in the area of healthcare compensation valuation ("CV"). He authored the first systematic account of the theory and practice of CV in the BVR/AHLA Guide to Healthcare Industry Compensation and Valuation, which he co-edited with Mark O. Dietrich. Mr. Smith is the most extensively published author on the newly emerging appraisal discipline of CV in the healthcare industry today.

He holds the Accredited in Business Valuation ("ABV") certification from the American Institute of Certified Public Accountants ("AICPA") and is a licensed CPA in two states. He can be reached at 214-459-6411 or [tsmith@american-appraisal.com](mailto:tsmith@american-appraisal.com).

## Endnotes

- <sup>1</sup> The topic of commercial reasonableness raises a secondary but critical set of issues that revolve around the definition of commercial reasonableness and its relation to FMV that are beyond the scope of this article. For an in-depth discussion of these issues, see "BV, CV and the Relationship Between Fair Market Value and Commercial Reasonableness" (Chapter 9), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Mark O. Dietrich, pp. 179 to 192.
- <sup>2</sup> For a copy of this survey, see [www.mgma.com/store/mgma-surveys/](http://www.mgma.com/store/mgma-surveys/).
- <sup>3</sup> *Physicians Moving to Mid-Sized, Single-Specialty Practices*, Tracking Report No. 18, August 2007, and *A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey*, Data Bulletin No. 35, September 2009. [www.hschange.org](http://www.hschange.org). These articles provide some analysis of the trends in physician practice size.
- <sup>4</sup> *Reasonable Compensation: Application and Analysis for Appraisal, Tax, and Management Purposes*, by Kevin Yeanoplos and Ron

Seigneur, Business Valuation Resources, LLC (BVR), 2010, pp. 7-10.

- <sup>5</sup> See *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Research Brief, No. 16, November 2010, Center for Studying Health System Change, [www.hschange.org](http://www.hschange.org).
- <sup>6</sup> See Medical Group Management Association, [www.mgma.com](http://www.mgma.com) for more information on physician practice dynamics.
- <sup>7</sup> It should be noted that for certain hospital-based specialties – such as anesthesiology, radiology, neonatology, or hospitalists – coverage payments or subsidies from hospitals are frequently needed to supplement the professional fees that such groups collect for providing coverage at a facility. Otherwise, such groups would only be able to pay below-market compensation levels, and would eventually be unable to provide services at the facility. The economics of hospital-based specialties, however, should be distinguished from those of office-based physician specialties. Thus, some of the points made in this article may not be fully applicable to the valuation of hospital-based coverage arrangements. For an in-depth discussion of this issue, see "An Introduction to Physician Services and Specialties" (Chapter 13), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, section 4.0, Distinguishing Between Office-Based and Hospital-Based Physician Specialties, pp. 338-41.
- <sup>8</sup> *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, Robert A. Berenson, Paul B. Ginsburg and Nicole Kemper, *Health Affairs*, Vol. 29, No. 4, 2010. *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?* Ann S. O'Malley, Amelia M. Bond and Robert A. Berenson, *Issue Brief*, No. 136, August 2011, Center for Studying Health System Change, [www.hschange.org](http://www.hschange.org).
- <sup>9</sup> One of the lessons of the 1990s wave of physician practice acquisitions and employment by hospitals was that hospital systems frequently did not understand physician billing and collection issues and performed poorly in this area in comparison to the pre-acquisition practice.
- <sup>10</sup> For example, diagnostic testing through echocardiograms, EKGs, and nuclear camera studies are routinely provided in cardiology practices as part of the continuum of patient care services. Imaging modalities, such as MRI and CT, as frequently offered in orthopedic groups, while chemotherapy is part of most medical oncology practices. Primary care practices frequently provide basic lab and radiology (X-ray) services to patients. Most ob/gyn practices provide ultrasound services as part of prenatal care.
- <sup>11</sup> Based on the author's experience over two decades in reviewing rates for small and large organizations.
- <sup>12</sup> The Economics of Health System and Integrated Delivery System Practices (section 2.11), "The Economics of Physician Clinical Services and Compensation" (Chapter 14), *BVR/AHLA Guide to Healthcare Industry*

- Compensation and Valuation*, by Timothy Smith, pp. 360-63.
- 13 This shift is implicit in various presentations made at conferences and webinars in the past few years for various healthcare-related organizations or valuation societies. The content of most presentations about establishing FMV for employed physicians in HOPs usually focuses on the use of survey data.
  - 14 Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III), 72 Fed. Reg. 51015, September 5, 2007.
  - 15 Popular surveys include those published by the Medical Group Management Association, ("MGMA"), [www.mgma.com/store/mgma-surveys/](http://www.mgma.com/store/mgma-surveys/), American Medical Group Associations ("AMGA"), [www.ecommerce.amga.org/iMISpublic/Core/Orders/product.aspx?catid=3&prodid=2330](http://www.ecommerce.amga.org/iMISpublic/Core/Orders/product.aspx?catid=3&prodid=2330), Sullivan Cotter and Associates, ("SCA"), [www.sullivancotter.com/surveys/physician-compensation-and-productivity-survey/](http://www.sullivancotter.com/surveys/physician-compensation-and-productivity-survey/), and Hospital and Healthcare Compensation Service, ("HHCS"), [www.hhcsinc.com/hcsreports.htm](http://www.hhcsinc.com/hcsreports.htm).
  - 16 Physician wRVUs are part of the Resource Based Relative Value Scale ("RBRVS") established by the Centers for Medicare & Medicaid Services ("CMS"). They are intended to rate the time, mental effort, judgment, technical skill, physical effort, and stress associated with providing a specific medical procedure or service.
  - 17 For a complete discussion of the economics of physician services, see "An Introduction to Physician Services and Specialties" and "The Economics of Physician Clinical Services and Compensation" (Chapters 13-14), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 331 to 370.
  - 18 See "Evaluating RVU-Based Compensation Arrangements," *Health Lawyers Weekly*, November 14, 2008, Mark O. Dietrich and Gregory D. Anderson and "Evaluating RVU-Based Compensation Arrangements" (Chapter 36), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Mark O. Dietrich and Gregory D. Anderson, pp. 835-41.
  - 19 See *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Research Brief, No. 16, November 2010, Center for Studying Health System Change, [www.hschange.org](http://www.hschange.org).
  - 20 The market rates reported included the standard fee schedule and the 75<sup>th</sup> percentile negotiated rates, stated as a percentage of Medicare.
  - 21 For a detailed account of the assumptions and analysis used in this example, see "How Reimbursement and Physician Compensation Vary by Market" (Chapter 37), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 843-55.
  - 22 While the latter outcome may not trigger significant FMV compliance concerns, it certainly puts any potential employer of physicians, whether health system-owned or physician-owned, at a competitive disadvantage for hiring, especially when other competitors in the market recognize these local dynamics.
  - 23 Regional data is particularly used since such data is usually available with significant respondent sizes. Moreover, the surveys often publish summaries indicating material differences in regional compensation. Users frequently take these regional analyses and trends to be applicable to their local market.
  - 24 For a detailed analysis of the impact of local market conditions, see "Healthcare Market Structure and its Implication for Valuation of Privately Held Provider Entities – An Empirical Analysis" (Chapter 3), *The BVR/AHLA Guide to Healthcare Valuation*, Third Edition, by Mark O. Dietrich, pp. 99-129.
  - 25 Based on the author's experience in both markets and on information provided by parties with significant knowledge of these markets.
  - 26 As indicated in the HSC data and based on the author's experience.
  - 27 For a detailed account of this study, see "An Analysis of the Relationship Between Productivity and Compensation in the MGMA Data and Its Implications for Valuation and Compensation-Setting Practices" (Chapter 39), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 869-89.
  - 28 This outcome is consistent with the findings of the previously discussed analysis of reimbursement and compensation and the work of Dietrich and Anderson.
  - 29 For a presentation of alternative valuation methods, see "Valuing Physician Employment Arrangements for Clinical Services: Cost- and Income-Based Valuation Methods" (Chapter 24), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 573-610.
  - 30 For a discussion of such methods and analysis, see "Valuing Physician Employment Arrangements for Clinical Services: Cost- and Income-Based Valuation Methods" (Chapter 24), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 573-610.
  - 31 42 C.F.R. § 411.351. The Stark law is also known as the Ethics in Patients Referrals Act.
  - 32 42 C.F.R. 1001.952(b)(6).
  - 33 42 C.F.R. 1001.952(c)(6).
  - 34 Examples include IRS Revenue Ruling 59-60 and the International Glossary of Business Valuation Terms, [www.bvresources.com/FreeDownloads/IntGlossaryBVTerms2001.pdf](http://www.bvresources.com/FreeDownloads/IntGlossaryBVTerms2001.pdf).
  - 35 Professional appraisers are those valuation consultants who practice pursuant to an appraisal credential given by a professional appraisal organization, such as the American Society of Appraisers or the American Institute of Certified Public Accountants. Standard appraisal methodology considers the use and application of the market, cost, and income approaches and arrives at a conclusion of value based on a synthesis and reconciliation of all applied approaches.
  - 36 For further discussion of this issue, see "Complying With the Healthcare Definition of FMV in Appraisal Practice" (Chapter 6), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 127-54.
  - 37 Such deference to regulatory considerations is part of the standard appraisal methodology. See the jurisdictional exceptions provided under the Uniform Standards of Professional Appraisal Practice ("USPAP") and the *Statement on Standards for Valuations Services 1: Valuation of a Business, Business Ownership Interest, Security, or Intangible Asset*, issued by the American Institute of Certified Public Accountants.
  - 38 The International Glossary was developed and adopted by the four major U.S. business appraisal professional societies (American Society of Appraisers, American Institute of Certified Public Accountants, Institute of Business Appraisal, and the National Association of Certified Valuation Analysts) along with their Canadian counterpart (Canadian Institute of Chartered Business Valuators).
  - 39 For an in-depth discussion of reconciling the regulatory and classic definition of FMV, see "Complying With the Healthcare Definition of FMV in Appraisal Practice" (Chapter 6), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 127-54.
  - 40 Under the International Glossary of Business Valuation Terms, the value to a specific buyer or seller is deemed to be investment value, not FMV.
  - 41 The hypothetical seller of the service, i.e., the physician, has alternatives in the marketplace, possibly including remaining in private practice or seeking employment in physician-owned private practices.
  - 42 Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16107, March 26, 2004, and 72 Fed. Reg. 51015, September 5, 2007.
  - 43 For a discussion of such methods and analysis, see "Valuing Physician Employment Arrangements for Clinical Services: Market-Based Valuation Methods" (Chapter 23), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 537-72.