



MONTANA HFMA, MHiMA & MGMA

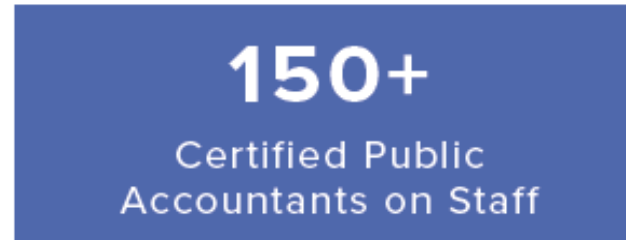
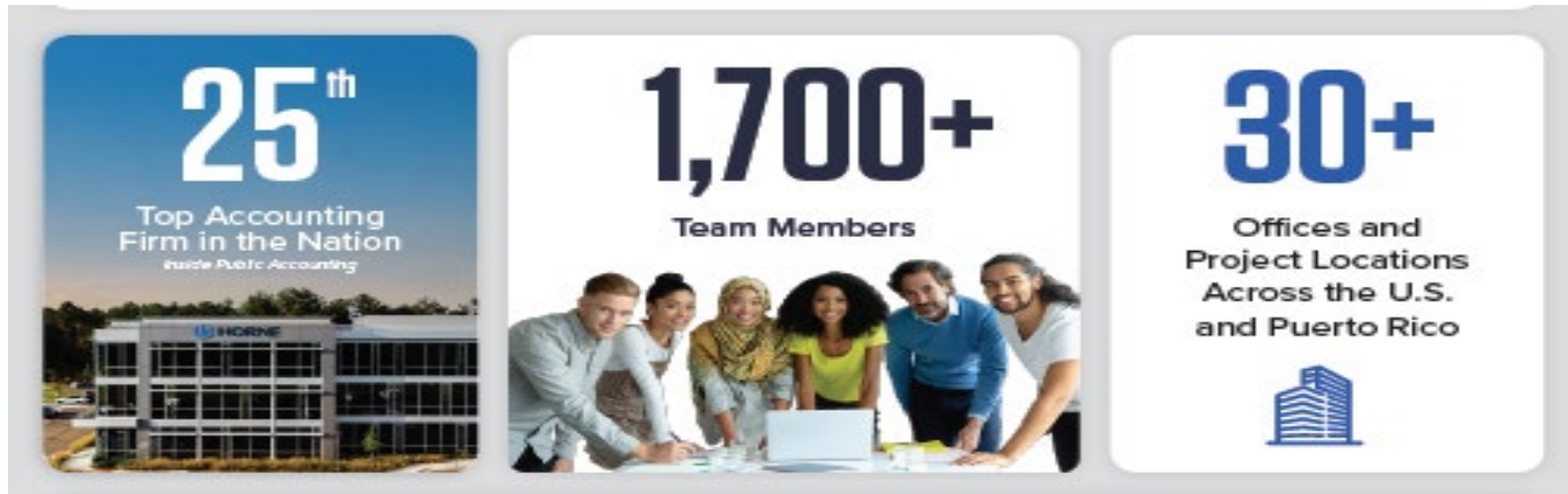
2025 Joint Spring Conference

Physician Compensation and Contracting Best Practices

*Rud Blumentritt, CPA/ABV, CVA
Partner, Healthcare | HORNE*

May 8, 2025

About HORNE



Presentation Overview

- The current regulatory landscape
- FMV traps and misconceptions with case studies
- Contract Management and Contracting Red Flags
- Commercial Reasonableness
- Compensation Salary Surveys
- DIY Valuation

Regulatory Landscape



HORNE

Regulatory and Market Factors Impacting Physician Contracting

- Complex and Highly Technical Fraud and Abuse Laws
- Strong Whistleblower Activity
- FMV and CR Misconceptions and Pitfalls
- Market Consolidation and PE Impact
- Aggressive Gov't Enforcement

Key Contracting Issues in Recent Enforcement Cases

Gov't “Red Flags”:

- Physicians paid over the MGMA 90th percentile are “red flags”
- Making more money under hospital employment than in private practice
- Physician compensation in excess of professional collections

Valuation Specific Concerns:

- No valuation or FMV support
- Using old valuations or draft valuations
- Manipulation of the valuation process or data

Compliance “No-Gos”:

- Paying physicians for the production of another provider
- Payments for services not provided

Defenses that had little impact:

- Nonprofit status
- Community need – “sole provider”
- Median compensation
- “Hospitals all lose money on their physician practices” (made by Tuomey in closing arguments)

Expected Enforcement Trends

HORNE.COM



Continued aggressive DOJ enforcement practices



Shift from “pay and chase” to early detection (data analysis, predictive analytics, trend evaluation, AI etc.)



Continued large dollar settlements in the news



Continued strong whistleblower activity



Physician compensation as a big factor for whistleblowers



Strong trend toward settlement post-Tuomey



FMV Traps and Misconceptions



HORNE

FMV Traps – 75th Percentile “Safe Harbor”

- **Concept:** “If we pay all of our physicians at or below the 75th percentile of the market, the resulting compensation will always be FMV”
- In 2021 Final Rule Commentary CMS reiterated that it has no such policy
- Origins?
- Ignores facts and circumstances of the “subject transaction”
- Statistically does not make sense

FMV Traps – Practice Profits for FMV

- **Concept:** “We are setting compensation based on the calculated net profits of the practice”seems reasonable, right?
- Physician activity alone driving practice profit or other factors?
- What other factors contribute to practice profit?
- Favorable contracts, billing practices, operational efficiencies?
- Be wary of OH allocation impact
- Should the physician benefit financially from these situational factors?
- Part of the decision, but use with caution and with full awareness

FMV Traps – Using a Competing Offer

- **Concept:** “employed physician has a higher written offer of employment from a competitor...we will use that to re-establish FMV”
- Can we use a competitor’s offer to establish FMV?
- Argument in Favor: “we are using an arm’s length negotiated rate”... “its what the market will bear”
- Problems/Concerns:
 - Using a single market data point
 - Is it really “arm’s length”?
 - Do we know everything about the offer?
 - What due diligence was performed?

FMV Trap – Referral Parties “Negotiating FMV”

- **Concept:** “We negotiated back and forth with the target physician to arrive at FMV compensation”
- Be wary of assuming that any “back and forth” negotiations with a physician constitutes “arms length” bargaining and arrival at FMV
- See Kosenske Case - “...as a legal matter, a negotiated agreement between interested parties does not “by definition” reflect fair market value.” United States ex rel. Kosenske v. Carlisle HMA, Inc., 554 F.3d 88, 97 (3d Cir. 2009).

FMV Case Studies



HORNE

Case Example #1

A hospital employed primary care physician is currently compensated on a productivity model at \$50/wRVU. A local competing hospital has recently offered the physician (in writing) \$65/wRVU to become an employee of the competing facility. The hospital CEO agrees to increase the physician's current compensation to match the competing offer, noting that this offer represents the current "going rate" in the market and thus reflects and satisfies the FMV requirement.

Are there any compliance concerns here?

Case Example #2

A hospital is recruiting a physician for employment to provide clinical services to the hospital. To establish physician compensation the hospital and the physician negotiate a rate through back and forth “arms length bargaining”. The negotiations are documented, and both parties are satisfied that the agreed upon compensation amount reflects FMV.

Do you see any potential compliance issues?

Case Example #3

A hospital employed cardiology group is requesting an increase to existing compensation. In an effort to address the physicians' request, the hospital's CEO contacts you as a HC appraiser to discuss with the group. In the meeting, the physicians provide a chart that demonstrates the number of hospital referrals the group makes annually to the hospital. The chart accurately details a 25% increase in highly profitable hospital inpatient referrals over the past 3 years. As such, the physicians believe this data supports a commensurate increase in physician compensation and further can be used to support the increase as FMV. It is noted that even after the compensation increase the hospital will still be making a sizable profit on those referrals. A "win win" situation for both parties.

Are there any compliance issues with this logic?

Case Example #4

A rural hospital has a compensation policy of paying all of its physicians based on the MGMA survey's 75th percentile regardless of referral patterns or productivity level. This is based on the long-standing principle (supported by CMS) that 75th percentile is essentially a FMV “safe harbor” – particularly for underserved medical areas where physicians are extremely difficult to recruit. For this reason, they don't believe that they have any compliance issues related to FMV or need any additional due diligence to support FMV.

Do you believe this is a sound policy?

Physician Contracting



HORNE

Physician Contracting “Fails”

- Large % of your contracted physicians have outlier compensation levels
- Inconsistent contracting practices
- Preferential contracting with high-referring physicians
- Consistent outbidding of competitors for physicians
- Failing to document support for assumed financial losses
- Long-term contracts without look-back provisions
- Not adhering to your own compliance plan

Physician Contracting Best Practices

- Compensation committee that adequately documents the basis for its determination of compensation
- Pre-transactional documentation
- Periodic overview of all existing contracts
- Rely upon appropriate data to establish FMV compensation
- The same process is used for ALL physician contracting
- Don't let your own plan be used AGAINST you!

Commercial Reasonableness



HORNE

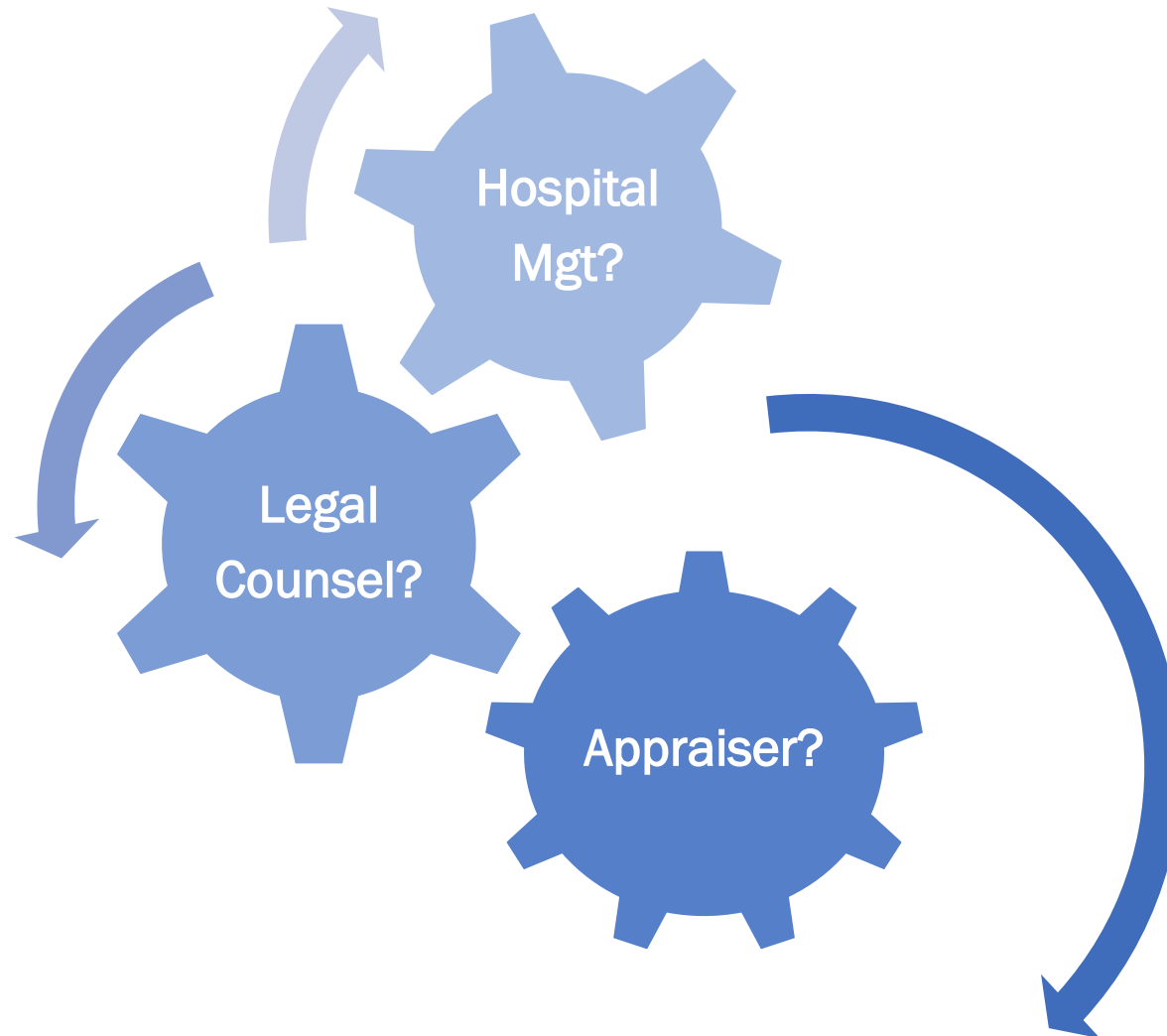
Commercial Reasonableness

- New Stark Definition of Commercial Reasonableness
- Prior to 2021 not defined in the regulations (only in the commentary)
- New regulatory definition:
 - “Commercially reasonable means that the particular arrangement further
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.”
- CMS commentary – CR Is NOT a question of valuation – separate and distinct.

Is it Commercially Reasonable?

- Is the arrangement FMV?
- Does it serve a business purpose?
- Is the level of service necessary?
- Does the arrangement duplicate existing services?
- Does it affect cost, quality, or access to care?
- Did the hospital explore other options?
- Does it further the hospital's mission and goals?
- Does the arrangement result in a loss?
- Strongly encourage "CR Checklist" for pre-transaction documentation

WHO DETERMINES IF THE TRANSACTION IS COMMERCIALY REASONABLE?



HORNE

Examples of Physician/Hospital Arrangements that Could Fail Commercial Reasonableness

HORNE.COM

- Month to month lease term for physicians when the market demand supports long-term leases
- Multiple medical directors (all paid FMV) for the same medical specialty.
- Hospital leasing physician owned real estate space at a FMV rate, but the space is not used, underutilized, or is strategically unnecessary or even a disadvantage (ex: across town).



Salary Surveys



HORNE

Key Takeaways from recent CMS commentary regarding Surveys and FMV

- Be wary of overreliance on survey data
- Use multiple surveys
- Appropriate compensation rate may not be in a salary survey
- CMS's refusal to create a rebuttable presumption or safe harbor for FMV
- Consulting salary surveys is an appropriate “starting point”
- Salary surveys may be the only determinant of FMV needed
- The arrangement must be consistent with the general market value of the “subject transaction”
- **Key Point**: Connect survey usage to facts and circumstances of the subject contract.

DIY Valuations



HORNE

Tips for DIY Valuations

- Employ a consistent method
- Pre-transaction documentation of process (not “bless the deal”)
- Pay close attention to survey data usage
- Refresh analysis regularly
- Consider reasonableness of stacking elements
- Avoid “opportunity cost” and “contribution margin”
- Documentation of commercial reasonableness
- Consider regular 3rd party testing analysis
- Develop “trigger” for 3rd party valuations
- Follow your own compliance plan!

Potential Triggers for 3rd Party Valuation Analysis

- Physicians with unique duties or skill sets
- Stacked arrangements
- Extremely productive physicians
- Unusual circumstances or practice patterns
- Specialties with a history of recruiting difficulty
- Challenging geographical or community situations (rural hospitals, HPSA, etc.)
- ANY beyond accepted internal risk assessment
- ANY business valuation
- #1 Reason – Any time your compliance plan call for it!

Questions?

THANK YOU!

HORNE.COM



Rud Blumentritt, CPA/ABV, CVA

Partner | HORNE

Rud.Blumentritt@horne.com

225.341.3197 (Office) | 601.310.7637 (Cell)

